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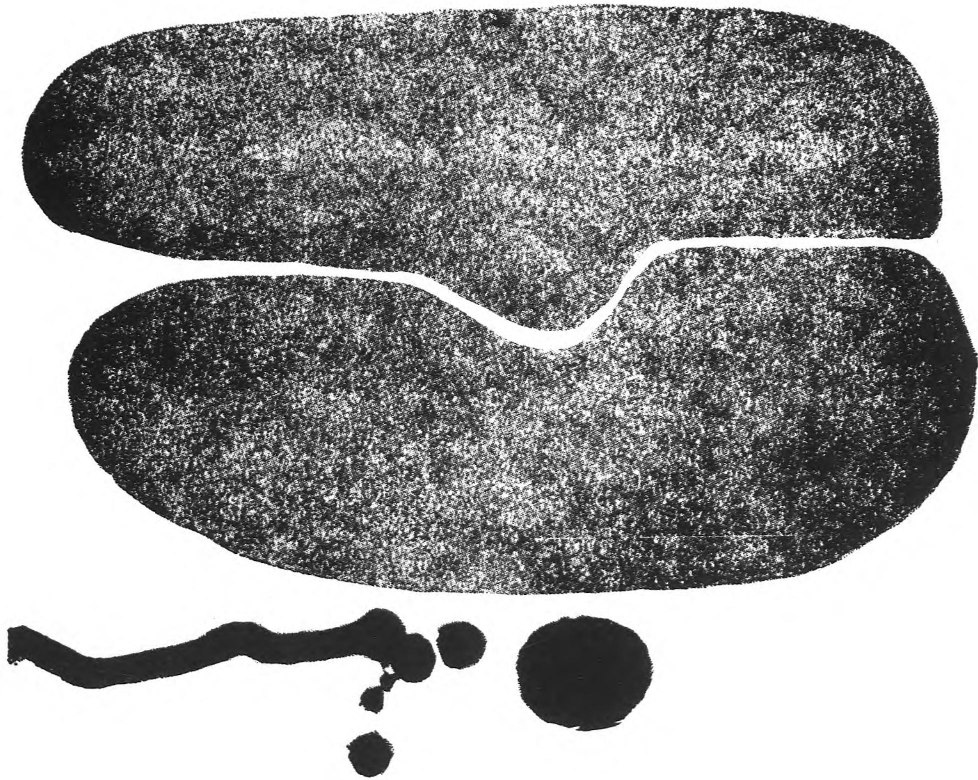

Vol. 10

JOURNAL OF THE BALINT SOCIETY

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Editor: Philip Hopkins

Editorial

It is exactly eleven years since I wrote a welcoming message for the first issue of this journal, in which I referred to Michael Balint's prediction that 'it will be very uphill work' to interest more doctors in the work he and Enid had started. He thought there would continue to be a shortage of trainers. Of course he could not have been aware of the development of the vocational training scheme which is now firmly established, and which as John Salinsky writes, employs many active Balint Society members, who are also General Practice Vocational Training Course Organisers who lead trainee-groups. In this way these groups provide trainee doctors with Balint experience as a regular feature of their weekly half-day release course.

In addition, of course, the Oxford Weekend which has now become a regular annual event also provides many new doctors each year with an opportunity to experience the value of a Balint group — and encourages them to find ways and means to start a Balint Group in their practice areas.

Furthermore, I am delighted to publish the first letter ever received in which Prudence Tunnadine reports that some 1300 doctors throughout Britain have attended the Seminars organised by the Institute of Psychosexual Medicine; this is good news indeed.

Quite recently a question was raised as to the validity of a statement made in the publication of the proceedings of the Fifth International Balint Conference with regard the possible economic savings for the National Health Service by Balint trained doctors. Here is surely an area where medical audit could well be useful, by simply comparing the prescribing costs of Balint trained doctors with others.

In her Balint Society Prize Essay, Sally Hull describes vividly how her Balint training helped her to deal more effectively with the patients who 'keep attending with problems that do not fall neatly into organic or psychological categories'. This group frequently causes huge prescribing costs unless their basic problems can be resolved. I would like to take this opportunity to congratulate her on her essay which not only tells us something of her experience as a trainee in general practice, but which also allows her to ask some very relevant questions with regard the possibilities of further research into the doctor/patient relationship.

In his paper about supportive therapy, Cyril Gill defines the terms used, and shows how effective such treatment can be.

In another paper in this issue, Katvin Fjeldsted describes her experience as a trainee in general practice, and the value of her trainee-group and shows very beautifully the changes brought about in a young woman patient, who otherwise would probably still be taking large quantities of various medications, by supportive psychotherapy. This form of treatment has much to offer many of our patients, despite the doubts cast by some doctors as to whether it is 'right' to 'make' patients 'dependant' on us.

The Balint Society
(Founded 1969)

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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.

Excursion to Maida Vale*

The influence of Balint training on medical practice

by Sally Hull
General Practitioner, Stepney, London

I remember reading with surprise a passage near the end of *Sense and Sensibility* where marriage partners are being sorted out. Jane Austen uses the device of a manservant, who has been pressed into service to describe a crucial piece of mis-information.

> 'Who told you that Mr Ferras was married, Thomas?'
>
> 'I see Mr Ferras myself Ma'am. this morning in Exeter, and his lady too, Miss Steele as was.'
>
> Did Mrs Ferras look well?'
>
> Yes Ma'am she said how she was very well; and to my mind she was always a very handsome young lady — and she seemed vastly contented.'
>
> Mrs Dashwood could think of no other question, and Thomas and the tablecloth, now alike needless, were soon afterwards dismissed.[1]

On the one occasion that Jane Austen allows a servant to participate in dialogue, she then proceeds to treat him as a mere accompaniment to the tablecloth. Throughout the novel from which this fragment is quoted the footman is not portrayed as having a significant life of his own. He remains a stereotype, unlike the members of county society who feature in the novel. The novelist's selective attention and neglect reveal much about the prevailing social views. At any time there is only a restricted section of society with whom the literate community is able to emphasise and to portray as fully developed characters.

About a hundred years later Thomas Hardy's *Tess of the D'Urbevilles* was published. There was a certain amount of critical outrage, but by and large the response was positive. The story starts with the seduction of Tess. She produces an infant, who soon falls ill and is about to die unbaptised.

> She lit a candle, and went to a second and third bed under the wall, where she awoke her young brothers and sisters, all of whom occupied the same room.
>
> Pulling out the washing stand so that she could get behind it, she poured some water from a jug, and made them kneel around, putting their hands together with fingers exactly vertical. The most impressed of them said:
>
> 'Be you really going to christen him Tess?'
>
> 'What's his name going to be?'
>
> She had not thought of that, but a name suggested by a phrase in the book of Genesis came into her head as she proceeded with the baptismal service, and now she pronounced it:
>
> 'Sorrow, I baptise thee in the name of the Father and of the Son and of the Holy Ghost.'
>
> She sprinkled the water and there was silence.

The section of the community who the author, and hence the reader, can see as truly human and identify with has become larger. The changing identity of what Raymond Williams has called the knowable community[1] reflects a process of cultural change in society. Literature has a role in articulating past changes. It also acts as the vanguard for further changes, because it can test them out in the relatively safe world of the imagination. Thus the novel, at one and the same time, reflects society and introduces change. The change which I have focused on in the novels quoted is the broadening of the knowable community. There is an increase in the categories of person who can be identified with as fully human and hence can demand a human response.

The training associated with the work of Michael and Enid Balint has reflected and participated in a similar change of emphasis within medicine, particularly within general practice. It has significantly enlarged the community of patients and illnesses with which doctors can engage in treatment, and has opened up new areas for therapeutic research which are carried out almost exclusively in the field of general practice.

