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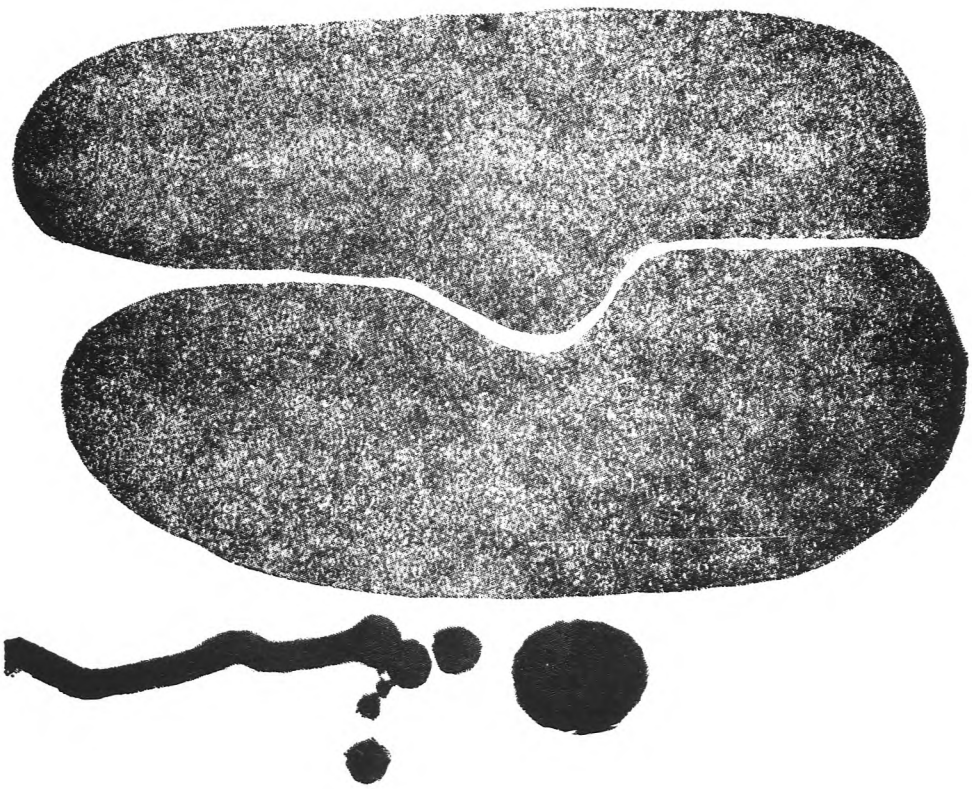

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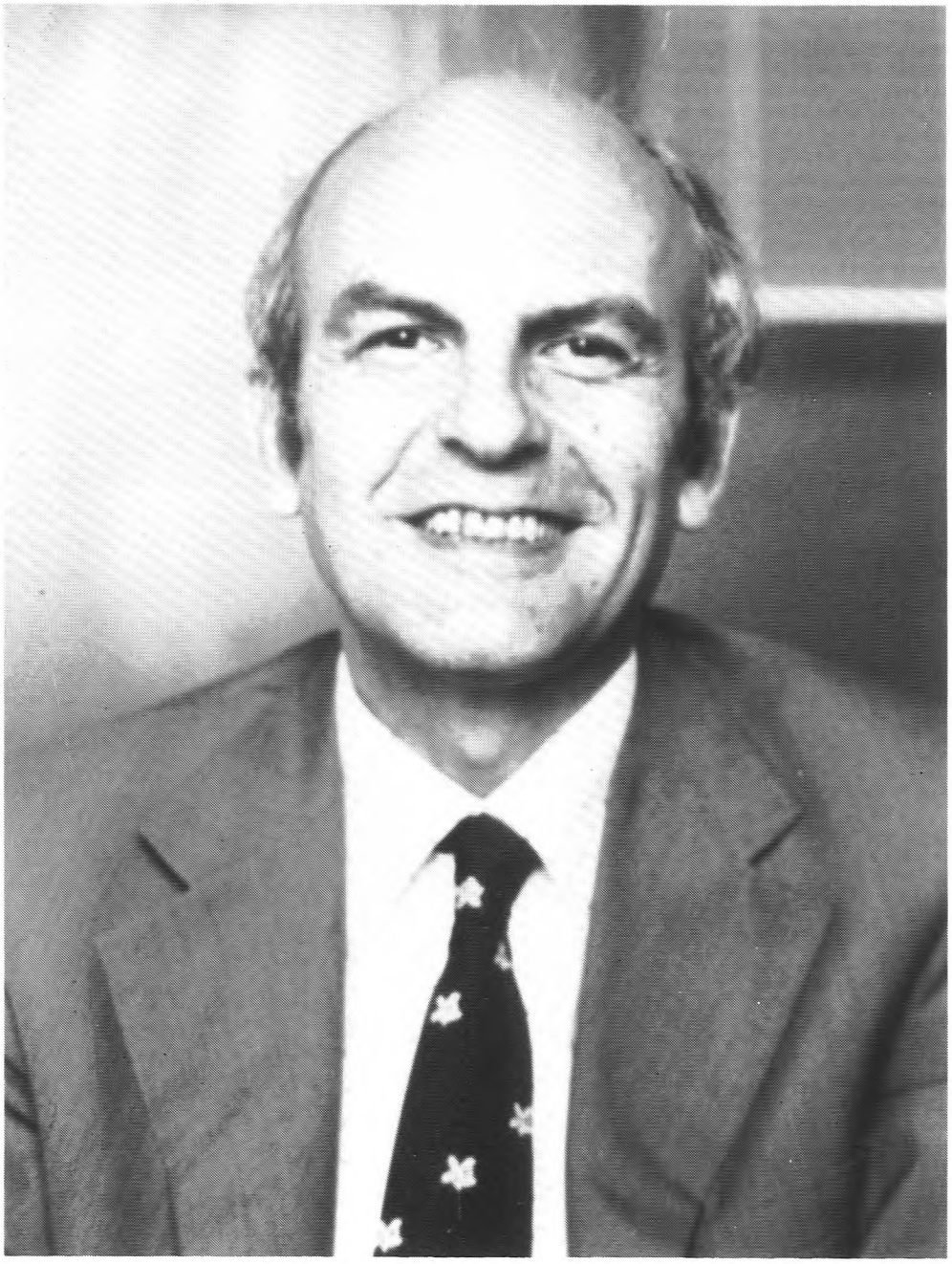

Photograph by Dr Philip Hopkins

DR CYRIL H. GILL
(1921-1987)
President of the Balint Society
(1980-1983)

Editorial

Some members were urging us, at recent meetings of the eighteenth session of our Society, 'to move on — to develop Balint's work further . . ' Whatever this means, it aroused in me sufficiently disturbed and conflicting feelings to make me want to read Michael Balint's earlier writings again.

I was delighted when Enid Balint-Edmonds agreed that it is a good idea to recall Michael's early ideas about training, and thought that his paper, *Training general practitioners in psychotherapy*[1] is an excellent choice for reproduction in this issue. Her misgiving about it is, however, that there may still be some misunderstanding about his being interested only in patients who needed psychotherapy or had emotional problems.

Enid emphasised that Michael was interested in helping doctors with *all* of their patients, i.e. to feel at home in the practice generally, whether treating a dying patient, or one who had just sprained his ankle or cut his thumb, as well as those with emotional problems. (This enhancement of skill may well be of considerable relevance in the recently developing 'burn-out' in doctors, which we are now hearing so much about).

Michael stressed that doctors could be helped to become more sensitive to, and so to develop a better awareness of their patients' psychological problems, and a better understanding of their needs. His initial idea was to 'train' doctors in awareness, rather than to 'teach' them about psychotherapy; Michael had no intention to turn general practitioners into psychotherapists.

Both Michael and Enid came to see the obstacle of 'time' in the general practice setting, and looked for possible new techniques which could be used. Perhaps it was not simply 'time' that the patient needed, and perhaps patients could be helped by improving the way in which the short time available for each consultation is used?[2]

The Tuesday Group was eventually formed to research this question, and concluded that this hypothesis was correct. The concept of the 'flash'[3] was closely followed by the realization that it need not be only the length of the consultation with a patient that is important, but that its intensity may also be relevant and effective.

Enid reminded me that Michael did not like the idea of splitting human beings into parts, and that he believed it is essential for the general practitioner to be responsible for his/her patient's total medical care. Patients should be referred to specialists only when a specialist's opinion is needed, or when they require specialist treatment which is beyond the expected limitations or competence of the general practitioner.

As Enid told me, Michael would never have wanted to create another category of specialist, the general practitioner-psychotherapist. Michael set out to help us learn how to listen to our patients more, and to *hear* what they are saying (or not saying), and then to listen to ourselves. In turn, this allows us to 'tune in' to our patients' feelings, and so create the greater intensity in the consultation that is needed in this new technique. They will then be able to use us all the better without necessarily becoming dependent upon us.[3]

There will still be those patients who require more time for special attention involving special techniques, such as recording an electrocardiogram; giving injections of hydrocortisone, or even for minor surgical procedures like excising a sebaceous cyst, or a full psychosomatic assessment which includes a detailed evaluation of the emotional state.

The general practitioner always has the choice, which must depend on his interest and enthusiasm, as well as on his competence — of all the possibilities opened up by the eclectic approach.

But we must be wary, for as Enid Balint-Edmonds said in her Michael Balint Memorial Lecture: 'Perhaps in any case in practice, patients get long interviews only when their needs happen to strike a response in the doctor.'[2]

At a meeting of the 'Tuesday group' in August 1967, when we were discussing why the presenting doctor explained the poor outcome of his treatment, that the patient would have needed more than the ten minutes allowed, Michael retorted sharply: *'Sorry, ten minutes should then be discarded if it hampers your style . . .'*[4]

So, just as the 'training-cum-research' approach helped us to discover the 'flash', which enabled us to make a more varied choice about our use of time; perhaps further research will uncover new concepts to widen our understanding still further.

There is no need to speculate where Michael's flexibility of thinking would have led him next, or whether we should go beyond him. He himself felt that continuing research was crucial.

At the end of the interview I recorded with Michael just five weeks before his death, his last words to be were: 'Recently we did the study of the repeat prescription,[5] which is one aspect of this non-illness, or fake-illness or organized illness situation. There are many more (studies), and if I life long enough, that will be the next ten years' research . . .'[6]

If 'moving on . . .' or 'developing Balint's work further . . .' means continuing the researches which Michael had in mind, I am all for it, as long as we continue to learn from his work with us, and go forward in the same spirit he would have done.

P.H.

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4. Hopkins P. International Balint Memorial Congress, 1986, Budapest: Personal memories of Michael Balint. *J. Balint Soc.* 1986. **14**,26.

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Prize Winners

Two British clinical medical students are to be congratulated for winning two of the three prizes awarded by the International Balint Federation in the essay competition. In addition, there was an all expenses paid trip to Switzerland to attend the Annual International Balint Meeting at Ascona on 26th March 1988.

These annual awards, which were first presented at Ascona in 1972, are donated by Pharmaton, the Swiss organisation who have developed a range of herbal and vitamin health products during a twenty-five year international research programme.

The winner of the first prize of 2500 Swiss Francs, was Miss Carole Anne Tallon, B.Sc., a third year medical student at the University of Leicester Medical School. Miss Tallon attended a meeting of the Balint Society at the Royal College of General Practitioners on 26th April 1988 to receive her cheque.

Her prize winning essay on the set subject, *My experience of the doctor/patient relationship during medical training* appears on page 22 of this issue.

The third prize (1500 Swiss Francs) was awarded to Mrs M. J. Harding, a clinical medical student at Cambridge University. Unfortunately, Mrs Harding was unable to attend our meeting.

Balint-Groups for Medical Students

I met Dr Anne Watson, a general practitioner from Oxford, by chance over lunch at a weekend medical symposiumn, and was delighted by her enthusiastic response when I mentioned, as I frequently do at such meetings, the name of Michael Balint.

Dr Watson regaled us with her memories of her experiences in Balint's earliest student Balint-groups at University College Hospital in 1962.

Over the years, I have met other doctors who also were members of Balint's student-groups, and all have displayed similar reactions. Remembering how I missed previous opportunities to ask if any of these doctors would like to write something about their memories of their experience, I wasted no time and said I did not think she would have time to write anything for this current issue of the Journal, but would she consider something for the next one?

'There was no way,' she said, 'It was all so long ago . . .' but I persisted. All right, she would think about it. Three days later, it arrived. A letter describing how she had felt so overwhelmed that she had written 'something' in the train home that Sunday evening, and here it was!

If anyone has any doubts about the value of encouraging medical students to take part in student Balint-groups, let them read Dr Watson's article (p. 20).

And indeed, read also Jack Norell's account of the remarkable development in Yugoslavia where medical students participate in Balint-groups, (see p. 29) and benefit in no less a way than some of our luckier students do at University College and Guy's Hospitals.

If any of you out there would like to attend a meeting about this very important topic, please write to me. I will let the Council know your wishes, and perhaps a meeting can be arranged.

P.H.

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Training General Practitioners in Psychotherapy

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Present Situation Regarding Psychotherapy in General Practice

It is generally agreed that at least one-quarter of the work of the general practitioner consists of psychotherapy pure and simple. Some investigators put the figure at 50%, or even higher; but, whatever the figure may be, the fact remains that the present medical training does not properly equip the practitioner for at least one-quarter of the work he will have to do.

Although the need for a better understanding of psychological problems and for more therapeutic skill is keenly felt by many practitioners, they are reluctant to accept professional responsibility in this direction. The most frequent reason advanced is that they have too much to do and it is quite impossible for them to sit down and talk with one patient for an hour at a time, week after week. Impressive as it sounds, this argument is not, in fact, firmly based. It is true that establishing and maintaining a proper therapeutic relation needs much more time than prescribing a bottle of medicine. In the long run, however, it can lead in many cases to a considerable saving of time both for the doctor and for his patient (and for the National Health Service).

What actually happens at present in most of the so-called psychological cases of general practice is an almost mechanical prescribing of phenobarbitone if the patient is not depressed, and of some "tonic" if he is. If this fails, various specialists are consulted, usually resulting in "reassuring" reports that nothing organically wrong has been found. Eventually a psychiatrist is also consulted, often not so much as a deliberate policy as *faute de mieux*. This situation, however, is created as much by the difficulties of the psychiatrist as by those confronting the general practitioner. It is common knowledge that the psychiatric services are pathetically unequal to the ever-increasing demand; they are flooded with patients, and consequently the psychiatrist must pick and choose. If a patient is picked he is put on the waiting-list, eventually taken on for treatment, and, more often than not, lost completely to the practitioner. If the patient is not picked the report sent to the doctor hardly ever helps him in his psychotherapeutic task except advising him to give sedatives *or* tonic.