Of course a number of other strands have contributed towards this change in emphasis. The formation of the Royal College of General Practitioners and the inception of vocational training have done much to raise the standards and self-esteem of general practitioners. Fifty per cent of able medical graduates now take a positive decision for a career in general practice, and this contrasts

*The Balint Society Prize Essay, 1981.

sharply with the rather depressing state of affairs described by Michael Balint in the 1950s:

> 'It is well known that most, though not all, general medical practitioners are selected negatively; that is, those who turn towards general practice do so because for some reason or another they do not feel that they can make the grade as specialists.'[2]

Another important strand in this change of emphasis is the more general retreat from an optimistic view of science and technology. The perils of relying too heavily on the power of technological medicine have been expressed graphically in Illich's *Medical Nemesis*[3], in various television programmes[4] and in last year's Reith lectures[5]. Within the National Health Service economic and political forces have created an atmosphere in which community and primary care are being encouraged, at the expense of technological medicine.

General practice is benefiting from these shifts of emphasis, but a great deal of further research into the impact of these changes is needed, such as How do these changes affect the way patients present to their doctors? How have doctors' views of themselves changed, and how does this affect what they offer their patient, and what is the impact on the doctor patient relationship of the new humanistic therapies, which are part of the shift away from technology?

In this essay I propose to examine aspects of these questions in the context of the doctor/patient relationship, the area which the Balints have opened for examination.

Change in patients

It is difficult to assess recent changes in the way patients present to their doctors, real though they are, without the benefit of historical distance. I have lived, but was not in practice, through the period of these changes. Patients now expect their doctors to respond to explicit overtures about their emotions and feelings in a way that they did not thirty years ago. In this sense, patients' strategies have altered, and their expectations of their doctor are greater: more conditions are thought appropriate for medical advice. But this new mode of presentation, this language of the 'feelings', may often be only a late twentieth century smoke screen for the timeless sensations of dis-ease which will always be uniquely personal to each patient, and will remain a challenge for the doctor to respond to appropriately. 'Anxiety', 'depression' or 'nerves' is only the current way of naming the dis-ease which the doctor is still expected to cure. Many patients expect antidepressants to ease their state of mind just as there were bitters and tonics to ease their discomfort fifty years ago. The new language and the shift to a psychological diagnosis do not prevent the doctor and patient colluding together to avoid a thorough mental examination.

But the changes have brought benefits. It is now generally accepted that bodily events might have a psychological origin, and the stigma of seeking help for psychological problems is less than it was. But these benefits may only be accepted intellectually. The desire for personal change raises ambivalent feelings, and the hope often remains that the latest technological investigation of the physical problems will be the key to the cure.

Changes in patients' expectations are related to an altered view of their doctors. Enid Balint has suggested that this altered view is related to the change of doctors' status within society, and to the shift towards participative styles of leadership, both generally, and within the doctor/patient relationship.[6] A participative style of consultation may well be the natural medium for a revealing self-examination in the doctor's surgery, but it is not enough. The training experience of the doctor remains crucial because the changes required of doctors have little to do with information and much more to do with the doctors as individuals.[7]

Change in doctors

I plan to examine two aspects of the change in doctors: first, the process of change as it occurs in an individual doctor, and secondly, the impact of some of the structural changes that have occurred within general practice.

Personal change

During my trainee year I was faced with a number of patients who kept attending with problems that did not fall neatly into organic or psychological categories. Anxious to treat them, I remember asking, among other questions: 'How do I start?', 'What do I say?', 'How is it done?'. The answers were frustrating. I was told just to listen attentively. This did not seem very helpful. Surely there were techniques to be learned before starting? But nothing was offered. Instead I was left with the patient, stripped of the usual encumbrances, mechanical or technical, which can protect doctor from patient in the field of traditional hospital medicine. Like others, I was anxious about what I might uncover. What Pandora's box might be opened? What would I dredge up from the unconscious? Perhaps I would just be a voyeur, examining the contents of someone else's trunk and then putting them away unchanged because I had neither the technique nor the personal charisma to effect change or healing. These are all reasonable anxieties, shared by many doctors. They reflect our

own personalities and the gaps in our training. And anyway, patients often tell us about things difficult to bear and about situations we are impotent to change.

If, despite all the resistance inside ourselves, we begin to listen attentively, then several things become clear. First, as Michael Balint pointed out, if the patient feels that the doctor is not really interested or is acting out of phoney motives, he will retreat.[8] Secondly, it took me some time to realise that patients would only tell me things which they already knew. Putting things into words, and telling a doctor may make them more explicit, but the initial revelations of patients are not news to them.

So, starting to listen became less of a problem. By far the largest part of it was simply being available. Questions of control and personal resources emerged again when the patient had started, and I was afraid that I would not be able to stop at an appropriate time, appropriate both for myself and for the patient. But as Michael Balint indicates, there is usually no problem in stopping; it is simply a question of not starting. The doctor or the patient can decide not to start, not to continue, or to revert to a traditional method of treatment.[9] This is not to deny that there are casualties. But equally there is a finite risk associated with even the most optional surgical procedure.

My first case illustrates the need for training in order to turn the doctor's knowledge into a practical form that can be used by him and the patient.

A few months after I began attending a Balint group as a vocational trainee, a man in his thirties was brought by his sister to see me. He was dishevelled, wearing dark glasses and although about six feet tall weighed only 36kg. He had spent some years in South America, and while abroad had had more than one admission to hospital for illnesses which he named as 'constipation' or 'anaemia'. It transpired that he had been very thin for about ten years and all that time he had felt there was 'something wrong with his inside'. His mother told me later that at the age of four he had put himself on a diet of bread and water for three weeks to frighten her. When I first saw him he was dehydrated and seriously ill. He was admitted to hospital, and I discussed his case at some length with the doctors involved, explaining that I thought he was seriously disturbed emotionally, and probably had anorexia nervosa. A few weeks later he was discharged after extensive and unrewarding investigation. The hospital summary commented, '. . . as far as his psyche goes, he appears to be withdrawn and misinformed (sic) but I am not sure whether he actually has any pathology.' The patient refused to see any other doctors but was prepared to see me for regular weighing and a chat.

This made me aware that there is serious and even life threatening disease which remains unrecognised in the hospital setting. Moreover, this patient made it clear that he was prepared to accept whatever I was providing, but would not go anywhere else for help. So I was left with someone who was very sick; I had only the vaguest idea how I might proceed. I found no prototype case history, especially of a patient who refuses all traditional methods of treatment. When he refused formal psychotherapy because it would be 'too painful'. I told him that he might kill himself if he went on like this and that he should consider the effect that would have on his family. He seemed interested but detached.

When I took the case to the group they helped me to see how angry I was with him; that I was angry because I was frightened of the responsibility of coping with such a sick man, and that I rather hoped he would go away and not bring his trouble back to me.

To my surprise he came regularly until I left the practice. His weight increased to 53kg and at times we discussed the peculiar and independent life of his digestive tract. He saw this as the source both of his illness and of his difference from others. At the same time it was his instrument of attack, by withholding or self-starvation. As I brought further instalments to the group they pointed out that my desire to stuff him full of useful interpretations, or 'rich foods', would only make him sick. He only needed enough food just to stay alive. They had to tell me it was important to remain with this patient, not to force feed him. That would have been a repetition of what his mother had tried to do.

Experience with this patient, and reflecting on the way I handled him through the group, clarified various things which had been mere head knowledge until then. Various Balint aphorisms came to life. Asking questions was counter-productive: he either did not answer or was evasive, and once an unpromising answer had been given the subject was more difficult to broach. I also learned about choosing the right time to examine different aspects of a patient's problem, and doing this with the patient. After all, a formal hospital examination had produced no evidence of underlying pathology. It had become less a question of effecting changes or of doing things to the patient, but more of observing what the patient did to me. By the end of the year it was possible to make a diagnosis.

Before treatment could continue I had also to come to terms with my own expectations of how this patient and his illness should be conducting themselves — my 'apostolic function'.[9] I wanted him to put on weight and to do so quickly! The group had to remind me, frequently, that it was his

life, his time, and that to be of any use to him I had to proceed at his pace.

My second case occurred a few months after I joined a new practice. The patients I presented to the group during this period of change reflected my own struggle to adjust to the new environment. Initially there was a period of regression. Patients and their problems became stereotypes and lost their individual nuances. There followed a period of aggressive intrusiveness, in which I was determined to get to grips with things. The way I worked with this second patient reflects this period, and my feelings that I had to 'crack him open' before I could manage his illness.

Mr R was a postman in his fifties. He had been a fairly frequent attender with a long history of intermittent back pain, musculoskeletal pains and conductive deafness, for which he wore a hearing aid. His illness began some weeks after his wife thought he looked pale and took over the gardening duties for him. He presented initially at home, and subsequently in the surgery, with acute pains in the joints: hand, shoulder and knee. They lasted a few hours and usually woke the household in the early hours. He was seen in casualty twice and even got a Casualty Officer to put him in a splint for acute carpel tunnel syndrome. Fairly extensive investigations revealed nothing abnormal, and whenever I saw him the pains were gone though his complaints were loud. His pain seemed out of proportion, and his frequent appearances prompted me to present him to the group. Initially I thought of this man as a nuisance; something had to be done because he had intruded on me through his insistent pain.

The group asked why I was so annoyed by him. They persuaded me to listen to him and to give him a longer interview. This produced a minefield of information about his early life. He described himself as 'nearly an orphan'. When his mother died his father had fostered him out with an aunt and her eight children. He told me about his wife who he described as 'very innocent' when they married. She had had a nervous illness for the first five years, seeing several doctors. After three miscarriages they adopted two children, one of whom had asthma. Since then she remained in good health, managing first to foster children, and latterly to run a housing scheme for elderly people.

Eventually Mr R was prepared, as a last ditch manoeuvre, to go along with the idea that some of his pain might be psychological. In one memorable consultation he told me about a colleague who had recently discarded his hearing aid after seven years psychological deafness caused by a bad marriage. We stumbled on together. I had not stopped looking at his joints, and did an occasional ESR. But mainly we talked about the sort of things that brought on his pains. He had always described his marriage as a 'wonderful team', 'hand in glove', but one day he described their Saturday together, the genesis of an argument, his failure to pull his weight in their team when putting up curtains, and the pain which developed.

Over the course of these consultations the severity of his pain eased. There were no more calls or night-time visits to casualty. And his wife started 'aching': first she had an accidental brush with a cyclist and then was hit by a nocturnal intruder. One day he showed me his hands again. To my surprise he had developed synovitis in his wrist and hand joints, and his rheumatoid factor had become positive. Three weeks later he presented with a ruptured popliteal cyst and had to spend some time in hospital.

What was happening here? Was it just that I had failed to make an early rheumatological diagnosis? (He knew that I held a hospital post in rheumatology.) Or had he developed arthritis as the only acceptable solution? It certainly changed the direction of our relationship, and eased the conflicts with his wife. I remain puzzled about the enigmatic relationship between this patient and his disease, and about my own part in its emergence. Could this dilemma have been solved otherwise?

The doctor/patient relationship reflects the doctor's state of well being and maturity. The changes involved in my transition from hospital to trainee and then to principal were reflected in the different ways in which I handled cases. If this is generally true then working with trainees and doctors in their early years should offer scope for examining particular aspects of the relationship. For example, why do particular patients always gravitate to the trainee? Why are little known doctors better at handling certain cases than the permanent partners, and so on?

Structural change

As well as the changes of location and status which beset the individual doctor, there are organisational changes which affect the way general practitioners practice. Since the 1960s an increasing number of doctors have entered into partnership with others or have formed group practices. Michael Balint used to talk about the general practitioner being homesick for his mother hospital.[10] If one is so inclined, it is easier in a large partnership or group to mimic the hospital and to become specialists.

Another major change since the 1960s has been the introduction of attached ancillary staff, which has given rise to the concept of the primary health care team. This development means that the general practitioner now has more treatments at his disposal than previously, in the form of people to call upon.

Of course this can be an advantage, and often works well. But on occasion the general practitioner can retreat by placing his head below the parapet provided by his team. He can hand out prescriptions for other people's time just as he used to hand out tranquillisers. As in the hospital, the patient then becomes a case for which the doctor retains only a partial responsibility. The following case illustrates the point.

A young woman who came to see me was an insulin-dependent diabetic and had never taken much interest in adequate control. She came because of urinary problems, but it became clear that she was miserable because her boy-friend had left her six months ago, and their pregnancy had been terminated. Her first visit was at the time the baby would have been born. She found herself looking into the prams and was unsure why she was so miserable. We talked about her diabetes and why her weight was increasing. I suggested that she see the diabetic community nurse who is attached to the practice. A few weeks later the nurse reported that she had been unable to make much headway. Although she had visited several times there had been no reply even when the lights were on. The patient came back and asked me to stop the nurse coming. She felt she was prying. I 'knew her case' and she would bring the blood samples to me. I had written the prescription on the wrong pad, so that a good medicine had become an intrusive irritant. Patients choose with whom to discuss their problems, and doctors should be prepared to respond.

This case, and the patient's decision about who she would talk to, introduce the wider issue of who else in society, apart from the doctor, has responsibility for the patient's illness? And that brings me to my final question, how have the 'new therapies' influenced the doctor/patient relationship?

Challenge of the 'new therapies'

It is a truism that yesterday's revolution becomes today's *status quo*. Has a new, conservative orthodoxy of Balintism emerged? Do doctors want, or need, the same sort of training now as thirty years ago? Then as now only a proportion of doctors will ever want, or be able to make use of Balint training.[2]

There have been some changes. General practitioners now lead groups without undergoing analysis, and groups are starting without access to trained leaders. However, the challenge remains of involving a second generation of doctors, and of helping them to recognize the need for 'Balint' training.

But the greatest challenge to the new orthodoxy of Balintism comes from the new therapies, the therapeutic movements loosely grouped together in the 'humanistic psychology' or 'human potential' movements. These have emerged as a reaction to psychoanalysis. They emphasise various aspects of analytic therapy, trying to correct what their protagonists see as limitation and bias. They depart from traditional practice by emphasising the expression of feeling at the expense of understanding. Their holistic approach is demonstrated by their recognition of conflicts and tension in terms of bodily sensations, and by expressing and dealing with these in action as well as words.

A variety of group experience is now advertised, both for laymen and professionals. Many are undoubtedly freakish, many rely on cathartic techniques with little follow through. In this *Turtle Diary* Russell Hoban caricatures the problem."

> 'The place was Maida Vale. The people had long hair and wore sandals which they mostly took off. There were a lot of good looking feet in the crowd. The bearded men looked like Great Men of History from the neck up: Darwin, Pasteur, Mendeleyev, Faraday. From the neck down they look like layabouts . . . . More than half the men were boys and more than half the girls were women who looked as if they'd seen a good deal of a certain kind of life and had cooked many hundredweights of brown rice. Oriental pillows on the floor, Buddhist and Zen books on the shelves, the I Ching, Laing, Castenada, Hermann Hesse, the Whole Earth Catalog. Smell of old incense in the air . . . . She began to tell us about her therapy while some of the people in the room sat in the lotus position with very straight backs and others held their heads. One girl wailed a little now and then, another muttered the whole time.'