Thrown back on his own resources, the doctor, often shamefacedly, prescribes some placebo or gives a "reassuring" pep talk. (It is a common joke to ask, "Reassuring — but to whom?") Then there are the advocates of common-sense psychology who advise the patient to have a holiday, to change his job, to pull himself together, to leave home, to get married, to have a child or not to have any more children but use some contraceptives, etc. None of these recommendations is necessarily wrong, but the fallacy behind them is the belief that an experienced doctor has acquired enough well-proved "common-sense" psychology to enable him to deal with the psychological problems of his patients. But minor surgery, for instance, does not mean that a doctor can pick up a well-proved carving-knife or a common-sense carpentry tool and perform minor operations. On the contrary, he has to observe very carefully the rules of antisepsis and asepsis, he must know in considerable detail the technique of local and general anaesthesia, and must have acquired reliable skill in using scalpel, forceps, and needle, the tools of the professional surgeon. Exactly the same is true of psychotherapy in general practice. The uses of empirical methods acquired from everyday life are as limited in professional psychotherapy as are carving-knife and screw-driver in surgery.

Experiences in Teaching Psychotherapy to General Practitioners

In the past twenty-five years or so, psychiatrists in many countries have run courses for general practitioners, courses which were often arranged because of the pressing and ever-increasing demand for them.

The results of these courses have been generally disappointing. This is a surprising outcome, for the general practitioner of some years' standing is a very good trainee. He has had time to assess the value and limitations of what he has learnt at his medical school and hospital, he has also had a fair amount of frustration and success in his practice, and he has seen enough of human suffering to make him sensitive. (Seen from this angle general practitioners are much better material for training in psychotherapy than young medical students.) The reason for the failure of these courses would appear to be that theoretical lectures, even when based on, or illustrated by, case histories or clinical demonstrations, hardly give more to the general practitioner than what he can get from reading books. Strongly influenced by the traditional medical training based on lectures and clinical demonstrations, both practitioners and psychiatrists forget, in a mutually attractive teacher-pupil relation, that psychotherapy means acquiring a new skill and not learning some more theories and facts. Nothing is easier or more satisfying for a psychiatrist than to take a patient's case and deliver a lecture about the theoretical implications, the unconscious dynamisms, and the likely diagnosis of the patient. Moreover, such teaching is gratifying indeed to both. The specialist can shine, and the practitioner feels enriched and reassured. But this gratifying collusion is disappointing in the long run because in reality it is too facile and

does not give the means of effecting therapeutic changes.

Instead of allowing this teaching-being-taught atmosphere to develop, the aim of such a course should be to help the practitioner to acquire a new skill. This means a considerable, though limited, change in the personality of the doctor. The doctor has to discover in himself an ability to listen to things in his patients that are barely said, and, in consequence, he will start listening to the same kind of language in himself. This fairly difficult change of attitude is not needed if the doctor does not have to do the listening himself, but is taught and told what other people have found out about the "human mind" — namely, the theories of psychodynamics, of personality development, of transference patterns, and so on. In the same way as a new physical skill can be learnt only in the actual situation while dealing with the problems in it, so is it with the acquisition of a psychological skill. This is why concentrated full-time courses lasting for some weeks have proved to be of very limited value. The general practitioner must use his own current experience as a basis for learning the new skill. Past experiences are unsatisfactory for this purpose, since the memory of an emotional involvement is always less alive, less vivid, than the actual experience itself.

So far, so good; but the skill to be acquired involves understanding and guiding the development of the two-person (patient-doctor) relation, and the presence of a third person would fundamentally change this situation. This condition automatically excludes the presence of the tutor. Therefore the material on which the whole training has to be based is the doctor's report of what happened in the interview situation between him and his patient. This necessary condition implies a number of uncertainties. The doctor has not yet learnt what to look for and he is somewhat self-conscious and apprehensive because of his lack of skill and understanding; like everyone else, he too is apprehensive of criticism, and, consciously or unconsciously, tries to make his activities appear in the best light and to minimize his shortcomings and mistakes. On the other hand, in order to train him, his blind spots, shortcomings, and mistakes have to be brought out quite clearly and discussed as frankly as possible. It is difficult enough to do this in any sphere of physical activity which is near to the core of the personality — say, for instance, in dancing, social behaviour, or table manners — but it is still more difficult in the psychological sphere, where the whole personality is always involved. Moreover, any such personality change needs time, and it is impossible to hurry it. The only training which systematically caters for those difficulties is the psycho-analytic training, which provides for a personal analysis lasting for many years and amounting to several hundred hours.

Experience at the Tavistock Clinic, where courses in psychotherapy for general practitioners have been given for more than twenty years, has confirmed the limited value of "teaching" psychotherapy. Consequently in the last few years a new approach has been tried — namely, to shift the emphasis from "teaching" to training, using group methods to achieve to a certain extent, although admittedly not completely, the necessary changes in personal attitudes.

At first the aim was a very modest one, amounting only to the awakening of an awareness of psychological factors, enabling the practitioners to give a better and deeper assessment of their patients' problems and illnesses. According to the doctors' reports, the result has been a great saving of their time, much less need for complicated hospital examinations (hence a considerable saving for the National Health Service), and, last but not least, some help to the patients. Admittedly all this amounted only to something of a better diagnostic skill. But, having achieved a better diagnostic skill, the practitioners then wished to know how to treat the patients. This demand was not unexpected, as, with a greater awareness of the problems, the practitioners' desire to do something to alleviate them was bound to follow. To answer this demand a two-year course in psychotherapy was organized. I now report briefly on the principles and methods used in this course. My main reason for doing so at this stage is that I believe similar courses may be contemplated elsewhere, and I felt that the approach developed may be of value to others and an exchange of ideas about the problems involved would improve the quality of the work.

Training in Psychotherapeutic Skill:
(a) First Attempts

We started by advertising "introductory courses in psychotherapy for general practitioners" in the medical press, and every practitioner interested was admitted to one of the courses, each taking in, on an average, 8 to 12 doctors. Each course lasted for a term and consisted of weekly case conferences of two hours each. No systematic theory was given. The practitioners were asked from the start to describe any recent "psychological case" they had had to treat, and the discussion was kept so far as possible concrete — that is dealing with the individual problems of the patients in question. For some doctors this was enough; one or two dropped out during, and a few more at the end of, the first term. The remainder were the ones — mentioned above — who asked for more. To provide this further training, the weekly case conferences were continued, but each conference session was now followed by a tutorial meeting on the general outlines of psychodynamics, based mainly on psycho-analytic concepts. Both events took place on the same afternoon, and lasted from 2 to 5 or 5.30. This arrangement continued for two terms, and as the demand for still more training persisted it was decided to institute a two-year course*

The method used in our training scheme was developed and tested to a fair degree jointly by Enid Balint and myself while training for the Family Discussion Bureaux a group of social case-workers who were trying to help people with marital problems. The human problems facing these workers were roughly the same as, although in some relevant points simpler than, those of the general practitioners. Some of the similarities were the starting situation — namely, a patient in trouble coming for help and a professional

*In fact, our total intake was 36 doctors. Of these, seven were irregular attenders right from the start. Of the regulars nine left after their first and a further five after their second term, leaving 15 who are doing the present two-year course.

offering understanding, the developing patient-doctor or patient-worker relation, especially the need for controlling the doctor's or worker's subjective involvement in this relation, and so on. What was different was the usual presence of illness, often physical, in the doctor's material, and the all-important fact that the general practitioner cannot "pass the buck". Unlike general practitioners, social workers and, for that matter, specialists may say — and as is well known they often do say — this or that patient is not "my cup of tea"; "I am not interested in this kind of illness"; "I cannot find any justification for his complaints"; "the illness is so slight, or so severe, or so progressed, that it is a waste of my time to treat the man"; "give him some reassurance and ½ gr. phenobarbitone thrice daily and leave me alone"; etc. The general practitioner, come what may, *must* see his patient through, sometimes even to the bitter end: he cannot "refer him back" with an easy and empty cliché.

Before describing our scheme I wish to discuss at some length the implications for training of this factor, as its realization profoundly influenced our attitude.

(b) Practitioners and Their Relation to Specialists

The first of these implications is that the general practitioner must remain in his practice during his whole training. This rightly emphasizes the mutual roles of the psychiatrists on the one hand and the practitioners on the other. Both of them are doing their jobs, neither of them is so important that for his sake the other must make sacrifices; their jobs and their roles are those of peers. A further consequence is that the general practitioner remains in full and unrestricted control of his patients, he is the one who is running the show; the psychiatrist accepts the fact that his own role is that of an expert assistant, not that of a manager, and still less of a superior mentor or teacher.

Although this approach preserves, even enhances, the practitioner's dignity, it is only with great difficulty that it can be accepted by him. One reason is the burden of responsibility, sometimes really severe, that it involves. It is so much easier to farm out responsibility, to say, "I have asked all the important specialists and none of them could say anything of importance; I really need not be better than the bigwigs." No such escape is permitted in our course. Although the opinions of specialists are asked for and listened to, they are not accepted as final or binding; they are criticized for what they are worth, and then the doctor in charge is asked to decide what is to be done with the patient and to accept undivided and unmitigated responsibility for his decision. Often the decision influences the patient's whole future. This fact too must be borne in mind.

No wonder that the practitioners, as often as not, do not like to shoulder this heavy burden. What is more surprising is the willingness of the psychiatrists (in fact of all specialists) to enter into a collusion with the general practitioner in order that this responsibility may be dissipated, if I may say so, into thin air. The patient with psychological complications is often seen by several "eminent" people, each of whom gives his opinion about one or other part of the problem, but the final responsible decision is seldom explicitly stated even if it has to be taken. If possible, no decision is taken; things are left hanging until fateful events supervene and make the decision anonymously, allowing everybody to feel that after all it was not his word that counted. On the other hand, if things turn out well everybody concerned may feel that his contribution was highly important, if not the decisive one.

One feature of our scheme was to unmask this anonymity by making the practitioner accept that he is and must remain in charge of his patient. If the doctor needed more help than the course could give him he was free to refer his patient to the clinic for consultation only. The patient was then tested by a psychologist and interviewed by a psychiatrist (usually the leader of the course), but only if the doctor was willing to continue the treatment. The results of the tests and of the psychiatric interview were then brought up in our conferences and mercilessly scrutinized. The final test of their value, which kept psychologist and psychiatrist equally on their toes, was the standard question of how much help in his further treatment of the patient did the doctor get from their reports.

This is a severe test indeed, as I can testify from first-hand experience. Neither I nor the psychologists who took part in this scheme found it easy to accept that some of our reports were merely nice phrases, repeating in a different form the facts known only too well to the doctor, and giving him hardly any help in his difficult task. This sobering realization of the shortcomings of our work is only one of the many lessons that general practitioners can teach us specialists.

The "collusion" and anonymity mentioned above is an excellent way out of this often very trying self-criticism. The specialist need not see the futility of his reports, and may rest perched on his "eminent" pedestal; the doctor may grumble and feel justified in his contemptuous opinion of the useless and pretentious specialist, and no one need do anything. Our scheme, by bringing face to face as equals specialists and practitioners, has made this escape impossible. Admittedly we, as everyone else, have had cases in which very little or nothing could be done; this fact then had to be accepted explicitly and in full and open responsibility.

I have already mentioned another kind of escape, the establishment of a teaching-being-taught atmosphere. This temptation, although very attractive to both practitioners and psychiatrists, should in most cases be resisted. When listening to a case an experienced psychiatrist can almost always without any great effort make a "clever" diagnosis and even foretell with reasonable accuracy what will happen in the doctor-patient relation for the next period. If he indulges in such a "conjuring trick" he severely interferes with the doctor-patient relation and inhibits the doctor's powers of observation and ease of handling the case. The doctor will then try either to confirm the psychiatrist's prophecy or to prove it to be incorrect, according to the actual relation between them. In any case the individual doctor and the group are deprived of the opportunity of finding out for themselves the advantages or disadvantages of one or the other ways of handling the problem.

(c) Present Training Scheme

The weekly case conferences are the mainstay of our scheme. About 10-12 are held in each of the three terms. To secure intensive participation and, on the other hand, to obtain varied enough material, we found it advisable to have groups of six to eight doctors. In addition to the conferences we offer to any doctor who asks for it individual supervision of his cases — that is, about an hour a week of "private" discussion. While the conferences are taken by the leader of the course, the individual supervision is provided — aided by some external help — by other clinic consultants. Psychotherapeutic tecnhique is highly individual. In order to avoid the danger of muddling the practitioner by the often widely diverging views and approaches of the various consultants, the supervisors were asked to attend some of the case conferences before taking on any doctor for supervision. It was explicitly stated that they were not expected to subordinate their individual views to those of the course leader; on the contrary, they were asked to take part in the case discussions as frankly as they wanted. The reason for their attendance was that they should acquaint themselves with the atmosphere of the conferences, and, on the other hand, that the doctors should have the opportunity of finding out who they would like to supervise their cases. As these supervisions are expected to run on well-known lines, I wish to restrict my report to the psychodynamics of the case conferences.

I have already pointed out that we try to avoid so far as possible the ever-tempting teaching-being-taught atmosphere. Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when doctor and patient are together. This kind of listening is very different from "history-taking", and here we encountered much difficulty when trying to free the doctors from the automatic use of this kind of approach. The main difference is that history-taking is concerned almost exclusively with objective events or with events that can easily be expressed in words — that is, events towards which both doctor and patient can adopt a detached "scientifically objective" attitude. The events that are our concern are highly subjective and personal, often hardly conscious or even wholly beyond conscious control; also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless, these events exist, and, moreover, they profoundly influence one's attitude to life in general and still more so to falling and being ill, accepting medical help, etc.

"Automatic Patterns"

It may safely be said that these events, happening all the time in everybody's mind, are only partly sensible adaptations to the ever-changing environment; to a large extent they are governed by almost automatic patterns originating mainly in childhood but influenced by emotional experiences in later life. The first task for our scheme was to awaken in the doctors an awareness of these automatic patterns, and then to enable them to study more and more in detail how these patterns influence the patient's attitude towards his own illness, and, on the other hand, how they colour or even determine his relations to any human being, and especially to his doctor.

Another factor affecting the patient's developing relation to his doctor is the doctor's response, which also is partly governed by automatic patterns. The interplay of these two sets of patterns, whether and how they "click" with each other, determines to a large extent the efficiency of any treatment. Its influence is less important in short-lived acute illnesses, but almost crucial in chronic ones. In order to achieve a better fit, and with more patients, the doctor must have made a wide choice of responses, which means that he must become aware of his own automatic patterns and gradually acquire at least a modicum of freedom from them.

What is Needed

Intellectual teaching, however good and erudite, has hardly any effect on this process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which one can face the experience that quite often one's actual behaviour is entirely different from what has been intended and from what one has always believed it to be. The realization of this discrepancy between one's actual behaviour and one's intentions and beliefs is not an easy task. But if there is good cohesion between the doctors in the group, the mistakes, blind spots, and limitations of any individual member can be brought into the open and at least partially accepted by him. The group steadily develops a better understanding of its own problems, both collectively and individually. The individual can more easily face the realization of his mistakes when he feels that the group understands them and can identify with him in them, and when he can see that he is not the only one to make mistakes of this kind. Moreover, it takes only a short time for the group to discover that the technique of each member, including the psychiatrist group leader, is an expression of his personality, and so, of course, are his habitual mistakes.