In spite of the Messianic fervour, there is something important going on that cannot be ignored. More so as small group experience is becoming common for many general practitioners, particularly those involved with vocational training. A distinctive feature of the new therapies is their emphasis on non-verbal techniques. Of course doctors have known and used these centuries. But the challenge is to examine *how* we use them. We all know the significant difference it can make to be examining a patient while talking to them, the importance of touch to a dying patient, or one with skin disease. Training and research needs to be extended into these therapeutic manoeuvres as they occur within the doctor/patient relationship. Surely this is another aspect of Michael Balint's innovative concept of the doctor as drug. Research is needed into the indications and dosage.

There are problems with the methods used by these therapies, whether in new-style training groups for professionals or in therapeutic groups for patients. (Indeed in many groups these categories are not as distinct as they are in Balint groups.) Confrontation techniques can amount to no more than being clever 'detective inspectors' about emotions rather than facts. If a trusting working alliance is not achieved then techniques of emotional release may only be first aid. Many of these 'new' groups rely on an intensive spell of work lasting only a few days. But personal change occurs slowly. Patients need to 'live with', and consolidate in real life the changes facilitated by their doctors. Similarly doctors need to consolidate the changes facilitated by their groups. As Enid Balint has indicated, patience is needed because there are no short cuts in the learning of a skill.[1] In both traditional Balint groups and these 'new' training groups the quality of the leadership is critical. The aims are similar although the task may be different. Michael Courtenay has outlined two of the aims of leadership in Balint groups equally apply to 'new' training groups: first, to protect doctors from personal over-exposure in the group ambience, and to prevent it turning into a theraputic group and secondly, to allow every doctor in the group to come to understand something about himself as perceived through his relationship with a number of the patients presented.[7]

Conclusion

Enough historical perspective exists to assert that the doctor/patient relationship has undergone significant changes since the 1950s. They include both personal and structural change within general practice, reflecting a shift of attitudes within the society. The changes throw up a number of questions about future developments, both for general practice and for the role and style of Balint training. For example, how can the primary health care team learn to operate without fragmenting the patient? How can the special experience associated with trainees and the early years in practice be used to examine particular aspects of the doctor/patient relationship? How can the best of the 'new' therapies be incorporated into general medical practice? Should their techniques be used on doctors to facilitate their relationship with patients, or should doctors be using them on patients during the consultation? These are areas in which the research and training methods of Balint groups could be applied during the next thirty years.

(The leaders and members of the group I attend will recognise some of this material. They have helped me clarify much of it, for which I am grateful.)

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Supportive Psychotherapy in General Practice — A Case History

by Katvin Fjeldsted,
General Practitioner, Borgarspitalinn, Reykjavik, Iceland.

An account is given of the management of an emotionally disturbed young woman during a general practitioner's trainee year. The problems presented in this kind of supportive therapy are discussed.

Patients with emotional or psychosomatic problems constitute a fair proportion of every general practitioner's workload. Sometimes such a patient is able to reach an understanding with the doctor very quickly. There is a rapid development of trust and insight and further progress looks promising. However the general practitioner, especially a trainee is then faced with a number of doubts and difficulties. If there are physical symptoms, to what length should efforts to exclude organic disease be taken? At what point if any should psychiatric referral take place? Should regular appointments be offered, and if so at what intervals and for how many weeks or months? Once started, how does one stop? How does the doctor cope with the responsibility to take on a problem of this kind without support? What does the doctor actually do?

The following case history describes a patient I treated during my trainee year and with whom problems of this kind were encountered.

CASE HISTORY

Miss A., aged 21, came to see me, accompanied by her mother. I had seen her twice before with a minor gynaecological problem and those two consultations were fresh in my memory. She had told her mother that I was the doctor she wanted to see, perhaps because I was a woman, and perhaps also because she had decided that I might be able to help her. She had also made an impression on me and I had made a note on her card that there were definitely some problems in this girl's background that she might wish to talk about.

To say that she was accompanied by her mother is misleading. She was actually brought by her mother and it struck me as if she were a naughty child brought by mummy to see the doctor to be put right. The problem as presented by mother was: There is something wrong with the child's tummy, there must be something serious inside and could she be sent to hospital? She doesn't want to go to college, she doesn't want to eat her food, has lost a stone in weight and keeps vomiting. This has been going on for three weeks.

I kept looking at the girl who sat silent and hunched on the chair, thin, tall, willowy. There was something about her which made me feel that there was more to this than met the eye. Somehow the whole set-up and the way the problem was presented warned me not to be too quick to collude with mother which she appealed for me to do. After a short talk, mainly dominated by mother, I asked the girl to go into the examination room, both to have a closer look at her and get away from mother's observant eyes. Physical examination was unremarkable and my impression was strengthened that this illness was not of a physical nature. I decided that investigations or hospital referral would be counter-productive, and would only reinforce mother's attitude. I asked the girl if she would like to return later that afternoon when I would have more time. This she did despite her mother's lack of enthusiasm. In the following three weeks I saw her ten times and a picture of a very disturbed family gradually emerged.

She is the only daughter of a Jewish couple, at that time in the process of divorce. She is a student, bright and sociable, with three boy-friends all of whom are Gentiles and not approved of by her family. She has two younger brothers and there is a lot of sibling rivalry. Her mother's family looks down on her father's family and feel that her mother had married beneath her. Many people in mother's family are not on speaking terms with one another. The divorce proceedings have brought an extra strain on the household as both parents still live at home but don't share anything, not even the toilet roll or the toothpaste. Her father had moved into the girl's room and she in turn went into her mother's bed where she had been sleeping for a month at least, when she first saw me.

Gradually the physical side of things slipped into the background, the vomiting became rarer and less important. At one point, I gave in to family pressure and made a psychiatric out-patient appointment, but

the waiting time was six weeks. During this time we continued meeting twice a week for an hour each time. Sickness and vomiting were out of the picture by now and the main focus was on her relationship with her parents and also on her college and group of peers. She expressed a strong desire to move away from home but in spite of those opportunities which arose she remained firmly in her mother's bedroom. At times she was unwilling to talk, but after I stayed silent with her a few times, I changed my approach and directed the discussion to a less emotional topic, which usually started her talking again.

Two weeks before the hospital appointment, I tried to alter my purely supportive role to a more interpretive one in which I talked about our doctor/patient relationship. After two sessions she became angry and silent. Maybe the timing was premature or the introduction less subtle than it should have been, and the following consultations were characterized by a lack of contact.

Then came the out-patient appointment and at the psychiatrist's suggestion I went with her. He put her on the waiting list for admission for three months, mainly for a change of environment. She would be allowed to attend college from hospital, and I would continue seeing her. There would probably be no other form of therapy.

Following the appointment Miss A. expressed resentment directed at the psychiatrist; she was angry and thought he was stupid. She again stopped eating, and did not talk to anyone. After further deterioration she was admitted to hospital three weeks later, where she remained for three weeks. I visited her as planned and our sessions were increasingly positive.

After discharge on her request, she moved in with a friend, resumed some social activities and returned to college. There were pressures on her to return home as her mother was now on her own, her father and two brothers having moved out. Her presence at home would make a difference as regards possession of the house in the divorce proceedings, but she did not want to be used like this and made arrangements to get a place in a hostel near her college.

My trainer looked after her when I had to go away for a while. All was going well until her best friend took an overdose of antidepressants and died. This brought Miss A straight back home into her mother's bed, even though her own room was now available; and she thought and talked a lot about suicide. She was very distressed and her parents found this difficult to bear. A domiciliary consultation was arranged and another psychiatrist recommended compulsory admission, but he managed to scratch the dining table with his bag and thus alienate her mother!