Admittedly crises occur from time to time, when one or other member finds it difficult to accept the full implications of some of his ways of handling his patients, or the realization of some facets of his personality that he had been only dimly aware of. These, however, can be borne, as they are also group events and do not solely concern the individual. It has been easy to describe this state of affairs, but it is rather difficult to explain its dynamism. So long as the mutual identifications of the members are fairly strong, any individual member can face strains because he feels accepted and supported by the group. His mistakes and failings, although humiliating, are not felt as singling him out as a useless member; quite on the contrary, he feels that he has helped the group to progress, using his feelings as stepping-stones* Crises may occur when

*In psychiatric terms, the depression caused by the realization of one's shortcomings must be fully accepted; identification with the common group ideal must remain, now as before, a desirable and attainable aim, but the group leader must watch very carefully when and how one or the other member is forced or allowed to slide into a paranoid position of the one who has been "singled out".

there is some tension between one or the other member and the rest of the group which the leader has not detected soon enough (I would add that neither his role nor his psychiatric training confers on the group leader an absolute immunity against this hazard), and, instead of re-establishing good cohesion, his criticism may help to widen the gulf.

Signs of this isolation or tendency to isolation and the accompanying touchiness can be regarded as the equivalents of what psycho-analysis calls resistances. On the one hand, they are premonitory signs that some major personal attitude of the individual is being tackled in the group situation; on the other hand, by the way in which the isolation is achieved and maintained, they show what the problem is. In the same way the reaction of the integrated group towards such an attempt at isolation reveals the other side — that is, the counter-transferences of the group to the particular personality problem. The way in which a member isolates himself, as well as the way in which the group deals with it, must be shown up. They represent very valuable material for studying interpersonal relations, and their full realization is a necessary condition to the re-establishment of a workable cohesion.

If such crises occur too often, or leave a bitter resentment behind, it is a sign that the pace of training has been too exacting and that the group has been made to work under considerable strain for some time. It is an equally ominous sign, however, if no crises occur at all; it means that the sensitivity and grasp of the group are not developing, the group and its leader are in real danger of degenerating into a mutual admiration society where everything is fine and we are nice, clever, and sensible people. It is a fact that acquiring psychotherapeutic skill is tantamount to discovering some hard and not very pleasant facts about one's own limitations. This unpleasant strain must be faced, and the group develops as long as it can face up to it, and stops developing as soon as it tries to avoid it. It is the task of the group leader to create an atmosphere in which each member (including the leader) will be able to bear the brunt when it is his turn to bear it.

It is a precondition of our technique to establish this kind of atmosphere in the group, and it is only in such an atmosphere that it is possible to achieve what we term "the courage of one's own stupidy". This means that the doctor feels free to be himself with his patient — that is, to use all his past experiences and present skills without much inhibition. At the same time he is prepared to face severe objections by the group and occasionally even very searching criticism of what we call his "stupidity". Although every report and case conference is definitely a strain and an effort, the result is almost always a widening of one's individual possibilities and a better grasp of the problems.

Importance of Timing

One of the most important factors in this kind of training is timing, which in the first approach means not to be in a hurry. It is better to allow the doctor to make his mistakes, perhaps even to encourage him in this, than to try to prevent them. This sounds rather foolhardy, but it is not; all our trainees have had considerable clinical experiences, and this "sink or swim" policy was justifiable. Apart from not undermining the confidence and dignity of the doctor, it has the added advantage of providing ample material for discussion, since everybody was seeing patients all the time and was anxious to report his findings and discoveries, his successes and difficulties. As I have confessed, this policy may have been too much for some doctors, and we had a fair number of "casualties" who did not wish to continue.

If the timing is good enough, the doctor feels free to be himself and will have "the courage of his own stupidity". Gradually he becomes aware of the type of situation in which he is likely to lose his sensitivity and ease of response, or, in other words, to behave automatically. Meanwhile the reports of the other doctors have shown him what other ways might be adopted in similar situations. The discussion of the various individual ways, demonstrating their advantages and limitations, encourages him to experiment. (One practitioner announced the result of such an experiment thus: "I have done a real 'Smith' in this case — and it worked," meaning he had adopted the attitude he felt Smith usually adopted.) Every such experiment means a step towards greater freedom and better skill.

Attitude of the Group Leader

Perhaps the most important factor is the behaviour of the leader in the group. It is hardly an exaggeration to say that if he finds the right attitude he will teach more by his example than by everything else taken together. After all, the technique we advocate is based on exactly the same sort of listening that we expect the doctors to acquire. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues — that is, speaking only when something is *really* expected from him and making his point in a form which, instead of prescribing *the* right way, opens up possibilities for the doctor with the patient's problems, the leader can demonstrate in the "here and now" situation what he wants to teach.

Obviously no one can live up to these exacting standards without some shortcomings. Fortunately there is no need for perfection. The group leader may make mistakes — in fact, he does quite often — without causing much harm if he can accept criticism on the same, or even somewhat sharper, terms as he expects his group to accept. This must be watched very carefully, and any hesitation by the group in exposing the leader's mistakes must be pointed out. Obviously this freedom cannot develop if the leader tries to hedge or to explain away his failings. It is a very wholesome sign if the group can run the leader down, even if they have some fun at his expense, if only they can do so without rejecting him or turning hostile to him. (Incidentally, this frank criticism is another way in which practitioners can teach us specialists.)

The Training Technique

One more word about the number of doctors who dropped out. The technique described here is still in its experimental stages — that is, it is crude and harsh. We are fully aware of this and we have decided to accept the risks involved. Our first consideration

has been to develop a technique that is workable for a fair enough proportion of the doctors interested, in order to test out whether such a training technique is possible at all. The results of the two pilot projects — the Family Discussion Bureaux scheme for social workers and the Tavistock Clinic scheme for general practitioners — are highly encouraging, although as yet not final. As soon as our technique is fairly securely settled, our next concern will be to examine our "casualties" — that is, the reasons why so many of our entrants have to leave us. It is true that psychotherapy in the same way as, for instance, surgery, is not within everybody's reach; nevertheless our "casualty rate" is too high. Conversely, this means that our training technique is, for the time being, inelastic and too exacting for a great number of practitioners.

There is, however, one very important difference between this kind of training and any other training in one or other of the many specialties in medicine. Any advance in therapy demands a new skill from the doctor, even if it amounts only to learning the correct ways of prescribing a new drug. In other words, mastering a new therapy means a change. But, whereas the changes required by new techniques in any of the other branches of medicine do not touch much upon the doctor's personality, the technique of psychotherapy involves the personality fairly deeply. From this angle the action of some doctors who dropped out is perhaps a sensible defence against an unauthorized violation of their private mental life, a defence that must be treated with respect. The diametrically opposite danger is that the group training may degenerate into therapy pure and simple. We are fully aware of this possible complication, which, in fact, is present in every form of psychiatric training, but as our scheme is a very young one we have not had to come up against it.

Summary

A training scheme in psychotherapy is described, in which the emphasis has been put on acquiring a personal skill instead of on teaching. The aim is to make the general practitioners aware of what their patient wants to convey to them, not so much by his words as by his whole behaviour, and of how their own general behaviour and actual responses influence what the patient can actually tell them. We have tried *not* to teach them what psycho-analytic or any other theory could say about the working of the human mind; instead we have aimed at enabling them to be free enough to feel and understand what is going on between the patient and themselves in their surgery.

Residential Balint Weekend at Pembroke College, Oxford

From 6 p.m. Friday, September 9th to 1 p.m. Sunday, September 11th, 1988

General practitioners, whether trainees or established principals, experienced teachers of general practice, and course organisers, are invited to sample the experience of attending a Balint group for a weekend.

There will be an initial demonstration group, consisting of a few volunteers, on Friday evening; following an interval, there will be an open discussion of the group's work. Most of the rest of the weekend will consist of work in Balint-groups, each having two experienced group-leaders.

All who attend are requested to come with suitable case-histories to present for discussion, and all group-members will be expected to be committed to stay for the full course of four group-meetings on the Saturday and Sunday.

Accommodation will be available for a few husbands/wives who may wish to spend a weekend in Oxford, and who may wish to share the meals, including the Conference Dinner on Saturday evening, but sadly, they will not be able to attend the meetings. They will be welcome to join in the walking tour of Oxford which will be arranged.

Section 63 approved.

Further details and programme/booking forms are available from the Secretary:

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

Angina — Head or Heart*

Peter G. F. Nixon, FRCP
Senior Consultant Cardiologist, Charing Cross Hospital

Introduction

The great majority of patients examined by a cardiologist these days are not suffering from disease, but from the physiological effects of living in a turbulent, changing and uncertain environment where overloading of the body by information in-put, generates such high levels of arousal as to outstrip the body's homeostatic self-regulatory processes or, in middle-age, the competence of the coronary circulation, with resultant angina or myocardial infarction.

In order to keep up with the psychological and social needs of our patients, and to practise scientific medicine with logic and precision, we must adopt Michael Balint's model and become patient-centred instead of 'disease-orientated'. I hope my talk will support his principles, and show how a patient, after a heart attack for example, can choose between an anabolic or self-healing way of life and a catabolic, self-destructive course. I thank you most sincerely for this opportunity to address this Society.

People are not naturally equipped for dealing with heart attacks. They waste time and get lost as they muddle their way through cycles of denial, rage, bargaining and depression before getting to grips with one of life's most serious problems. Left to their instincts, they settle upon inefficient responses to the crisis. Many deny the existence of the problem, and, by doing so, lose the chance to make the best of themselves. Some take on a role of saintly resignation and opt out of life's competitive struggles. Others are overwhelmed by despair and fall easily into heart failure. A large proportion are driven by fear or rage to struggle mindlessly against the heart's limitations and warnings: trying to escape from the imprisonment of restricted activity, they fly like Icarus in uncalculated bursts of excessive effort and then crash, wings burned, forever pushing themselves through cycles of exhaustion and defeat that inexorably worsen the physical condition of the overtaxed heart. Up to three quarters of patients coming out of coronary care units have arrhythmic hyperventilation, and this disordered breathing pattern ensures that both the blood carbon dioxide tension and the balance of the autonomic nervous system are kept inconstant and unstable (fig. 1).

The consequences are abnormally high heart rate and blood pressure responses to effort, breathlessness, chest pain, pseudo angina, ectopic heart beats and arrhythmias, and, sometimes, coronary arterial spasms. It takes great clinical skill to distinguish between these functional symptoms and the underlying 'organic' disability.

One of the major reasons for the prevalence of these incompetent responses is the fact that the heart attack makes its sudden appearance when the individual is already exhausted by a year or more of extreme effort and vigilance[1, 2]. The coping ability is drained in exhaustion, and the body's self regulation mechanisms (homoeostasis) lose their ability to keep a healthy balance between the degradative processes of wear and tear (catabolism) and the reparative, healing and defensive work of anabolism (see table). The heart attack comes eventually, not as an accidental chance, but as a catastrophic failure of the overstretched mechanisms for preventing intra-arterial thrombosis, vascular spasm and arrhythmic disorganisation of the heart beat.

The removal of the exhaustion and its associated disorders is necessarily the starting point of rehabilitation. Through learning to recognise and deal with the processes of its removal, the patient acquires defences against recurrence, and diminishes the fear of further catastrophes.

The reductionist terms of scientific medicine and the binary diagnostic systems which hold patients to be either 'diseased' or 'undiseased' are inadequate. The conceptual limitation of the teaching hospital that provides drugs and operations for disease but cannot cope with the idea of training a sick person to be well is a very severe handicap. We need a map or guide to mark the *position of the patient* or the *direction of his course* at any particular moment. I have introduced the human function curve (HFC) (fig. 2) for this purpose. It allows us to diagnose the patient's position on a spectrum ranging from healthy function at one extreme, through normal fatigue, exhaustion and illness, to a catastrophic change or breakdown at the other extreme (P). The spectrum is drawn as a curve related to performance or coping ability and to arousal (struggle, effort). On the upslope, performance increases with effort. On the down-slope, every increment of arousal to effort is associated with a deterioration of performance. We try harder, but the harder we try, the faster we fail.

The curve is shown with a peaked top because most coronary patients can pin-point the event or the change of personal relationships that marked their 'going over the top' into exhaustion and ill-health and put them on course for the catastrophe a year or so later.

The 'intended' dotted line is drawn to emphasise the fact that the exhausted coronary patient is preoccupied with the gap between what he can do (actual performance) and what he thinks he ought to be achieving (intended performance). Unless he is well-trained and disciplined, and constantly alert to the dangers of his predicament, he will contribute to his own deterioration by struggling ever more fiercely, but always downwards, until he collapses in illness or breakdown. His will-power may produce surprising spurts of high-performance activity, but they will be drawn from ever-reducing reserves, and they should not be used by the patient to persuade himself that his staying power is as good as ever.

*This article is based on a talk given to the Balint Society on 23 February, 1988.