The threat of admission distressed mother and daughter alike, and in spite of my trainer's anxiety about the possibility of suicide she was not admitted. Her mother undertook to care for her at home with frequent visits from my trainer. The girl now decided that she was possessed by an evil spirit from an ex-boy-friend who incidentally had also been the dead friend's boy-friend for a short period of time. The Rabbi was called in and there was talk of exorcism. Miss A was certain that the boy-friend was to blame for her friend's death and her own illness, and started harbouring murderous thoughts towards him, 'He can't be allowed to get away with it'.

This was the situation which I found on my return. She then started coming to the surgery again for our regular consultations, initially accompanied by her mother and then on her own. We spent a lot of time talking about her deceased friend and their relationship, mutual interests, her friend's illness and suicide, the good times and the bad times. This was a difficult phase of bereavement and once again my ability to carry the anxiety and the responsibility was severely tested. The threat of suicide was always in the background. Two months after her friend's death we decided to cut down to weekly sessions and for the following two months she improved immensely in body and spirit.

I started preparing her for my departure, but three weeks before I was due to leave, she took a small overdose of Valium and was admitted to hospital. This was four months after her friend's death. She was in hospital for five days and was discharged after reassuring the psychiatrist that she was no longer suicidal. The following two weeks were my last in the traineeship. We continued meeting, the sessions were again mainly spent on her dead friend, and on the future. She was planning to return to college and work on her thesis. It was arranged that she would continue seeing my trainer on a regular basis after I had gone.

DISCUSSION

Physical Symptoms:

The decision not to investigate or refer this patient because of her presenting physical symptoms was proved to be right by events. It was arrived at mainly by intuition and because of the absence of physical signs. The way in which the patient's mother insisted that the illness was of a physical nature, and how passive the girl was during the initial encounter made me feel I must not collude too easily with what was presented. Investigations would have been difficult anyway because the girl refused to let anyone near her with a needle!

Psychiatric referral:

This patient and I rapidly formed a special relationship. The question of referral is not a simple

one in such a relationship. If initiated by the doctor, it can be interpreted as rejection by the patient. If referral does not take place, the doctor undertakes to try and solve the relevant clinical problem, thus taking full responsibility and shouldering the patient's anxiety, trying to shelve his/her own. This may have a satisfactory outcome and it may not.

Some problems are of a chronic nature, have no obvious solution, and will be with us for years to come. Referral may lead to solution to the problem; suggestions to the general practitioners about the way to solve it or, alas typically, 'I have reassured the patient', which makes most general practitioners shudder. In a case of this nature it is unlikely that a psychiatrist would have been able or willing to undertake regular long interviews for psychotherapy in a National Health Service setting.

In the event the psychiatrist consulted was content to advise, offer inpatient facilities where needed and let the general practitioner carry on. This seemed to be the most satisfactory solution.

How long should one go on?

In this case the relationship was limited by the ending of the traineeship. Twice a week seemed to suit both of us initially, and was cut down to weekly sessions only after a considerable time. Holidays were covered by the trainer and the final separation carefully prepared. It was probably not coincidental that the patient took a small demonstrative overdose shortly before the relationship was terminated.

What does one 'do'?

Here it was mainly a question of continuing interest and willingness to take long term responsibility, to listen and show concern. The relationship was at times put to a severe test, arousing anxiety, and making demands which were not easy to shoulder. For a while I tried to change my function to a more interpretive one, but this was unsuccessful and soon rejected. In retrospect, it was perhaps unnecessary. Once she realised that I was going to see her regularly and could tolerate her distressed feelings, there was considerable relief and a gradual improvement.

How to share responsibility

Short of refering a patient for a specialist opinion there are few ways open to the general practitioner. For the trainee, and experienced trainer and a peer group are of most value. In my case both proved very valuable. This patient was discussed and followed up with interest in the local trainee group, arousing the same anxiety that I myself experienced. my trainer and I spent a considerable amount of time discussing this case. In addition the psychiatrist was very supportive.

The outcome was that this patient, in spite of severe emotional and psycosomatic problems was treated in general practice, and in spite of numerous crises managed to return to normal functioning in society.

At the time of writing, eight months after our last session, she has finished her final term at college and has completed her thesis for an honours degree. Her gastrointestinal symptoms have all settled. She has resumed normal social activities. Although she is still mourning her dead friend and is emotionally vulnerable there seems to be grounds for cautious optimism about her prognosis.

FOLLOW-UP REPORT IN APRIL 1982

She completed her college course in 1980 and was awarded a 2nd class honours degree. She had hoped to do postgraduate work but was unfortunately unable to get a grant for this. There have been no serious health problems in the last year; she now seems to be eating normally and there is no longer any family anxiety about depression or suicide. There have been a number of minor physical symptoms but she has shown no interest in possible emotional causes! She is still living with her mother but has a reasonably active social life.

What is supportive therapy?

by CYRIL GILL
General Practitioner, Hampstead, London

After a few interviews with a patient recently, I felt he might benefit from something more intensive than I could given him, so I referred him for psychotherapy, but I got a letter back saying 'I think the kind of supportive treatment you are giving him is all that can be done for this patient'. Now this feels a bit of a put-down for the patient and for me, though I don't think this was intended.

We all tend to look down on anything that is not 'a cure' or 'the best'. But the concept of 'cure' or 'fail' is clearly inappropriate in traditional medicine, and is even less appropiate to a patient's emotional life. Naturally all doctors want patients to get better in some way, and that goes for psychiatrists too.

I once joined in a teaching session for medical students in which the psychiatrist was talking of the dangers of being trapped by dependent patients into chronic relationships, instead of giving them treatment of some kind. If they would not take their treatment one should send them away he said. In general practice of course, as I pointed out, this is just what one cannot do. Being available for someone who wants to see you is the essence of it all. So the general practitioner may aim for cure for the few, for making some people better, but for a large number of people the doctor may be just keeping them where they are.

This apparently unglamorous pool of patients must include some for whom we may well be missing opportunities for something better; we may even be making some of them worse. There are some, I hope, who are kept going by their doctors in an acceptable compromise with their problems, with a supportive relationship, whatever that may mean.

If we look at the vocabulary used in this type of interaction:

Support is an acceptable word. It is all right for general practitioners to say they are doing it.

Dependency by the patient on the doctor. This is a less respectable term. Though obviously patients must be dependent on the doctors who are supporting them. But it is definitely frowned on if the doctor or the patient is enjoying it at all, or if it goes on for too long.

Manipulation is a dirty word, implying that patients are making doctors do things that they do not want to do, or do not understand. The bargain between doctor and patient has not yet been properly struck.

Collusion is an even dirtier word, implying that both doctor and patient are playing gratifying games with mutual deception.

But support, dependency, manipulation and collusion are not very clear concepts and have vague end points from each other. I wonder if one can make a list of the essentials in an acceptable chronic supportive relationship, i.e. one in which the patient does not unfortunately change appreciable, yet attends the doctor frequently. In this list I will surely have missed the points relevant to my own blind spots, but here it is:

> The doctor must know, to an adequate extent, what is going on. He must be aware of his own gratifications (if any) in the situation, and subordinate them to the perceived needs of the patient. The patient has the right to remain distant from the doctor, but the doctor must always try to understand the meaning of this distance, and of anything else the patient is saying and, whenever possible, to share this understanding with the patient. The doctor must always be on the look-out for a sudden change in the relationship, which might give an opportunity for something new.

In the book, *Six Minutes for the Patient,*[1] the authors were full of enthusiasm for this sudden change, or golden moment, that could make a valuable change in the patient's feelings, and we have been trying to live down this enthusiasm ever since. By contrast, the book, *Treatment or Diagnosis,*[2] concerning patients who get repeat prescriptions, shows perhaps excessive self criticism of the doctors concerned. They describe the doctor / patient relationship in such cases as a compromise between on the one hand a patient who wants something in life which he is unable to get for some reason, and on the other hand a doctor who has found a prescription that will keep the patient quiet. Peace between doctor and patient is bought at the price of a prescription that is often deceitful, and a damping down of the patient's problems.

The research group who wrote *Treatment or Diagnosis,* focused on these repeat prescription

cases, and they were somewhat ashamed of what they found. I would suggest that the interaction, 'supportive treatment' or 'repeat doctor' is just as common as 'repeat prescription' and that it merits closer study. Indeed in this book, we see that the authors wrote, 'in the next phase of our research we shall try to devise methods of replacing the repeat drug by a sympathetic understanding of these patients' individual problems; that is, psychotherapeutic methods that would allow the patients to remain at a distance from their doctors that they feel to be safe and tolerable. We know that this will be a long and arduous task and this book is an interim report (p.144).

I hope we may take up this challenge, starting perhaps from the difficulty that if we allow patients to remain at a safe and tolerable distance, we must accept that there will be some who will stay there whatever therapy they are offered. Perhaps I can now define the group of patients who are getting chronic supportive treatment or 'repeat doctor' in just this way. I think that I can pick out many from my own experience.

These are patients whom one sees regularly, or more often in recurrent bouts, where we find we are going over similar ground over the years, and where there is little discernible improvement in the patient's condition, though obviously there will be minor changes. There may be quite a lot known and shared between doctor and patient, and there are probably strong feelings involved. The patient may be using the doctor as a token of some important figure, parent or lover perhaps, where there has been imperfection in real relationships, and the patient may carry the doctor about in their minds for 20 years or more, as an idealised substitute for a real relationship. This is a big responsibility if one looks at it, and I am afraid that one will find a few cases where the doctor's gratification, or blind spots, match the patient's problems in a *folie à deux*.

There will be other cases where the doctor lacks some essential insight into the relationship to make it more useful, and I hope that there are some where there is a useful compromise with an insoluble problem. The criteria for evaluating such relationships are not really very clear at all. There is always the uncomfortable idea that somewhere there is to be found a doctor to cure every patient, but I doubt if this is valid. In the group of cases I am describing, doctor and patient may get stuck in many types of interaction. One might roughly summerize some of them to include:

> Look after me like a child, but tell me I am grown up; or Keep on trying and fail, so that I can respectably fail too; or Approve of me, though I am no good really, but don't you dare to agree with that; or Give me something so that I won't need to bother you so much.

Perhaps the commonest would be some form of interaction, 'Help me, but don't get too close, or something bad will happen.' All these descriptions of relationships suggest a mixture of anger, fear and guilt which cuts people off from real relationships, a problem which can usually be fairly easily traced to unresolved childhood conflicts. In times of stress, a conflict is brought to the doctor and re-enacted in the relationship. In some cases perhaps the doctor's understanding allows temporary regression. The understanding would have to be accurately and skillfully handled with a willing and able patient, to enable him to resolve the conflict and advance, but something less accurate and less skillfully handled may allow the patient to recover from the crisis back to some sort of compromise. It follows that it is usually the patient who is initiating and maintaining these types of contacts, and it is the general practitioner who is limiting them. Presumably the thing that we should watch out for is the patients we are not handling very well, but who are willing and able to resolve the conflicts with a different approach.

I well remember a Welsh couple I saw repeatedly for 10 years until they returned back to Wales. He was a caretaker with hypertension which was controlled without any problem. His wife, who was ten years older, was incurably deaf. The two of them always came together, and I never once visited them at home. Everything was extremely respectable. He looked after her with great devotion, but I doubt if they had any sex life. I don't really know because we could never discuss anything personal, except for the delights of rural Wales or his wife's many and shifting symptoms. Most of these stopped politely at the waistline, and, he always turned his back if she had to undress for examination. Sometimes I had to investigate her, but mostly I got away with harmless cheap remedies such as Vitamin B, or Mag. Trisil Mixture.

I clearly had to keep on trying to treat her and fail, so that she remained too ill for any unseemly intercourse between them, I suppose. Their previous doctor had been a conscientious man who kept impeccable notes which nevertheless showed his exasperation at this couple, whom he had tried to separate, investigate and train to be reasonable. I was greatly helped by hearing *'Under Milk Wood'* on the radio for the first time, while I was struggling to get to know this couple. It enabled me to imagine all the unspeakable thoughts which this Welsh couple were too respectable to allow themselves. They wanted a general practitioner who would not try too hard, and who could tolerate their medical games. This is very nearly a repeat prescription case, but what they preferred was a doctor who repeatedly failed to cure the wife, and the prescriptions themselves were irrelevant.

When patients give up an illness such as asthma in exchange for a more honest dependency on the doctor I must confess that I find the next stage often very difficult, and they may remain dependent on me. For example, a 40-year-old woman with a difficult background of childhood rejection and adoption, used her asthma since childhood to get attention and avoid problems and troubles. Doctors have always been important figures for her. When I first met her 20 years ago she was having severe asthma as her brief marriage was breaking up. We were able to share the understanding of her deep mistrust of the close relationships, which she so desperately wants. Since then she has used me regularly in crises, and tells me her successes as well as her disasters. Her asthma has stopped completely, but she remains promiscuous and dissatisfied with her life. Work and hobbies are valuable to her, and she has other people besides myself who support her in various ways, but her relationship to me is extremely important, because it is intimate yet controlled; not too close and not too far, and, above all, it is a longlasting relationship. This is one factor that makes general practitioners so important compared to similar but briefer professional contacts.

A rather more complicated case is perhaps typical of many which we all carry. She is a 50-year-old woman with two failed marriages and two grown up children. She lives alone in a large house where she brought up her children. Her own mother had psychotic breakdowns in crises, and so does she. While her children were young and at home she remained well, though the marriage was poor. Presumably the constraints of being an active wife and mother were helpful to her in preventing psychotic breakdowns, at least. Now she lives alone with a typewriter and a telephone, trying to keep herself alive. She is holding back intense anger at her last ex-husband, who is said to keep ringing her up and abusing her.

At about 18-month intervals she goes into a borderline psychotic state, where she holds back bad feelings and tries to make everyone happy. I always know when this is happening because she comes to see me with a false smile on her face, saying that she is not going to get angry with her husband, and she is not going to kill herself, and she must protect her children from the knowledge that she is getting ill again. Often she rings up her children on these occasions to tell them that she is all right, and they ring me up to tell me that she must be getting ill again. In these bad times she usually walks around my surgery holding back intense feelings, which I have to help her let out and contain. On two occasions when I was not around she had an acute psychotic episode, running out into the road. On each occasion the police took her into hospital on Section, where she promptly discharged herself. She does not like drugs, but gets through her psychotic bouts in a week or two, mostly with telephone conversations with me.

There are other 'repeat doctor' patients, where I am more uneasy about my interaction. These include younger people who repeatedly get stuck in the same groove. They may take on too many burdens, then fail and come to be looked after for a while, or they may choose the same kind of unsatisfactory sexual partner repetitively or some conflict of aims may lead them to defeat their own efforts. One may see the reason for this, but they only want to do minimal work at the problem. Half the patients I see who pour out their thoughts and feelings, once or twice, disappear just as I think they should go on. Sometimes no doubt they are right to do so, but often they return a year or two later and pick it up after another mess-up.