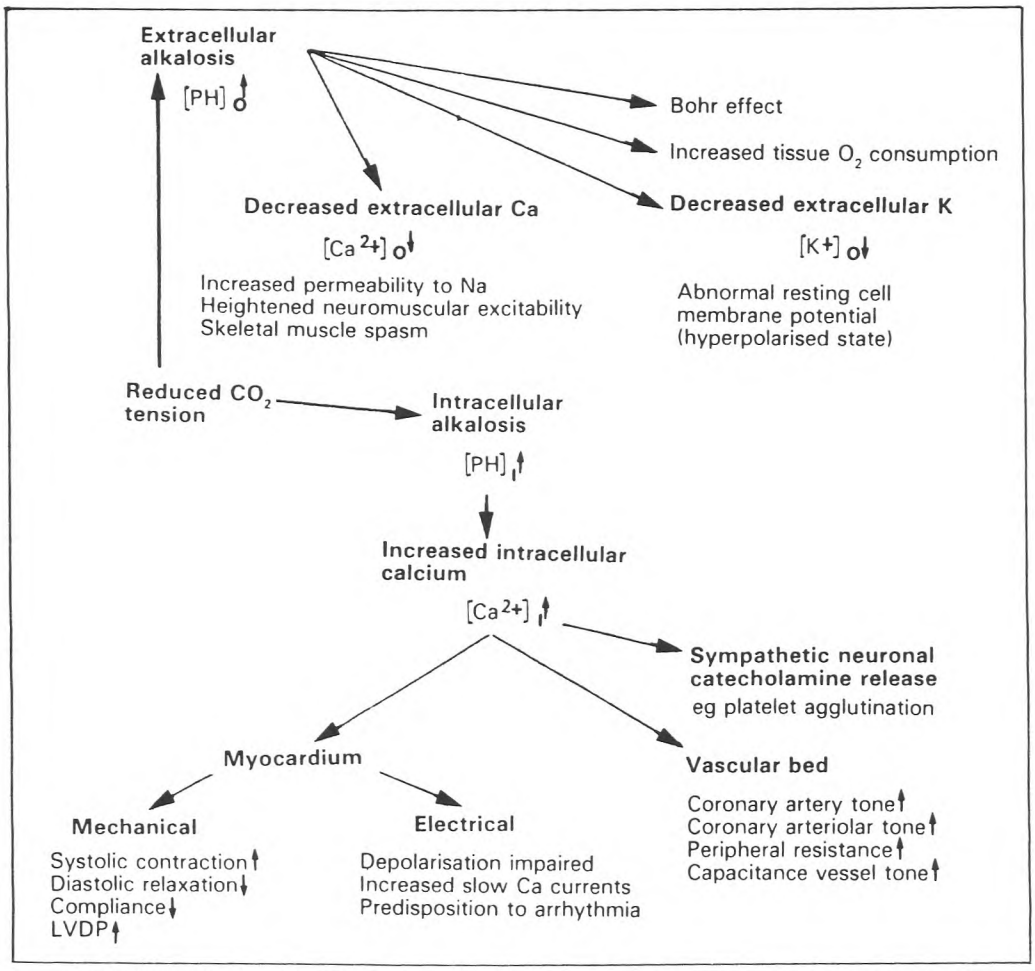

Fig 1: The mechanisms by which hyperventilation, causing a fluctuating reduction of the blood CO_2 tension, induces vasomotor instability and disturbances of function (courtesy of Abdul Hamid Al-Abbasi, 1982)

The word 'arousal' has many uses. It can be employed behaviourally, as in this instance, to denote the level of the individual's general drive state[3] but it can also refer to the activation of the neuro-endocrine system. The individual on the down-slope of HFC, struggling and falling and moving further and further from a healthy coping state, undergoes powerful stimulation of the sympathoadrenomedullary system (S-AM) and of the pituitary adrenocortical system (P-AC). The S-AM hyper-arousal is associated with rage, fear, frustration and extreme effort: the catecholamine drive is high. The P-AC hyper-arousal is associated with defeat, despair, loss and isolation: cortisol levels are raised. The combination of powerful S-AM and P-AC arousal is largely responsible for the processes of catabolism getting the upper hand (see table). The body's anabolic mechanisms for healing, maintenance and defence are suppressed to provide as much energy as possible for struggle and vigilance; and the individual begins to be vulnerable to the illnesses that will eventually deprive him of the freedom to go on living as he wants if he does not halt his down-slope course.

The human function curve enables us to grasp the idea that some individuals have high curves and others low. A high curve permits great performance, whereas a low curve invites exhaustion, ill-health and coronary breakdown at an early age. The handicaps that produce low coping curves in coronary patients are well known but not well publicised. They include poor mothering, poverty and struggle in childhood, failure at school, loneliness, inadequate social support, migration, suffering intolerable and overwhelming burdens, and losing prediction and control of life's course.

The curve also enables us to picture the various influences, drives or urges to arousal that can get out of hand and thrust us 'over the top' into exhaustion, ill-health and breakdown. Some of these drives are generated within us: they include unhealthy levels of

Catabolic and anabolic processes (Sterling and Eyer, 1981)

Hormonal pattern during arousal	
Catabolic hormones increase	*Anabolic hormones decrease*
Cortisol	Insulin
Epinephrine	Calcitonin
Glucagon	Testosterone
Growth hormone	Estrogen
Antidiuretic hormone	Prolactin
Renin	Luteinising hormone
Angiotensin	Follicle stimulating hormone
Aldosterone	Gonadotropin releasing hormone (GnRH)
Eythropoietin	Prolactin releasing hormone (PRH)
Thyroxin	
Parathormone	
Melatonin	

Anabolic and catabolic states
Anabolic state
Increased synthesis of protein, fat, carbohydrate (growth, energy storage)
Decreased breakdown of protein, fat, carbohydrate (growth, energy storage)
Inreased production of cells for immune system (white blood cells of thymus and bone marrow)
Increased bone repair and growth
Increase in sexual processes (cellular, hormonal, psychological)
Catabolic state (arousal)
Halt in synthesis of protein, fat, carbohydrate
Increased breakdown of protein, fat, carbohydrate (energy mobilisation)
Elevated blood levels of glucose, free fatty acids, low density lipoprotein, cholesterol (for energy)
Increased production of red blood cells and liver enzymes (for energy)
Decreased repair and replacement of bone
Decreased repair and replacement of cells with normally high turnover (gut, skin, etc)
Decreased production of cells for immune system (thymus shrinks, circulating white cells decrease)
Decreased sexual processes
Increased blood pressure, cardiac output
Increased salt and water retention

anger, anxiety, tension and cynicism; lack of assertion skill (inability to say 'no' to the demands of others); restlessness and feeling guilty about relaxation; inability to be satisfied by any level of achievement; and the type A behavioural pattern that is dominated by haste and hostility[5]. Other drives come from outside us, from exhausting environmental circumstances, and they include bereavement; financial hardship and unemployment; blizzards and heat-waves; the strains of adapting to large and frequent life-changes; the need to meet high or conflicting demands without the possibility of success; and the experience of severe and prolonged stress with inadequate social support. It is not surprising that the poor and lowly paid suffer four or five times as much from coronary disease as the rich and affluent, nor that modification of the conventional risk factors (smoking, dietary cholesterol, raised blood pressure, lack of exercise) provides small protection.

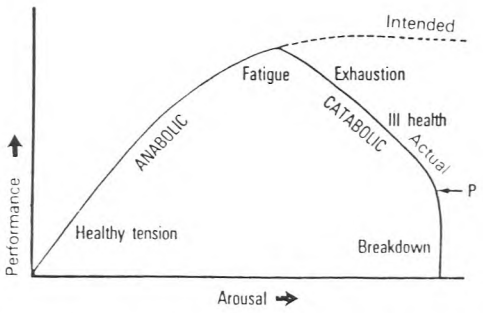

Fig 2: The human function curve. Performance relates to coping ability and efficiency. Arousal relates to effort, and, at the higher levels, to struggle. P represents the 'catastrophic cliff edge' of instability where little further arousal is required to precipitate a breakdown.

Diagnosis of the Patient's Position on HFC

Healthy Function

The individual feels well. His manner is relaxed. Physical recreation brings pleasure without guilt. Burdens and pressures that would cause loss of happiness and health are rejected. Increasing the arousal enhances performance. Other people look upon him and his relationships as healthy and see him as adaptable and approachable. The qualities required for success are abundant: rapid and flexible thought, originality, vigour, expansion and stamina.

Acceptable Fatigue

The individual feels and shows tiredness and does not deny it. He takes steps to recover as soon as possible. Maladaptive habits that waste time and energy can be shaken off, and inessential drains on the energy can be jettisoned or deferred. Performance can increase with arousal but more effort is required. Disciplined effort, youthful conditioning for competition, social pressures and mild stimulants such as tea, coffee and cigarettes play a greater part in sustaining the performance. Sleep patterns remain physiological. Others see the individual as healthily tired but are not made anxious because the qualities required for success are still evident. Therapy is neither sought nor required beyond reassurance that the fatigue is healthy.

Exhaustion

Lipowski's list of the effects of information-input overloading provides a useful basis of classification for cardiological work[6]. The brain's signal-handling becomes less efficient, fewer problems are solved by our 'automatic pilots', and we become more easily aroused — hot and bothered — about more things. Thus the heart is given more work to do and the product of the heart rate and blood pressure becomes greater for a given amount of effort.

Performance is impaired by loss of energy and stamina, loss of speed and accuracy of response, and increasing feelings of resentment and paranoia. Vigilance and restlessness increase. Discriminative powers deteriorate and the subject becomes less capable of managing his time and resources efficiently. Judgement is impaired. The loss of leadership qualities compels more reliance to be placed on rank and seniority. Reducing adaptability causes defences to be erected against change, and a tendency to dwell in the past instead of in the future. There is a temptation to sit around eating, drinking and talking too much instead of getting on with the task in hand. Aggression

flares up and destroys the goodwill of potential allies. Maladaptive coping habits are commonly adopted. They include acquiescence in sleep deprivation, denial of major problems and indulgence in exhausting displacement activities. People in this phase of exhaustion are prone to hurl themselves into ill-judged physical effort, producing the risk of myocardial infarction and cardiac arrest. Total failure of coping is very close when the patient feels desperately trapped, unable to carry on and unable to opt out. Feeling trapped, he is likely to hyperventilate, and the hyperventilation can trigger off coronary arterial spasm and fatal arrhythmia.

Social disorganisation occurs when the subject stops listening to others. He loses insight; becomes impossible to live with or work with; and neurotic traits get out of hand.

Neurohumorally, it is thought that S-AM and P-AC activity can rise to extremely high levels, and phaeochromocytoma-like levels of catecholamine activity have been recorded. It becomes extremely difficult for the body's self-regulating mechanisms (homoeostasis) to withstand the catabolic assaults and maintain a healthy internal milieu.

Ill-health

The ill-health that inevitably occurs when the exhausted press onwards and downwards towards P can take many forms. The fruits of disabling anger, social disruption, alcoholic bouts, automobile and industrial accidents, loss of resistance to infection, flare-ups of psychosomatic or psychiatric illness and the various syndromes of chronic habitual hyperventilation are commonplace, but the cardiovascular disorders are a natural choice for people whose life is a perpetual struggle to close the gap between their actual performance and the level of achievement they think is intended of them, particularly when they possess a highly responsive arousal system and the will to force themselves beyond the limits of physiological tolerance. Their period of greatest danger comes when they are defeated and cut off, or lose their place in the pecking order[7].

The commonest cardiovascular forms of ill-health encountered in cardiac rehabilitation are:

1. Loss of fitness and stamina. Deconditioning.
2. Hyperventilation disorders: effort syndrome or da Costa's syndrome.
3. Ectopic beating and arrhythmias.
4. Catabolic disorders, eg hypertension (fig. 3), hyperglycaemia, hyperuricaemia and increased blood coagulability.
5. Electrolyte shifts and fluid retention conducive to arrhythmia (potassium loss) or heart failure (sodium retention).
6. 'Coronary' syndromes such as angina pectoris, acute coronary insufficiency, recurrences of myocardial infarction and cardiac arrest where the highly-aroused demands put upon the heart outstrip the competence of the coronary circulation. Atheromatous coronary lesions can range from the most severe to the most trivial in these cases, and need not even be present. The heart can suffer ischaemic injury from coronary vasospasm, intravascular thrombosis and, probably, from catecholamine toxicity.

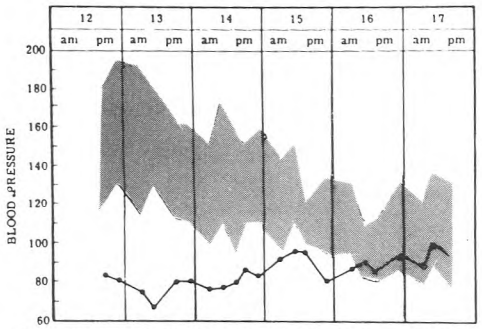

Fig 3: Businessman aged 54 years. The blood pressure (stippled area) and heart rate (●–●–●) changes during a sleeping resting regimen prescribed for recovery from a period of homeostasis violation induced by exhausting effort and loss of sleep during a business tour in the Middle East. From April 12 to 14 the sleep required hypnotics but from April 15 to 17 it occurred naturally. Afterwards the blood pressure returned to its customary level of 110/60 and remained there. Without a sleeping/resting regimen in such cases, the blood pressure usually remains raised, becomes resistant to hypotensive drug therapy and increases with further effort

The Implications of Arrival at a Coronary Breakdown

Irrespective of whether P presents with angina pectoris, coronary insufficiency, myocardial infarction, cardiac arrest or a dangerous arrhythmia, the patient's general condition is profoundly disturbed. The chances are that he has been exhausted for a year or more but has been concealing, denying or rationalising the deterioration of performance. He is highly aroused and low in coping ability. He suffers from disrupted social relationships and inadequate support, and is handicapped by childhood poverty and a hard life. Devoid of effective responses for dealing with his new predicament, and helplessly dependent upon whatever medical system he has fallen into, his body has been violated by lengthy periods of catabolic abuse, and his heart is in urgent need of anabolic conditions for healing.

The Direction of the Patient's Course

Unfavourable

Many patients are led in a wrong direction from P these days because few professionals understand the effects of arousal. Many increase it by putting their patients into alarming coronary care units, withdrawing warm and supportive human contacts, and causing severe sleep deprivation. When the patient shows the inevitable deterioration they may attempt to offset the arousal disorders of the recently injured heart with cardiac depressant drugs, or make threatening noises about surgical treatment designed, in their minds, to expand the competence of the elderly coronary system to meet the grossly exaggerated needs of the heart which has been given no respite from exhaustion, vigilance and a powerfully catabolic internal milieu. In Florence Nightingale's day the vulnerability of the injured heart to arousal was well known, and every care was taken to provide protection.

If the patient survives the acute phase of his breakdown he will still be put at risk by our contemporary failure to understand exhaustion and its management. The symptoms of the overtaxed heart may be suppressed with palliative drugs instead of being removed by rest and sleep, and whatever reserves

of energy are available may be squandered by clumsy and ill-timed risk factor evangelism. Commonly the patient is compelled to make so much effort so soon that anginal disability and an invitation to open-heart surgery become almost inescapable. If wisdom is the exercise of judgment acting upon experience, common sense and available information, then folly appears to be as common in the management of coronary care as it is in the government of nations[9].

Favourable

The first salutary move takes the patient out of exhaustion, and off the down-slope, and replaces the catabolic conditions with anabolic. It has two vehicles. The first is the sleeping/resting regimen which maximises the anabolic healing time in each 24 hour period; reduces the demand upon the heart and coronary circulation; aids the recovery of autonomic and respiratory stability; and brings the patient rapidly through the phases of denial, rage and bargaining into the acceptance he requires for effective rehabilitation. The second vehicle is provided by the nurses and therapists who provide anabolic conditions of security, relaxation, well being and dignity, and the warm personal relationships that enable the patient to reduce his vigilance and arousal.

When the exhaustion is removed and the patient is ready to take an active part in his own recovery, he is led up through the activities of daily living (ADL) at a rate which steadily increases the height of his coping curve without thrusting him 'over the top' into exhaustion and the re-creation of coronary illness. During this period of re-growth, close attention must be paid to the handicaps that might have created a low coping curve in the life before the heart attack and to the influences that might have shifted him rightwards from healthy function to a down slope catabolic mode.

At this stage it will be found that many patients are alexithymic, that is to say, 'colour blind' to exhaustion and the somatic effects of hyperarousal; or in a condition of anome, prone to high and disabling levels of anger through their loss of roots and starvation of healthy human attachment.

Once the patient is seen to be capable of returning to ADL or achieving healthy compromises without re-exhausting himself, it is reasonable to begin a programme of physical training for fitness and stamina with an easy rein.

Throughout the passive and active phases of rehabilitation we try to ensure that the best possible use is made of the patient's psychological and physiological resources for recovery, and the acronym SABRES makes a useful check list of the biological imperative:

S = Sleep: awareness of the quantity and quality required, and how to get it.

A = Arousal: awareness. Learning to relax and modulate the effects of rage and struggle, despair and defeat well enough to keep out of catabolic disarray.

B = Breathing: awareness and control in place of hyperventilation's upper chest irregularities of rate and depth and sighing.

R = Rest: achieving the ability to be still and calm when the heart requires to be rested.

E = Effort: recognising and respecting the limits of beneficial physical and mental effort, and the onset of healthy tiredeness.

S = Self-esteem and confidence: restored by the close support of the trainer and the successful employment of SABRE.

When the patient has learned to master and respect these biological imperatives, he can usually enjoy a surprising degree of freedom. He may become stronger and more able than he was before the heart attack.

The greatest reward is to hear the patient say, a decade later, that the heart attack was the best thing that happened to him: 'It really made me start to live.' It should be observed that this reward is only given to the doctor who serves the patient by teaching him to be autonomous, to take charge of his health and to fight back — to be his own doctor, if you like — and freeing him from life-long subordination to medical systems and pharmaceutical despotism.

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For Your Bookshelf

Serious students of Michael Balint's writings will be particularly interested in three of the current paperback titles in the Maresfield Library which have been reprinted and distributed by H. Karnac (Books) Ltd.

Primary Love and Psychoanalytic Technique. 288 pp. £9.95. (ISBN No. 0 946439 33 8)
This volume was Balint's first book to be published in the International Psycho-analytical Library series (No. 44), in 1952, when it received high praise. It contained a number of Studies written during the year 1930-1952 on three intimately interlinked topics — human sexuality, object-relations and psychoanalytic technique. Also included is the last paper published by Alice Balint, *Love for the mother and mother-love,* said by Balint to be one of the most important contributions to our understanding of the mother-child relationship.

Problems of Human Pleasure and Behaviour. 300 pp. £9.95. (ISBN No. 0 946439 34 6)
A further volume of Balint's Studies, also first published in the International Psycho-analytical Library series (No. 51), in 1957, is divided into three parts. The first deals with *The individual and the Community,* and contains seven essays, ranging from *Individual differences of behaviour in early infancy and an objective method for recording them,* (the subject of his Manchester M.Sc. thesis) to *The problem of growing old.*

The second part deals with clinical problems, and contains the whole of his address from the Chair to the Medical Section of the British Psychological Society on 25 January 1955, entitled *The doctor, his patient and the illness.*

The third part contains seven papers about *Men and their ideas,* which include Pavlov, Ferenczi, the Marquis de Sade, and Roheim.

Thrills and Regressions. 148 pp. £7.95. (ISBN No. 0 0946439 33 8)
In the first part of this volume, also initially published in the International Psycho-analytical Library series (No. 54), in 1959, entitled *Thrills,* Balint describes how the new ideas and terms he introduced help to a better understanding of a number of common human experiences.

The second part, *Regressions,* contains his attempt to evaluate the usefulness of his proposed new approach for the understanding of some common clinical observations.

The third part, an *Index,* contains notes on various subjects raised in the main text, and also includes a chapter on *Distance in space and time,* by Enid Balint, who comments on the new approach and quotes its application in her own patients.

Although these books were largely intended for reading by psychoanalysts, there is much of interest in them for general practitioners, and others who have been drawn to the work of Michael Balint.

A forthcoming title which will be of special interest to all English-speaking Balintians is:

The Technique at Issue: Controversies in Psychoanalysis from Freud and Ferenczi to Michael Balint. André Haynal. 13.95.
It is sad to see that Chapter 6, *From Budapest to London,* which is devoted to the years Michael Balint lived and worked in Britain, remains disappointingly short.

Nevertheless, there is a great deal of interest in the description of Balint's original contributions to psychoanalytic theory for non-analyst readers.

As I have already recommended in my lengthy review, (see Book Review, Vol. 15, p. 30) following my dictionary-in-hand reading of the original French version of this splendid book, its English translation will make an excellent addition to any practice library.

These titles are available form: H. Karnac (Books) Ltd. at:
5 Gloucester Road, London, SW7 4QC.
118 Finchley Road, London, NW3 5HJ.

P.H.

The Special Patient and the Silver Screen*

John Salinsky,
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Ever since I was a child I have had a great affection for the cinema, and I still find it very exciting to sit in a darkened auditorium watching the curtains roll back and the screen light up. Television and video are, of course, much more convenient, but for my taste the pictures are too small. There is no substitute for the twenty foot image projected onto a real cinema screen, to which I like to get as close as possible, the better to lose myself in the film. So when I have time to spare, I still make the trek out on rainy evenings to see films old and new. Some of the great films have cast a sort of spell over me; I have seen them again and again and they linger in the memory, becoming part of my own imaginative inner world.

But one cannot spend all one's time in the cinema or daydreaming. There is a real world to cope with and a living to earn, in my case by attending to the needs of my patients. Curiously enough, just as there are certain films which have a special meaning for me, there are certain patients who are often in my thoughts. Like the films, I can see them again and again without getting tired of them. My receptionist calls them my 'Special Patients' and I sometimes wonder how they have managed to qualify for this status. Some of them have been quite seriously ill, it's true, but illness alone is not enough. There are plenty of ill patients who are conscientiously cared for, but never become Special. Could it be that Special patients are simply very attractive, delightful people whom it's fun to be with? If so, I should feel rather uneasy about spending so much time on them. But no, this can't be true either; I can easily call to mind a number of Special patients who have been quite unattractive, even repellant, at least to start with. And yet, some chord has been plucked; some string within me must have vibrated in sympathy, arousing interest and concern. Take, for example, a Special patient whom I shall call *GLORIA*.

When I first met her, Gloria was 38 years old, separated from her husband and living with her three teenage children in an unremarkable semi-detached house. Her eldest son, aged 17, had telephoned for a visit because, he said, his mother was feeling very unwell and had fallen several times. When I arrived at the house, Gloria was lying in bed with a towel wound like a turban around her head. She was wearing dark glasses; her speech was slurred and she seemed disorientated. I caught the flavour of alcohol on her breath and quickly realised why.

The double bed in which she lay was strewn with a flotsam of multi-coloured tissues, cosmetics, bottles of tablets, soiled underwear and cigarette ends. When she took off her glasses I saw red rimmed eyes, and a once beautiful face with lines of bitterness showing round the corners of the mouth. I was ten years younger then, and less charitably inclined than I would be today to someone who seemed to be lying in a mess of her own making. I accused her of drinking too much and told her she should be ashamed of herself. I put a dressing on a small cut on her forehead and then went downstairs to interview the children, who gave me a frosty reception. The elder son agreed that his mother was probably drinking half a bottle of gin a day, but he seemed to regard this as quite acceptable. I left feeling very cross that my time had been wasted. I did not take in the anxiety that the children must have been feeling behind their defensive wall. I was unaware that the youngest was a girl of only eleven.

When I arrived back at the surgery I was surprised to find that my receptionist had another message for me — from Gloria herself. She demanded that I return to the house immediately and apologise for my insulting behaviour! If I did not do so, the message continued, I would receive a visit from Gloria's brother whom she described as 'a very violent person'. This was somewhat disturbing, but I decided to ignore the threat and the plea for further attention which it only partially concealed. No violent brother appeared and I was able to forget about Gloria and her family for a while.

Two weeks later, there was another request for a visit. This time she had severe abdominal pain and thought she might have an ulcer. When I arrived at the house, Gloria was downstairs in the sitting room and the children were nowhere in evidence. This time she was polite and coherent. She thanked me graciously for coming and neither of us referred to the previous episode. She accepted my prescription and suggestions for further investigation like a good patient, and I began to like her a bit better.

My next visit was several months later. This time she said only that she was suffering from anxiety, was unable to leave the house and wanted to talk to me. Could I possibly come round? I came round. When I arrived she was sitting downstairs in her nightdress. There was a fully ashtray and a half empty gin bottle on the table beside her. She told me that she had not set foot outside the house for two months, since news had reached her of the death of her husband in Florida. He had been an alcoholic and subject to outbursts of terrifying violence against her and the children. After 14 years of this marriage she felt she could stand it no longer and two years ago had fled to England with the children. But now that he was dead (of cirrhosis, apparently), she was full of remorse for having, as she saw it, abandoned him to his fate.

I also heard about her own childhood; a bleak story of cruelty and loneliness. Her parents had separated when she was 4 years old and she had been brought up in a series of convents. When she was 13 she was returned to the care of her mother whom she no longer recognised. In her later teens she had become a very pretty girl, much admired by the boys in her small American town where she lived with her mother and brother. She had been treated, for a while, like a princess, and she recalled those days with pleasure

*From a paper read to the Balint Society on 24th November 1987.

(and irony). Unhappily she became prematurely pregnant and was married at 18. For a short time, the glamorous life continued as her husband was rich and liked to live in style. Unfortunately, predictably, his alcoholism soon put an end to her enjoyment.

She now admitted quite freely to drinking heavily herself — but would not consider psychiatric referral or hospital admission. She requested and was given some tranquillisers, and I continued to visit her once a week. There were also additional out-of-hours visits when there was a crisis. Somehow I never seriously questioned her inability to leave the house and in ten years I cannot remember that she has ever been to the surgery!

On my regular visits I would listen to her complaints, discuss her feelings with her and prescribe the tranquillisers which seemed to help her anxiety. She continued drinking as well for the first few years, but this gradually diminished and then stopped altogether, except during a 'crisis'. The crisis calls were not very frequent (perhaps once in two months), but at first I found them irritating. They should not be necessary, I thought, given all the attention she was already receiving. On the telephone I would insist on being told exactly what had gone wrong and what it was she expected me to do for her at 9.00 p.m. on a Sunday, or whatever unreasonable time and day it was. She could never tell me and would sometimes hang up on me if I made a lot of difficulties. Gradually I realised that at these times she just wanted me to be with her for half an hour or so; not doing anything, not prescribing or advising, but just being there and listening. Like King Lear (Act II, Scene 4), she was asking me to 'Reason not the need'.

One crisis was precipitated by the defection of her daughter who, when she was 15, was taken into care by the social services and thereafter refused to communicate with her mother, or even let her know where she was living. The end of a love affair resulted in another out-of-hours summons and the marriage of her eldest son, in yet another. Crisis interviews generally took place in the bedroom, to which she would retire with her bottle of gin, her cigarettes and her tranquillisers. Sometimes she would be very drunk and frightened of being alone with what she called 'The Anxiety' as if it were some sort of foul fiend which pursued her. She would sit in her devastated bed, surrounded by the paraphernalia of distraction and oblivion: alcohol, tablets, cigarettes, letters, chocolates, newspapers and magazines. With tears smearing her mascara, she would plead with me not to leave her and to hold her hand.

Yet in between crises, she was very different. Downstairs in her sitting-room, she had a sort of ravaged grandeur, as she sat there with her cigarette and her glass — like a once great lady, a little down on her luck. She also had quite an acute sense of humour and I enjoyed her ironic accounts of her dealings with social workers, hospital doctors and the succession of dubious lodgers whom she took in to eke out her social security payments. Over the years I got used to Gloria's ways, learned to understand her a bit better and to appreciate her qualities.

But now it is time for me to explore how I came to fall into this Special relationship with Gloria and to spend such a lot of my time with her. Some of my readers may well feel that my Management of the Case has been inadequate, inept, self-indulgent, collusive or even unprofessional. It may be pointed out that sitting watching a lady drinking gin and tonic in her nightie is not the proper way to treat alcoholism. I may be reprimanded for the risks I have been taking by letting myself get 'too involved'. To all these charges I will at once plead guilty. I am much more interested in how and why it happened, than whether or not it should have happened.

It is clear that Gloria was 'Special' for me in a way which did not apply to any of my partners or her previous doctors, none of whom had fallen under her spell, despite opportunities to do so. It is well known to those who have worked in Balint-groups that group members be they nurses, social workers or doctors, tend to present patients whose problems or preoccupations in some way resemble their own. For example, a doctor who is pregnant may present patients with problems relating to fertility or maternity. Others may be especially concerned about depressed or angry patients as an indirect expression of some of their own unacknowledged troubled feelings.

Another way of putting it is to say that the 'Special' or 'interesting' patient is in some way a reflection of part of the doctor's own inner world of memories and feelings. Now as I have already revealed to you, my own inner world contains, among other things, a sort of multi-screen cinema, where a variety of classic films are always playing, in continuous performance. During one of Gloria's crises, I suddenly realised why she was so familiar and so fascinating. She belonged to one of those memorable movies, seen many times on the big screen and even more often in the private cinema of my skull. The film is Billy Wilder's 'Sunset Boulevard' (1950) in which Gloria Swanson plays the role of a faded star of the Silent era who has retreated into a private world where she is still a Queen. She lived in a decaying mansion surrounded by her memories, soaked in alcohol and supported by her collusive butler (Erich von Stroheim) who, we learn, had in happier days, directed her most celebrated pictures. Into this dream world stumbles a young screen writer (William Holden) who needs somewhere to hide his car from the hire purchase agents.

At first she mistakes him for the undertaker who is supposed to arrange the interment of a beloved pet monkey (a bizarre touch!); when she realises her mistake, she angrily dismisses him. But then the reporter recognises the famous face: 'I know you', he says, 'You're Norma Desmond. You used to be in Pictures. You used to be Big'. To which Norma Desmond replies with magnificent dignity: 'I am Big. It was the pictures that got small . . .'

When I hear that drawling transatlantic delivery in my mind's ear, I instantly recognise the resemblance between Gloria Swanson's Norma Desmond and my own 'Gloria': the faded beauty living in an unreal private world behind closed curtains; the squalid glamour of the bedroom; the terror and loneliness, tinged with paranoia and laced with alcohol. The tears and pleading alternating with tirades of savage bitterness. Above all, the slightly pathetic grandeur in

the midst of desolation and decay. The only difference is that Norma Desmond, the silent movie Queen, had no sense of the ironies of life; no ability to laugh at herself. That was supplied by Billy Wilder, the Director, whose casting of 'Sunset Boulevard' was cruelly brilliant. Gloria Swanson's own career had been very much like that of the fictional Norma Desmond; a brilliant star in the Silent era — all but forgotten when the Talkies came. Furthermore, she had worked with Erich von Stroheim whose final ruin as a director she helped to bring about when she had him sacked from the film 'Queen Kelly' in which she was the star. The irony of casting him as her butler cannot have been lost on either of them and it surprises me that they were willing to take part. Perhaps they were glad just to be 'back in the studios, making another picture'.