One woman in her forties with acne excoriée, can share with me that she is scratching and disfiguring herself because she does not like herself, and she knows why. She is obsessional and extremely lonely, and she feels herself to be unlovable, and resents it. She took time off work recently with a backache which seemed to be related to resentment at work burdens. She overworks to gain approval then suddenly it all gets too much. She acknowledged this in quite a good interview, and was able to relate her backache to these problems, but she was half-an-hour late for her follow-up appointment and kept her waiting another half-an-hour. She was extremely angry because, she said, I had implied that she had been imagining her backache. I let her pour it all out and she expressed anger at he employers too. She snatched up the final certificate, and did not turn round when I offered her another appointment.

Two weeks later she made another appointment but failed to come. Then she made another one and kept it. She told me that after the previous interview she had gone to work early when nobody was about, she had smashed a milk bottle hard against the wall, and left the mess there. Nobody at work suspected that it was her, and they thought they had a poltergeist. It made her feel better. I said perhaps she would like to throw a milk bottle at me too and at this she looked surprised and said 'No, no'.

She finds me very kind and I am the only person she can talk to. She is torn between seeing me as an authoritarian figure that makes her very angry, and as someone who seems to be confused and vulnerable like herself with whom she can identify. She feels a lot better after such interviews and usually makes another appointment to come and talk to me again. But she fails to keep it, and in six months or so we go over much the same sort of thing

all over again. Unfortunately if I try to organize something more for her she resents it and will not co-operate. I have the uncomfortable feeling that this patient could work through some of this, but I cannot get the key to unlock this exciting see-saw relationship which mirrors all her other problems from early days.

Now I know that I am not really suggesting anything new, but I feel that a group might set out specifically to look at these types of cases. I know many of my colleagues have referred to such ideas. For example, Aaron Lask read a paper on difficult families at the first International Balint Conference, where he suggested that the doctor became one of the family.[3] Stephen Pasmore talked of getting patients back 'on course',[4] and Erica Jones referred to patients who want to be left alone, then picked up again from time to time.[5]

All these ideas imply something that is certainly not static, nor does it advance much if at all, but the patient seems to reach an uneasy compromise relationship with the doctor, where the problems are kept alive, but somehow made bearable, but usually nothing more. Perhaps for some of them, compromise could be improved upon. For the doctor many of these cases are unsatisfactory. He may either overvalue his part and feel that he is really as marvellous as the patient's image of him, and that he alone can keep the patient going. Or alternatively he may feel that he is being pushed into medical games which are grossly insincere, especially if the patient's compromise includes somatisations and manipulations. Either way, the doctor would need much help and encouragement to look at this work and improve on it. I suspect it would be often the doctor who needs to change more than the patient, and that this could involve shedding therapeutic zeal and apostolic function, and tolerating the patient's own very limited aims.

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Personalia

Dr Jack Norell who until recently was the college dean of studies, deserves our heartiest congratulations on his election to the Fellowship of the Royal College of General Practitioners.

Congratulations are also due for his appointment as editor-designate of The Practitioner.

Correspondence

Dear Sir,

In your recent issue it was noted that disappointingly few new Balint groups were working. I wonder whether our experience in the Institute of Psychosexual Medicine may throw any light upon this? We are, in origin, a sister organisation, for in the early fifties it was to Michael Balint that a group of, then, family planning doctors turned to study clinical events with patients revealing psychosexual problems to them in that setting; whether in clinics or general practice.

From these beginnings Tom Main took over the training. Some 1300 doctors throughout the British Isles, with a few from overseas, have to date joined our seminars which work on Balint principles. In 1974 when the NHS took responsibility for family planning and its training, we continued as the Institute of which since then I have been Director of Training. At no time since then have we had less than 200 doctors in training seminars at any one time. I would not wish in reporting these simple facts to sound as though 'anything you can do we can do better', but the contrast in demand and experience does perhaps require understanding. May I offer a few comments as food for thought?

Firstly, while Michael Balint himself sent forth a few of his 'old hands' to lead their own groups, it was only when Tom Main recognised that the demand for training must exceed the supply of experienced leaders, that our now pyramidal and nationwide training scheme could develop. Dr. Main led a leaders' workshop, as I believe does Enid Balint now, where 'beginner leaders' could study their leadership problems. We have thus, twenty-five years on, reached the stage where some of us who were 'beginners' then have long since become responsible for the 'breeding' by supervision of another generation of leaders in our own areas. In some places we have aready skilled young leaders who, in Yorkshire and Newcastle-upon-Tyne for example, will ere long be competent to train still younger leaders of a fourth generation. of course we are never satisfied with the quality of our leadership; try constantly to examine, review and improve this. But continuity, even through a minority, does seem assured, from our single original source.

Secondly, the problems we study are on a narrow front; not very narrow, but confined to psychosomatic problems in which the patient may reasonably expect of the doctor genital examination, as well as emotional understanding based upon the doctor/patient relationship. Further we study only the one-to-one brief encounter (with follow-up of course) rather than, as is necessary perhaps in the original truly 'Balint method', the lifelong relationship which a general practitioner has with his patients and their families. Yet in my time as Director, more than half of our new candidates for training have been general practitioners, despite the continuing interest of family planners, community health doctors, gynaecologists, venereologists and the occasional psychiatrist. Is it possible that the 'Balint experience' is more readily acquired; or more readily acceptable; when the study of the living events of doctor/patient interaction are thus concentrated on a narrow but deep focus; of, thus, self-evidently practical value in everyday practice which is quickly appreciated by those who have ears to hear? (We must all agree I am sure on the futility of evangelism towards those who have not the ears to hear. Balint work is not everyone's up of tea any more than ENT or obstetrics are everyone's cup of tea; nor within everyone's capability; nor should we expect it).

I noticed that towards the end of his life, Michael Balint's own groups were tending to study concentrated topics; requests for abortion, for example, or the care of the dying. Perhaps your readers may find these observations worthy of discussion.

Dr. Prudence Tunnadine, Director of Training,
Institute of Psychosexual Medicine,
111, Harley Street, London, W1N 1DG.

Dr. Tunnadine's letter was shown to members of Council, and Dr. John Salinsky has replied:

Dr. Tunnadine notes in her letter that the Institute of Psychosexual Medicine has over 200 doctors in training at any one time whereas there are 'disappointingly few' new Balint Groups working. The picture is less disappointing when we consider that many active Balint Society members are also GP Vocational Training Course Organizers, and are leading trainee groups. These groups provide trainee GPs with Balint experience as a regular feature of their weekly half-day release course.

In addition the Society's annual Oxford weekends have attracted a great deal of interest from other Course Organisers who would like to use the Balint Group method to help their trainees to learn about the doctor/patient relationship. These trainee doctors, like the psychosexual trainees are at a stage in their professional careers when they are particularly keen to develop new skills; I think that this is the reason for their receptivity to the 'Balint Experience' rather than the depth or breadth of the field being studied.

Book Reviews

Under the Doctor
by Stanford Bourne, 1981. Avebury.

This book results from the work of a group of physiotherapists who weekly for one and a half years under Dr Bourne's leadership.

The first part of the book is an extremely readable description of tensions and communication difficulties between doctors, physiotherapists and patients. The physiotherapist seems to embody feminine health and charm, yet she controls powerful man-made machines. She idealises, and is angry with, the hospital doctors who are busy saving lives and seem to be cynical about the 'good fairy' physiotherapists. Yet the biggest difficulties would seem to be those between physiotherapist and patient. No history is normally taken by physiotherapists. Their patients are all meant to be getting better though many of them are chronic and hopeless cases. They often feel burdened by the patient's regressed behaviour, and isolated in their work. There are various tensions in the physical contacts involved in the work. How should they use the personal material they sometimes picks up?