But wait a minute. If my patient Gloria is an incarnation of Norma Desmond, what part in the drama has been assigned to me? Have I become the gloomily faithful butler, Erich von Stroheim, who has given up all hope of ever 'directing' the action? Or am I more like the William Holden character who comes across the menage accidentally — and soon finds himself part of the household as Norma's confidante and lover? Readers who know the movie will be quick to point out that William Holden ends the picture as a corpse, floating upside down in the film star's swimming pool, shot dead by the jealous Norma when he tried to leave her. Having seen the film many times I have no need to be reminded of the outcome. However, I am comforted by the observation that, despite being dead, Bill Holden is able to narrate the whole story as a 'voice over' and thus retain a degree of objectivity. It is this detachment, the 'voice over' in my head, which I hope has enabled me to avoid an equally catastrophic fate at the hands of my own 'Gloria'. But that I must leave for the reader to decide.

At the end of the film, Norma/Gloria is about to be arrested for the murder. The police arrive and as she slowly descends the stairs (one of these wonderful Hollywood staircases), the crime reporters gather at the bottom together with the newsreel cameras. The sight of these cameras makes her believe that she is back in the studios, making another picture at last. Von Stroheim stands beside the cameras and pretends to be directing her again in order to get her to come down the stairs to the waiting policeman. And she descends, willingly enough, serenely happy in the delusional world which has now, in the narrator's words, 'enfolded her'.

We feel compassion for her and a sort of respect for her dignity. There is also the creepy sensation that goes with observing someone who is totally cut off from reality.

Meanwhile, what has happened to my patient, the real flesh and blood Gloria? I can report that she is still my patient, ten years after our initial meeting. She is now aged 48, although she would probably absent-mindedly subtract a few of those years. She survives on a large (but stable) dose of benzodiazepines and some tablets to control her hypertension. She has a small part time job and also looks after two lodgers. Her eldest son is married and independent, but stays in touch and has provided Gloria with a baby grand-daughter whom she is going to look after when her daughter-in-law goes back to work.

The two younger children have dropped out of sight. I hope that they have been able to repair some of the damage done in their early years. Gloria prefers not to talk about them but their rejection of her still hurts inside. She has a Canadian boyfriend of 60 who visits about twice a year and will one day, she tells me, come and settle down with her for life. Meanwhile she weeds her garden, gets out to the shops, enjoys her grand-daughter's company and hits the gin bottle only when there is a crisis. I still visit her every two weeks, renew her prescription and stay for about fifteen minutes. It is not particularly exciting these days; and not in the least dangerous.

One day, not very long ago, she was gracious enough to quote her son who had told her that she was very lucky to have such a conscientious doctor. Well, I knew that conscientious was not really the right word, and maybe she was just lucky that she resembled Norma Desmond: but I accepted the compliment anyway.

And now I must close this memoir and hurry along to the cinema. There's a new Woody Allen film showing and I do not want to be late.

"So, Vot Can Ve Tell?"

Anne H. Watson
General Practitioner, Oxford.

Recently I boasted about having been a medical student in the golden days of Balint-groups — run by Balint — when we were his 'first medical students'. "I want to work with you while you still know nothing about anything," he said, beaming through his thick specs.

We had just arrived — from University College London, or Oxford or Cambridge pre-clinical years, and felt we 'knew quite a lot really' — but he seemed so interested in us and exerted such benign authority, we were soon a group, meeting regularly, every Friday afternoon.

It was October, 1962. With breaks for electives and the machinations of medical firms and placements outside the hospital, this continued all my clinical student years. Now I am 50, a general practitioner, and have children who are students themselves. Why do I boast?

There are a lot of interwoven threads in the answer. The clinical student's years are full of tumultuous experiences for most of us. We live, possibly far from home for the first time, up to our necks in new responsibilities. Before we even meet a patient, feelings can run high — living beside fellow students, arguing with landlords, balancing grants, balancing work and leisure lived to the full.

When it came to sitting down beside a patient and taking the history, I for one, was amazed by the sheer need to talk . . . someone I'd never met before, old enough to be my parent or grandparent, pouring out intimate details, even in the setting of a 27-bed ward with little privacy. I remember the Friday group, we discussed this amazing verbal flow. 'Shtop — so vot can we tell?' A question round the group.

'Well, he's lonely. He's away from home.'

'She worries how the family cope without her.'

'Will she be all right after the op?'

'Will he feel the same about her?'

We groped for explanations. Recognition of the myriad thoughts in the mind of the patient began to dawn. What of the mind of the doctor? Our own reactions and feelings came pouring out too. History-taking could teach one a lot about the patient, and a lot about oneself. If the patient needs to talk, the doctor needs to listen. What about false case-work reassurance? I met that term for the first time in the group. Who is better for those smooth, possibly only half-true words, the patient or the doctor? And where are our feelings and their expressions? What if we are irritated by the patient, moved to laugh, or overwhelmed by his predicament? Nurses were sent off the ward for crying. How totally dreadful if the doctor should cry! What about fears of death, or preceding pain or dependency? What about discussion of sex? We had thought we knew so much, — being mostly young and un-married we were now not so sure.

"If you acknowledge your feelings, you can *use* them.'

'Don't pretend'

'If you think you know already, you can't learn.'

These became familiar Balint warnings and guidelines. Balint led the groups with energy, humour and understanding. Gradually, ideas took shape. If I felt so irritated by the patient (Mr X), perhaps so did Mrs X . . . his boss . . . his colleagues; so little wonder his relationships were unrewarding. Could this have led to sanctuary in a sick role? Presenting the case to the group could draw forth a characteristic of Balint's, one which seemed to us students almost like 'second sight'. Having presented the age, symptoms and possibly two sentences:

'Shtop! Vot do ve know?'

'I was just coming to that.'

Balint would then outline the history in nearly complete form. Somehow his encyclopaedic knowledge of human nature, and his memory of any particular case from week to week, would enable him to fill in the outline with uncanny accuracy. We would be impressed. We heard that sometimes patients moved house in order to be able to consult him. We too all enjoyed his humour and amazingly quick understanding.

Part of my own student life was spent as a patient, as a result of a bad road accident. Trauma and general surgery were not then nursed in separate units, so I stayed in the surgical unit for five months, long outstaying an apparently endless stream of 'short-stay' surgery; appendix, hernia, even patients with cancer seemed to be 'in-and-out' compared with the 'ball-and-chain' set, anchored with beams and pulleys.

At first it felt like incarceration, terrible. I could have drowned in self-pity. But somehow, the fascination of studying my fellow patients, and the shared life as a patient helped. The daily opportunities to watch 'The nursing process' in action, being ineviatably part of it myself — rescued me from despair.

My fellow-students, in their still-new white coats, made rewarding study. I think we were all trying to learn. Perhaps some tried too hard? Some looked so self-important striding about the ward and then so foolish when they could not answer a question. Some were quietly unhurried and conveyed real interest, real kindness. Patients liked them the best. How did they do it? It was nearly all non-verbal. What was it Balint had said? 'Don't pretend.' That was it. Pretending to be cleverer, busier, better-informed . . . does not convince the patient.

Time tends to blur painful memories, but I vividly remember those feelings. Such an experience is pertinent to all medical practice, I imagine. Perhaps especially general practice where we may have a long acquaintance with our patients.

The renaissance in general practice is now seen as a phenomenon of the 60's. Balint opened the eyes of the profession to the enormous therapeutic potential in the doctor/patient relationship. His influence went far beyond the doctors who worked with him, and is

to be found now in every area of general practice. He was master of the clinical process itself: what is going on during the face-to-face contact? Certainly in the 60's, some doctors were uneasy about his approach. Their guide to working followed a traditional approach guided by theory, the theory (for example) of the long-term effects of emotional deprivation in childhood. But what theories were there about the present and unique interaction between doctor and patient? Pre-occupied with theory, the doctor may persue questions which are really side-issues of the patient's present problem, but which seem to fit better with the doctor's own constructs. Undeterred, Balint would have doctors abandon, or be separated from, their theories in such a case.

In our Health Centre, we are now a training and a teaching practice. "If you think you know already, you can't learn'. The truth of this I've seen borne out by some of our students! It's a salutory reminder whatever I try to learn. And 'unless the patient tells you himself, you can't use that information.' A conflicting account from a spouse, or lurid details from neighbours . . . wait, it is only useable if the patient tells you.

The doctor must focus his attention on what it is the patient is trying to convey at that particular time, rather than the underlying causes, though clearly those may engage his attention on other occasions. The work which is done in an ordinary general practice context can be extremely important in itself — and its quality determines how effective the treatment which the patient receives from all sources will be.

I am glad that we have our own 'Balint-groups', attended by general practitioners from four local general practices, in the Health Centre here.

So I boast because I had the opportunity of watching, and learning from a master of the art at work during my formative years.

My Experience of the Doctor/Patient Relationship During Medical Training

Carole Anne Tallon*
Medical Student, University of Leicester Medical School

A relationship between two people is, according to the Collins English dictionary, a connection by kindred or affinity.[1] The relationship between a doctor and his patient is one of affinity, which is fuelled by the fact that the two people involved generally have the same objective in mind, and that is for the patient to get better.

In order to maximise the efficiency of the doctor/patient relationship, strong communication-links need to be established at the same time as the objectives of the people involved are being defined. This will ensure that both the doctor and the patient receive satisfactory feedback so that the encounters are not so stressful as to negate their therapeutic value. Doctors cannot automatically be expected to possess the skills necessary for the establishment and maintenance of such communication-links, and therefore require specific training in this area.

At the University of Leicester Medical School one of the course components of the first two preclinical years is entitled 'Man in Society'. This module endeavours to give students an appreciation of the behavioural sciences and their function in modern medicine, and adopts a scientific approach to the teaching of epidemiology, psychology and sociology. The students are also encouraged to cultivate their communication skills and are given the opportunity to participate in role-play and discussion groups; as well as having the use of various audio-visual aids.

Another part of the course which directly addresses this function is the Family Placement Programme, which the students start during their first term at medical school; each student is assigned to a discussion group which is under the supervision of a general practitioner. This doctor assigns each student to a family from his or her practice. The students make a minimum of seven visits to their allotted families during the preclinical course. After each visit, students report back to the discussion group for the purposes of sharing experiences and for discussion of any particular problems which may have arisen. Students must also spend at least one day at the general practitioner's surgery during the Family Placement Programme.

There are many objectives of the programme which are outlined to the students at the start of the course, and these are issues which must be investigated and commented upon in the final project report. For example, the student must be able to demonstrate an understanding of the social and psychological processes affecting the illnesses from which people suffer, the effects that the attitudes and behaviour of doctors have on individuals and their families, and the nature of the doctor/patient relationship for that family, among many others.

The families are allocated to students at random, but one requirement is that general practitioners select families of whom at least one member is receiving health care on a continuing basis in order to facilitate investigation of the outlined objectives.

The Family Placement Programme is undertaken at a time when a great deal of scientific theory is being taught to the preclinical students. I feel that it is important to integrate the behavioural with the biological sciences very early in the medical training. This helps to ensure that as future doctors, we are aware that illness can have a wide variety of possible causes: physical, psychological and sociological, and it also alerts us to the many varied therapeutic options available, including drug therapy, psychotherapy and counselling.

All doctors and medical students are themselves members of a family. They know what it is to be reared closely with other people, to have to accept and cope with other people's mood-swings, and to have strong emotional ties and an obligation to help other family members. Their personal life brings with it a vast wealth of experience upon which to draw if they are aware of its value. I feel that the Family Placement Programme, in providing me with a glimpse of the dynamics of a new family, thereby provided me with an adequate comparison for my own. This comparison helped to make me aware of the problems with which families must cope and also gave me some insight into the numerous issues which a doctor must take into consideration when dealing with patients, who are also members of a family.

I embarked upon the Family Placement Project in October 1985 and the only information I had before visiting Family L was that they were a 'middle-aged' couple. I was astonished to find how many preconceptions had formed in my mind prior to the visit as a result only of this simple description. I was expecting a much older couple than the one I subsequently met, and thus found myself quite unprepared for our initial encounter since my exploratory questions for an older couple would not have been suitable for R and C.

On reflection, I realised how important it is not to let such preconceptions cloud one's vision. Winefield and Peay[2] eloquently discuss this issue, using the experience of pain as their example: 'The doctor needs to be aware of the relativity of attitudes towards pain; this will free him or her from the

*First Prize winner of the Essay competition arranged by the International Balint Federation, and awarded 2500 Swiss Francs at the 16th Annual International Balint Meeting at Ascona on 26th March 1988.

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unthinking assumption that his own childhood-learned attitudes are 'right' in an absolute sense. It will make him better able to respect and understand the views of the patients who feel it appropriate to express pain more (or less) freely and to show greater, or less, anxiety about its future implications than he would.

R contracted poliomyelitis at the age of four years and has spent the rest of his life coping with a 'wasted' right arm and leg. Because of the lack of mobility this confers, his lifestyle is somewhat restricted and he suffers from respiratory tract infections and many varied aches and pains. He cannot recall a time when he was not disabled, so it is difficult for him to describe how his illness has affected his life because it is such an integrated part of him. He has the personality of a disabled person rather than the personality of a fit person now coping with a disability.

During my first visit to this family it was very obvious that they perceive R as the 'ill' family member because of his disability. They assumed because of this that I was interested only in R and not in C. Due to my lack of experience, I found myself being drawn into this misplaced belief and because of this, and partly because of C's reluctance to discuss anything but her religion, I found it difficult to explore C's perception of illness with regard to herself and her family.

However, over the course of the visits I got to know C just a little better, and learned that she herself does have one or two health problems. In 1982 she had a hysterectomy and is now on hormone replacement therapy. She is also hypertensive and overweight, and this, together with having had a hysterectomy, has caused her to have an altered body-image. She no longer sees herself as an attractive woman. Her hormonal status, which is not yet under pharmacological control, causes her to suffer from vaginal dryness and itching, and consequently her and R's sex-life has become virtually non-existent.

R sees himself as a person with what he describes as universal vision. He maintains an avid interest in current affairs, in his neighbourhood, and in television programmes. He also reads a great deal so as to broaden his horizons. He appreciates that having a disability could have the effect of making him become insular, and so he does all in his power to prevent this from happening. When he was a child and adolescent his father had prevented him from performing 'normal' activities which involved any degree of self-responsibility lest he should come to some harm. R resents his father but does try to understand his motives. R's two children were fit healthy boys and he encouraged them to be independent from an early age and thus was a strict-yet-liberal father to them.

C is a totally different type of person from R. The driving force in her life is her religious belief. Since 1980 she has been a Jehovah's Witness and therefore does not believe in celebrating such family occasions as birthdays, Christmas or other anniversaries. This, as it is easy to imagine, causes a great deal of tension in the L household. As indeed does C's habit of switching off the television in order to read aloud form the Bible. R actually told me that they had had the teak partition doors installed in their through-lounge so that C's Bible-reading would not interfere with his TV-watching. Another part of the Jehovah's Witness' doctrine is that the blood is a precious resource in which one's soul is contained. Thus they do not believe in blood transfusion and so, at the time of her hysterectomy, C signed a form which stated that under no circumstances was she to be transfused.

R told me how C's consultant had told him of this and recalled that it was at this point that he had realised that he no longer knew his wife. She was no longer the person he had married. I felt sad and helpless as I reflected on the apparent hopelessness of this situation.

At this point, I began to realise that C's beliefs and her problems were not only affecting her, but also R, since as a married couple, they therefore are part of the same family. It also caused me to reappraise what I had felt was the cause of C's altered body-image. As I got to know C and R as a couple, I learned that virtually the only things they had in common were their two sons and two grandchildren. They rarely go out together, even when on holiday in Lowestoft, and thus they have no common ground on which to meet as a foundation for a healthy working relationship, which is the basis of all good marriages.

I noticed throughout all my visits that R continually criticised C about her appearance, her views and her life-style. He contradicted nearly everything she said in front of me. On one occasion when she was out of the room, he told me that Jehovah's Witnesses are told to dress conservatively and that this was the reason why she looked so 'horribly dowdy'.

I began to see even more deeply into the problem of her altered sexuality: I saw that the absence of her sex-life was merely one aspect of the communications problem within what I saw as their decaying relationship. Neither seems to give the other any positive feed-back about themselves and thus there is no mutual confidence-building; something which I see as being the duty of the partners in a relationship.

One issue upon which C and R do agree is that people should take responsibility for their own health as far as possible; they both believe that people should take adequate exercise and a healthy diet, and they adopt a policy of moderation, if not frugality. Of the two, C is the partner who is receiving health care on a continuing basis because of her hypertension and her hormone requirements. She has a modest perception of her problems, and hates to think that by going to see her doctor she is taking up his valuable time that a more deserving patient might require.

R believes the same thing to a certain extent, in that he feels he understands his problems, such as his recurrent respiratory tract infections, so well, that he does not need to consult a doctor. For example he says that if he has a pain then there is no point in bothering the doctor with it since he himself knows by experience that it will go away in time. He no longer takes any analgesic or antibiotics.

Both C and R appreciate the necessity of good doctor/patient communications. R said that he likes 'modern' doctors who 'don't pull any punches' and are very straight with you; this is an ample illustration of Winefield and Peay's[2] view on the importance of

doctor/patient interactions: 'How the doctor responds to patients' disclosures and questions will strongly influence the patient's trust, and thus their motivation to accept advice. Many kinds of response unwittingly demean the patient: false reassurance (which dismisses the validity of his concerns), judgmental remarks or endless further questions.'

There are various ways in which people view their relationship with their doctor, because of 'perceived role differences as well as differences in their social class and expertise.'[3] Some people perceive their role as a 'passive' patient responding to an 'active' doctor. Korsch and Negrete[4] saw that this type of approach can be engendered and maintained by the use of interviewing styles which are characterised by 'closed' questions. C saw herself as this type of patient and explained that although she likes her general practitioner, she does feel intimidated by the whole business of consulting her doctor; she said that it is often only on leaving the surgery that she remembers all those things she would like to have asked but had not.

R sees himself as the type of patient who enjoys more of a reciprocal relationship with his doctor. After getting to know R, and observing his love of talking, I suspected that in a consultation he would certainly have no problems in communicating either his needs or his beliefs; indeed the doctor might possibly have trouble in terminating the interview; a thought upon which I often reflected as I made my way home from the L's house many hours after my estimated time of departure.

The only major crisis which occurred in the lives of Family L during the course of the programme was at Easter-time 1986. C's sister had committed suicide by jumping out of a window of the fourteenth storey of a tower block.

R explained to me that C was very upset and was feeling guilty because she felt she had alienated her sister from her life over the past few years, due to the fact that she saw her as a trouble-maker. R himself felt that he was partly to blame for C's reaction because he had not encouraged her to keep in touch with her sister.

Both reactions displayed by the L's are typical of the many grief responses to bereavement. Doctors have to face patients displaying these signs very often during their working lives and should prepare for themselves ways of dealing with the problem. At the time I was informed of this tragedy I myself had been feeling totally saturated with the processes of bereavement, since the father of the two girls with whom I lived, had died suddenly in late January. I had played the role of carer to them, helping them to work through the various emotions of disbelief, anger, guilt and depression as they appeared, and even though I too felt the loss of this kind man, I had not allowed myself the opportunity to grieve for him myself. This I believe was the reason why I felt unable to help the L family at that time. My lack of sympathy, or even of empathy, was because I was so emotionally drained from the experiences I had undergone.

According to Stedeford,[5] professionals such as doctors who are facing death for much of their working lives, actually need to resort to mental mechanisms in order to defend themselves from exposure to potentially stressful events.

I never felt inclined, nor indeed ever had a perfect opportunity to discuss the tragic loss of C's sister with either R or C. However, I did learn a great deal about myself from the unhappy experience. I reflected upon what had been happening to me over the past few months rather than simply worrying about how my friends were coping. Also, I learned the value of not identifying too strongly with someone else's crisis, so as to be able to observe more objectively their emotional response to a situation. That is, how to empathise correctly. According to Parkes,[6] 'awareness of what a problem means to a patient is not only necessary for facilitating communication, but may also be of therapeutic value in itself.'

At this time, I found the discussion group particularly helpful since we discussed bereavement and grief quite extensively. It helped me to see more facets of this human problem, made me appreciate the importance of considering the opinions of other people before reaching a conclusion for my observations, and also revealed to me how supportive group-therapy can be.

On my way to visit Family L for our first meeting, I had imagined that they would be a family with specific problems which, by talking them over with me, they would be able to solve. Now I see just how naive such a perception was. A family such as C and R do not particularly have specific problems, they have the general problems of a couple who have been married for thirty years and whose children have grown up and left home. Such as a sense of loss, and a gradual understanding that their role in the family is a changing one. In this respect I see them very much like my own parents who are in a similar position.

Other general problems which face C and R are their financial worries; C and R have a comfortable, centrally-heated house, a modern car; and take regular holidays. However, because of their lack of employment they are categorised as Social Class V, which to me shows the inadequacy of the system of social stratification when making value-judgments. It must be pointed out however, that despite their apparent comfort, money is in short supply, since they rely on government benefits now that their savings are depleted, and so money has to be a consideration in most aspects of their lives. This is unlike my own parents, who are Social Class II and therefore have enough money simply to be able as R puts it, to 'get up and go at any time'. It is very important that doctors recognise that social class can be a major pitfall for communications. By virtue of their professional status most health-care givers are middle class, and most of those in need of care are working class. It is well-established that middle class people receive a better standard of education than working class people, and also do not have to endure poverty, bad housing or inadequate nutrition. All of these factors of low social class have been shown to be factors likely to cause poor health.[7] For most doctors, their very middle-classness means that they have only second-hand knowledge of the social conditions of those for whom they care.

A further general problem facing C and R is the process of ageing. According to Hendricks, 'Ageing is a dynamic process encompassing complex bodily changes; the redefinition of social identities and

adjustment in psychological functioning'.[8] C and R have probably never read a book on the psychology of human ageing, even though every day they must face the changes occurring in their bodies and minds because of this process. Most patients will be relatively uninformed of the theoretical basis of their illnesses and other problems. It is part of the doctor's role to find successful means of applying his knowledge of the theory to the type of therapy which will best suit each individual patient. For some patients this will necessitate the provision of a full scientific explanation, while for others it may be better to be sensitive to a commitment not to know.

I personally find it very sad that although it is said that one of the positive aspects of ageing is that a couple can gain solace and comfort from each other because of the bond which has grown between them over the years, C and R seem to have very little communication about their feelings at all, and to all intents and purposes are facing their twilight years alone. From what they have told me, as they have grown older, they have grown further apart and perhaps C's fanaticism over her religion is merely one symptom of their conflict. Had I had the opportunity to get to know C better I would have tried to explore her feelings and perceptions of the concept of marrying a disabled man, and to investigate the implications of this in her life.

As for my ignorant assumption that I would be able to solve their problems, I certainly know better now. I have had only a glimpse through a small window at this family. What really 'makes them tick' does still elude me somewhat. On accepting this fact I came to realise that doctors should accept that they do not always know what is best for the patient, and that they should listen and watch for the cues which the patient may be trying to give out.

I have certainly learned that doctors cannot be miracle workers. They must be aware of their limitations, yet maintain a positive approach. Doctors need to be able to listen and empathise, thus building up the patient's confidence that their doctor is interested in their problems. 'Doctors need also to have confidence in their own capacity for growth and for taking responsible action. Action advised on this basis is more likely to be perceived as relevant by the patient, thereby producing more compliance, and will go some way towards establishing a strong bond between doctor and patient'.[9]

To a certain extent, these experiences gave some insight into what it must be like to be a family doctor. The general practitioner needs to be able to build up a picture of the families on his or her list so that at times of illness or other crises, any required therapy can be accurately focused towards the specific needs of the person concerned, as an individual and as a family member.

Another part of the project which gave me particular insight into the demands on a doctor, was the day I spent at a general practice in Leicestershire. Much of the morning was spent observing a doctor as he carried out his surgery, and this was very much as I had expected. However, one of the most inspiring parts of the day was when at the end of morning surgery, for about an hour before lunch, all the doctors in the practice met together and discussed any problems they had recently encountered, as well as any other current difficulties. I felt that this was an excellent opportunity for the practice to work as a team, so that their personal and professional resources could be pooled in order to benefit both themselves and their patients.

The group consisted of some senior doctors with many years of general practice experience and also some younger doctors with many modern ideas. They each appeared to have a particular interest in one field such as orthopaedics, or problems encountered by the elderly, and this means that the scope of the practice was far wider in that fewer specialist referrals had to be made. The practice members either consulted one another about such cases or referred their patients to each other within the practice.

Balint[10] believed that referrals by general practitioners to specialists, might be described as crises of confidence. Either the doctor feels that he may not know enough to be able to help his patient, or the patient has doubts about the sufficiency of his doctor's knowledge and skill. The appearance of a consultant introduces a number of complicating factors into the doctor/patient relationship: the patient is confused as to who is ultimately responsible for his treatment; and the doctor may feel he is losing control of the case. When a particularly difficult case involves the introduction of many different doctors, Balint referred to this as a 'collusion of anonymity'.

The experiences I had regarding family L do illustrate how a family practitioner is enabled gradually to get to know families on his or her list. As I have already explained, as a doctor gets to know a little about the background of the family, then the treatment for the family members can be more efficiently focused. However, for me, it took quite a long time to get to know as much about family L as I eventually did, and for most doctors this time may simply not be available. It is also important for doctors, even though this relationship might only be short-lived.

A further important point for consideration is that the doctor/patient relationship is not simply about the development of a good enough rapport so as to be able to glean information from the patient. It is also about a consideration of the expectations, of both the patient and the doctor; about treatment outcome, self-respect and self-esteem. It is also about having a healthy mutual respect for each other, and the filling of roles whilst not engendering a feeling of powerlessness in the patient.[11] The doctor must always remember that it is his or her duty to foster the relationship, since the patient is in a disadvantaged position in that it is they who are experiencing the crisis and who has not been given the benefit of training in communication skills.

These problems point to the need for doctors to be trained in the means of communication which will facilitate the gleaning of relevant information whilst inspiring confidence and a feeling of security in the patient. As doctors become skilled in this, then they will take less and less time to build up a sound rapport. It is only natural that some doctors are better at communicating than others and that some patients are more difficult to communicate with than others. Nobody can be taught to be compassionate; it is a quality which people have instinctively or not at all,

but guidance can be given on how to empathise and how to encourage the patients into giving all the information required so that they may be helped.

I feel that it is not sufficient only to tell medical students about such skills and then expect them to acquire them. Neither is it sufficient to introduce training for this only in the pre-clinical years and then to neglect this aspect of teaching once the students have begun working on the wards. As I have previously mentioned, it is vital that an awareness of the importance of communication skills is cultivated very early in the medical training so that students learn naturally to integrate them into their dealings with patients, but this should not be treated as the end-point.

Just as more and more medicine is explained to the student so that they gradually build up their knowledge of clinical conditions, further aspects of psychology and communication should be taught at the same time, so that the foundation of good practice may be built upon. This further teaching should not only involve lectures and video tapes of 'good' and 'bad' interactions with patients, but should also involve a degree of small group tuition whilst on the wards so that students can discuss their problems in the presence of a clinical teacher who is prepared to give guidance. The syllabus is already overcrowded and the students strive to accommodate all the teaching offered to them, but in time, as experience is built up, further medical student/patient interactions should prove to be more fruitful and therefore more economic of time. So long as this aspect of medical training is neglected, the doctor/patient relationship in general, will be far from ideal.

My personal experiences have caused me to recognise that it is important for doctors not always to act as autonomous units; if they recognise that the quality of care for their patient may be improved by knowing enough about the case in question so as to be able to seek other help in a sensitive and informed manner, then their relationship with the patient should only be improved. Doctors should also not be afraid of recognising their limitations. The experiences have also served to highlight the importance of looking at the patient as an individual rather than a collection of signs and symptoms and to recognise that there are many more facets to a person than those which are obvious in the original consultation.

I feel that I have benefited enormously in my dealings with people from having been encouraged to reflect upon my experiences. I feel sure that projects such as the Family Placement Programme, coupled with the teaching of communication skills throughout the medical training, should mark the way forward for present and future generations of doctors to provide a high standard of service which both they and their patients find infinitely more satisfying than those which do not offer good communications.

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From the 17th Annual General Meeting held on 30th June, 1987

An Address given by Mrs Enid Balint-Edmonds, FRCGP

The President has asked me to tell you about how the Balint Society was started, or rather perhaps how I started to work in a way which led to the work of the Balint Society.

I suppose I could say that it started during the last war when I was organizing and working in Citizens' Advice Bureaux in the London area. Although apparently hired to help people with practical problems, I continually found myself occupied with what seemed to be quite irrational troubles with people whose real, external reality problems were quite remarkably difficult, but not so upsetting for them when I saw them.

This led me, with a good deal of luck, to a meeting with a remarkable man called Dr Tommy Wilson, and to start working at the Tavistock Clinic with a group of people who were as interested and puzzled as I was about human relationships. Soon, the Tavistock Institute of Human Relationships was formed, and developed some very important work.

I decided to focus my work on human relationships in marriages and, after sitting around and talking to the group of people who were interested in various fields, but all in the same problems, I decided to go around London listening to what people had to tell me about life as they saw it after the war.

During this period I learned, rather painfully, to listen, but, as I had nothing to say, it was not very difficult. However, I learned quite a remarkable lot of things. Amongst them, perhaps the most important, was that listening to problems as people see them, is always different from seeing, or thinking one sees what the problems are.

After some time working like this, and before starting any therapeutic work, I collected some money and got the Home Office interested. A small group of people then began to work together, and in a very tentative way, we started seeing people with marital problems.

Quite a number of very senior doctors and psychiatrists helped us, but finally we met a recent arrival in London, Michael Balint. He agreed to work with us and, in fact, took us over completely and started the real work of studying relationships, and the unexpected nature of people's requirements from their marriages — and their therapists.