The second part of the book contains a transcript of one of the group meetings, and the leader's personal notes. Those of us who are familiar with the general practitioner and allied group leaders' workshop will appreciate this second part of the book, which reveals the leader's difficulties, and repays close reading. The leader naturally felt exposed to the same ambivalence expressed about hospital doctors. The group was enabled to look constructively at their tensions, but as the author says, understanding is not always helpful, and some of his perceptions of the group-processes are more useful for this book rather than the work of the physiotherapists.

Perhaps Dr Bourne will follow this book with one about the general practitioner groups which he runs at the Tavistock Centre?

Cyril Gill

Psycho politics
by Peter Sedgwick. 1982. Pluto Press, London. £4.95 Paperback.

Peter Sedgwick is a Lecturer in the Departments of Politics and Psychiatry at Leeds University. He has worked as a psychologist and educator in a Liverpool Child Guidance Centre, Grendon Psychiatric Prison and Rivermead Rehabilitation Hospital, Oxford.

In this book he does not, as the title might suggest, write about the psychological aspects of politics, but is concerned in what is described on the back of the book, with 'An exposé of conservative undercurrents in the anti-psychiatry of the sixties and seventies'.

The book is divided into parts: Part I deals with 'Anti-psychiatry', and includes in the first chapter well thought out discussion of illness and what it is — or is not.

Surprisingly, although there is much talk of the 'dualism of mental and medical symptomatology' the term 'psychosomatic' does not appear in the book's otherwise excellent index. And in the same place, although Ivan Illich exists, the humble general practitioner does not.!

Heavy reading though it is, Peter Sedgwick's account of R. D. Laing's work (in two very full chapters) shows clearly that he was more interested in Marxism than he would now admit, as Sedgwick states that 'Laing's retreat from socialism is tragic for his left-wing admirers'. But for all the detailed and often lengthy quotations from Laing's writings it is difficult to see just how much value this has to offer those of us who are working in the 'front-line'.

Sedgwick deals also with the work of three other 'conservative undercurrents in the anti-psychiatry and alternative psychiatry' of ten and twenty years ago. He provides detailed criticism of the ideas propounded by Michel Foucault, Erving Goffman and Thomas Szasz and proceeds to devastate them all. It is hard to apply the results of this to day-to-day practice, but it is fascinating to see the careful research that has gone into the production of this study, and stimulating to find such careful annotation of the 128 references quoted!

If I understand him, Sedgwick believes in mental illness — and particularly in the unity of body and mind — but he seems little aware of the work that has been progressing slowly over the past thirty years following the ideas described by the Balints. Instead, he has been remarkably impressed by the 'care-givers' of Geel — a small township in Belgium — who are 'not alone and isolated in times of crisis or difficulty'; they 'know no science . . . . their triumph does not depend even on a knowledge of Freud, Lacan, Laing or Wilhelm Reich. Still less are they indebted to the miraculous products of the pharmaceuticals empire; many patients have not seen a doctor in years . . . .'

But I did not learn this until I reached page 256, where Sedgwick tells his readers that 'The work of Geel is indeed the victory of humanity . . . .' Which surely is what Medicine is, or should be all about?

Philip Hopkins

Report from the International Balint Federation

What has happened since the last International Balint Conference in Cologne in October, 1981?

We have had the pleasure to welcome three new countries as paying corresponding members of the Federation. They are (after Japan which was the first), Denmark, Spain and Sweden. I think that New Zealand and Australia together will be the next paying corresponding members.

Today we are sure that there are no Balint group in Luxembourg and Czechoslovakia, but we have just received the news that there are already 70 Balint groups in German Democratic Republic. We shall try to find a corresponding member there and to create an East German Balint Society.

It seems that Balint's ideas are beginning to be known in Finland: we have written several times but so far without answer.

Dr. Kiraly from Hungary has written several times and at the Congress of General Practice, which took place in Budapest in June, 1981, she gave a lecture about Balint groups in the world.

I have contacts with several general practitioners in Canada, but it seems very difficult to create a Canadian Balint Society, although there are several Balint groups there. I shall try to write to Dr. Franck in Montreal and to Dr. H. A. Bacal in London (Canada).

After our visit to the U.S.A. and the two half-days of Balint work in New Orleans with Mrs Enid Balint-Edmonds during the 9th World Conference of General Practice, we received from Dr. Thomas Stern the general secretary, a letter that stated, 'The WONCA Planning Committee greatly appreciated the contribution of the Fédération Internationale Balint. Your presentation was spoken highly of and was apparently very successful.'

The 10th WONCA World Conference will be held in Singapore in 1983, I am beginning to make new contacts in Singapore I also hope that Balint's ideas will be developed in Asia too.

I have also received two letters from international organisations which are interested in our congress. We are slowly taking a place in the international area. The two letters came from:

(1) International Congress and Convention Association, which is situated in Amsterdam, Holland; and

(2) Union des Associations Internationales, which is situated in Brussels.

Finally, last but not least, we have started a correspondence with the World Health Organization. Preliminary negotiations are in course to admit the International Balint Federation to the non-governmental consultative organisations.

The next Balint seminar will be held in Geneva, Switzerland and will take place in 1982.

Dr. Roger Van Laethem,
General Secretary,
48, Rue des Bollandistes,
1040, Brussels,
Belgium.

The Balint Weekend at Oxford

September, 1981

The Oxford weekend was again well attended. We gave people more chance to see Oxford on Saturday afternoon. One problem was that there were rather too many leaders for the ten small groups, and though the groups themselves seemed to function well, the leaders were uncomfortable. We hope to give them a chance to meet in a workshop next year, to discuss leadership problems. We also hope some of our English speaking colleagues from abroad might join us for an extended meeting next year.

C. G.

From the Annual General Meeting held on 9th June, 1981

President's Report

The Society continues to attract new members and associates, especially people who have met us through the Oxford weekends. There is hope that the many GPs in the West country who have come to Oxford over the last few years, might get together to form a Balint group. Ènid Balint is assembling a new group to meet at the Royal College of General Practitioners in the autumn. We have had several contacts from American doctors who are running groups for Internists along Balint group lines. They hope to form a North American Balint Society shortly. Many of us older hands who originally joined Balint groups out of bewilderment that our patients needed something other than hospital type medicine, are now leading trainee groups. These new GPs are now well aware of the emotional and social aspects of their work but this does not make it any easier for them to acquire the necessary skills. We are hoping that a new generation of post-trainee groups will soon get started.

Cyril Gill

Residential Balint Weekend at Pembroke College, Oxford

From 7 p.m. Friday, September 24th to 1 p.m. Sunday, September 26th, 1982

General practitioners, both principals and trainees, are invited to sample the experience of being in a Balint-group for a weekend. There will be opportunities to discuss the experience, and the problems of learning and teaching in small groups.

The cost of the weekend, together with travelling expenses, will be reclaimable under Section 63 (six sessions).

Further details are available from the Secretary:

Dr Peter Graham,
149 Altmore Avenue,
London. E.6

The Balint Society Prize Essay, 1983

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme "If you ask questions . . ." Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with two copies, preferably on A4 size paper, with double spacing, and margins of at least 25mm. Length of essay is not critical. Entry is open to all (except members of the Balint Society Council). Where case histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in this journal. Essays should be signed with a nom de plume, and should be accompanied by a sealed envelope containing the writer's identity. The judges will be members of the Balint Society Council, and their decision is final. All entries will be considered for publication in the Journal of the Balint Society and the prize-winner will be announced at the 13th Annual General Meeting in June, 1983.

Entries must be submitted by 15th April, 1983, to:

Dr. Peter Graham,
149 Altmore Avenue,
London E.6.

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