Quite soon after this, in 1950, Michael thought he would like to work with general practitioners, as he had done in Hungary many years earlier. This, of course, led to the kind of work you all know. In fact, this is where *we* come in. Groups of general practitioners led by psychoanalysts studying doctor/patient relationships, instead of groups of non-medical workers studying marriages.

The interest of this beginning for all of you here, is that so many people want to start something new, but they do not know how to find leaders to help them. Indeed, we had no leaders to start with, and although Michael soon became our leader, I do not think we would have accepted him, or he us, unless we had already started in the way we had, and were prepared to listen to the unexpected, and so widen our horizons and be interested in what at first seemed to be very trivial and unimportant aspects of our clients' or patients' lives.

We did not want someone to teach us, and Michael did not want to teach, but to explore.

It was not the method of leadership nor even the qualifications of the leader that mattered, but his open-mindedness. Perhaps nowadays, when people look around for trained psychologists, psychiatrists or psychoanalysts, they may be lucky to find one who is willing to have a fresh look with them at everything, but the fresh look is the really important thing, and the danger of importing theories the greatest danger.

Secretary's Report

The seventeenth year of the Balint Society has been exciting and fruitful. It began in September 1986 with the now traditional annual residential weekend of Balint-groups at Pembroke College, Oxford. There were eighty-seven visitors in seven groups. The demonstration group led by Jack Norell included many of the 'Old Guard' and was greeted with polite satisfaction by the visitors. Mike Courtenay initiated a group of Course Organizers with little or no experience of the mysteries of Balint groups. We are planning another weekend next September.

A series of meetings at the Royal College of General Practitioners began in October 1986, with Dr. Kenneth Sanders' fascinating account of how, after attending seminars at the Tavistock Clinic with Balint and Turquet, he became an analyst and used the insights of both general practice and psychoanalysis to help his patients. He had written a book entitled *A Matter of Interest* which follows the theme of anxiety from birth to the end of life.

In November 1986, Dr David El-Kabir reported how he had changed from lecturing on medicine to discussing philosophy with his tutorial group at Oxford, and transferred this to running a residential group for trainees and patients at Whykeham Hall.

In February 1987, Dr Michael Courtenay initiated a new technique in the process of group dynamics by asking questions of the group members to illuminate and understand silences and what is often unsaid in the group. Private confusion and personal feelings were revealed. The discussion ranged over whether it helped or hindered the group.

In March, Dr Hilary Graham talked about *Supportive Psychotherapy in General Practice,* in which he described many interesting and useful insights into the ways he helps his patients, and relates to his partners. One of our largest audiences were very receptive to his ideas.

In April, Dr Greg Wilkinson reported on his survey of *Attitudes to Psychiatric Treatment,*

comparing those of our members with other general practitioners, members of the Psychopharmacology Group and some of those who took part in the Third National Morbidity Survey, as well as two groups of consultant psychiatrists. Unfortunately he could not correlate our attitudes with our prescribing costs as the figures were not available.

In May, Dr. Philip Hopkins gave the seventh Michael Balint Memorial Lecture entitled *Michael Balint: Training and Research.* He surveyed a number of general practitioners and asked what aspects of their education had most influenced their behaviour. He produced many quotations to show how effective Michael Balint's teaching had been. At the same time there were many photographs, together with extracts from a tape-recorded interview with Michael Balint just five weeks before his death on the last day of 1970.

Education in Balint Groups: Annual Meeting of the School of Balint Method

Dubrovnik, 15-22 May 1988

The theme of a one-week international course held by The School of Balint Method was held at the Inter-University Centre of Postgraduate Studies in Dubrovnik during May, was *Education in Balint-groups.* It was organized by Professor Muradif Kulenović, of the University of Zagreb's Department of Psychiatry.

The two dozen participants included family doctors, psychiatrists and psychoanalysts, psychologists and social workers; mostly local, from Croatia and Slovenia and neighbouring Hungary. The meetings, however, were conducted in English, the language common to everyone present.

A series of papers dealt with topics such as the evolution of Balint-groups over the last thirty years; the differing styles of Balint-group leadership in various countries — and within each country; Balint-groups for medical students (compulsory for some); the growing number of seminars for established doctors and paramedicals; the personal impact of Balint training; and the problem that has been with us from the beginning, whether the groups should be devoted to training or therapy.

It is very difficult to choose any particular papers for special mention as so many were excellent. Professor Muradif Kulenović opened the proceedings with his introductory paper, *Balint-groups, or the struggle against alienation of medicine,* in which he first described in poetic terms how' . . . the beauty of the city of Dubrovnik forms a unique harmony of the land with the sea, producing an unrepeatable whole because man built it in accordance with his needs. 'So making it the most suitable place for The School of Balint Method whose work ' . . . supports all efforts intended to humanize professional relationships, and so allows man to live in peace with other men and with Nature.'

The School's intention is to continue the tradition of the old Hellenic schools which cherished the immediacy and freedom in exchange of ideas. He sees in Balint-groups the opportunity for their participants to learn to sharpen their sensitivity to the most subtle nuances of human interactions, by listening to others and by taking part in the discussions.

Education in Balint-groups by leading to better understanding of the interactions in the doctor/patient relationship, helps us to liberate our creative potential; in turn this can be expressed and utilised in our private as well as in our professional lives, where our patients also benefit by being helped to live fuller and happier lives.

Experience in a Balint-group provides a unique way of learning, as well as an opportunity to achieve the means of better communication with others. Professor Kulenović emphasised how this becomes all the more important as medicine becomes more dependent on technological advances, with their dehumanising and alienating effects.

Dr Vladimir Gruden, reported the growing interest in the University of Zagreb in Michael Balint's ideas since 1967, when Professor Duska Blazević and her colleagues at the Neuropsychiatric Clinic in Zagreb, started their own research into the doctor/patient relationship.

Subsequently, the Psychiatric Clinic separated from the Neuropsychiatric Clinic and, over the years, many professors of medical psychology and other teachers in the Mental Health Centre visited similar institutions in other countries, ' . . . so enriching the Medical School in Zagreb with the knowledge and achievements from abroad in the work with Balint-groups.'

At first, Balint-groups were adapted for students, ' . . . so that they could learn from their own emotional experiences . . . later, further Balint-groups were formed for postgraduate students in psychotherapy, child and adolescent psychiatry and psychotherapy, social psychiatry general medicine, immunology, and other fields within medicine . . . Finally, in 1982 we included classical Balint-groups in the postgraduate programme for general practitioners. The motivation in our general practitioners is very great, and their interest is met by increasing the number of trained group-leaders . . .'

Dr Vladamir Zoric described the formation and development of other Balint-groups for general practitioners outside the University, in Yugoslavia since 1983, starting with 'The Tresnjevka Experiment 1983'. In 1987 further groups were started for social workers. Groups are now planned for stomatologists, doctors of occupational medicine, physiotherapists, nurses and special teachers.

In a fascinating paper, Dr László Benedek, a Hungarian psychoanalyst, first complained that although Michael Balint's original book, *The Doctor, his Patient and the Illness* has been translated into Hungarian, he has had to read his other books in English or German! Nevertheless, he described eloquently the influence Balint's work has had on him.

He quoted from Balint's earliest papers, published in the 1920s, (and written in Hungarian of course), in which he first expressed his interest in patient-centred medicine, and showed his developing interest in psychosomatic medicine. Dr Benedek asked if we knew these words, and he quoted from a paper written by Balint in 1926: 'Psychoanalysis is the only appropriate therapy in neurotic illness, but it is out of reach for most people. What can the general practitioner do? It is very simple — he has to dare to ask and to have patience, and what is more he has to have the courage to listen'!

Naturally, traditional Balint-group sessions

were held, in fish-bowl style. In addition, videotape-recordings were shown of the consultations which a general practitioner had with a particular patient. Another video depicted the case under discussion in a local Balint-group.

The many discussions which took place during this conference were quite productive. An excellent atmosphere prevailed throughout, and we all rapidly tuned in to one another, despite national, cultural and speciality differences.

Although a comparatively recent international member, Yugoslavia has quickly identified with Michael Balint's important principle of 'training-cum-research'.

Professor Kulenović deserves to be congratulated for creating such a programme of annual courses, which promise to make a valuable contribution toward resolving many of the doubts and discrepancies which still exist within our own Balint Society.

JACK NORELL

Book Reviews

Psychosexual training and the doctor/patient relationship, Ed. R. L. Skrine. (Pp. 389). Carlisle, Montana Press. 1987. (£17.50p).

The Institute of Psychosexual Medicine holds regular leaders' workshops, conducted by its President and its Scientific Director. Transcripts of the discussions amongst 20 seminar leaders provided the material from which the Digests in this book were created.

Separate sections deal with the psychosexual training of individual doctors; the behaviour of different groups; and the difficulties encountered by their leaders, who are encouraged to focus attention on the psychosexual problem instead of allowing it to be swept under the carpet.

Among other interesting topics presented are: the defensiveness of patients and their doctors; excessive cleverness of leaders; depression and agression within groups; and group dynamics.

Some of the contributions at these workshop sessions are extremely candid. For example, the reluctance of a group and its leader to criticise a doctor who had put off discussing a sex problem, prompted this comment:

"You can't save the doctor from awareness of her limitations. There is no way of saving her from that. She should be hit and hit hard, and if she gets hurt and depressed about it, that's excellent. She has got to change and there is no way of changing unless she gets really depressed about her present behaviour."

This could represent an interesting model for leadership. Or maybe what this amounts to is, "Don't do as I do, do as I say."

JACK NORELL

While I'm Here Doctor: A study of change in the doctor/patient relationship. Ed. A. Elder and O. Samuel, with a Foreword by Enid Balint. Pp 126. Paperback. (ISBN 0 422 61790 3). London, 1987. (£6.25p).

Michael Balint always insisted that his groups are for Training-*cum-Research.* Here, seventeen years, almost to the day, after his death, another book was published, by the members of a traditional Balint-group. For the first two of its four years' existence, Enid Balint was the group-leader. No doubt, this explains in large part the great success of the findings which demonstrate beautifully the true value of Michael Balint's original concept of a group which could discuss and explore their clinical problems freely without need to be defensive or inhibited about expressing their feelings.

And that is what the group was about — expressing and examining feelings — first, those of the patients consulting their doctors with a variety of symptoms and in states of distress. Then, the doctor's feelings. How receptive is the doctor? How does he/she feel when the patient opens up a little and discloses other things that may be causing the distress? What does the doctor do when the patient is difficult? How does an unsatisfactory working relationship — for the doctor or the patient — change for the better . . . or worse? Should doctors allow or even encourage patients to become dependent on them?

These are some of the questions which the group studied for four years, beginning in 1980. They started with the express intention of 'taking another look at the flash,' by continuing the research described by the group who wrote *Six Minutes for the Patient,*[1] *in 1973.*

They describe in this book something of their research into the 'changes' (or 'important moments') they found occurring during the consultation. They focused on trying to understand the content of the consultation in the *context* of the doctor/patient relationship as it develops over several years. In his excellent introductory chapter, *Uses and Abuses of the Consultation,* Jack Norell discusses many aspects of the consultation, and asks, among other things, "what is its job? Does it do it properly?"

How good it is that he, nor any of the other authors, generalise. As Jack says, sometimes, we take the initiative in such matters as child surveillance, immunization, screening for hypertension, cervical smears, and so on. Other times we wait to be consulted by the patient who wants our help.

And of course, different patients want different sorts of help. He brings in the growing awareness of the need for, and the value of more intensity in some consultations, not only for more time. Although he does not say it, I hope that it was also agreed that some patients do actually require more time, and in spite of several references throughout this book to the diminishing frequency of Balint-trained doctors using psychotherapy, I also hope that this may not be generally accepted.

Enid, in her foreword, as well as in her chapter, *Research, changes, and development of Balint-groups,* emphasises a change of attitude towards the use of psychotherapy by the Balint-trained general practitioner. Having had so much personal experience of the truly, often amazing effects of the scientifically trained doctor, who can be confident in his/her clinical diagnosis, and can successfully deal with his/her patient's emotional conflicts and tensions, that I must ask whether it was not found, at least sometimes, that patients cannot bear too much intensity in a short consultation and do require more time?

Interestingly, there is still a strange sense of confusion about what we mean by a 'short consultation'. In spite of the title, *Six Minutes for the Patient,* Michael Balint, in his chapter, *Research in Psychotherapy,* wrote, 'The average patient gets about ten to fifteen minutes from his doctor . . .'[1] (p. 1)

Yet only recently there has been much discussion, and increasing agreement that the average consultation-time in general practice leaves a lot to be desired. Even the Chairman of the Council of the

Royal College of General Practitioners has been calling for longer consultation times!

As we know, however, it is not only the length of time allowed for the patient, but also what use is made of that time. This is expressed very clearly in the two chapters written by Cyril Gill. The first, with Oliver Samuel, *The touch on the tiller,* starts with the statement, 'Most general practice consultations are quite brief.' The degree of understanding demonstrated is, of course, the reason why such short consultations can work, and be useful for the patient.

In Cyril's chapter, *The dependent patient,* he again shows the keen and deep understanding of his patients that was his wonderful gift, and which makes it compulsive reading.

All the other authors contribute very thoughtful and interesting accounts of what they derived from their group discussions. Although this book is a compilation of individual essays, rather than a continuous story about their research, it is all the better for that, since they show how different are the ways in which they all do the same job — deal with their difficult patients.

This is a book which should not only be in every practice library, but should be read by every member of every practice — and perhaps it might be considered for obligatory reading for final year medical students too.

P.H.

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Obituary

Dr CYRIL HUBERT GILL, MA, MB, BS, FRCGP

22.4.1921 - 25.9.1987

Cyril Gill died at his home in Hampstead on 25 November 1987, aged 66, only a short time after the tragic illness so bravely borne, had forced him to retire and give up the work he loved so much.

Cyril's early education was at Eton and Trinity College, Cambridge, where he read engineering. Later he trained in medicine, having been awarded the MacGrath Scholarship in Medicine, and graduated in 1952 from University College Hospital, London, where he remained until 1954 in a variety of resident posts, including those of Casualty Medical Officer at University College Hospital, and Resident Medical Officer at its St Pancras branch.

He started his thirty-three years in general practice in 1955 as a trainee, then assistant in the same practice which he was to build up into a group practice of five doctors, with attached nurses, health visitors, community psychiatric nurses and counsellors, and to become the senior partner.

Cyril became a Member of the Royal College of General Practitioners in 1972, and was elected to the Fellowship in 1983. He was involved with the development of undergraduate teaching in general practice as a G.P. Tutor at the Royal Free Hospital Medical School, as well as being the Medical Officer for the students since 1979.

His training in one of Michael and Enid Balint's groups started in 1962, and later he trained as a group-leader with Enid Balint. For many years he was the convenor of the Society's group-leaders' workshop.

In 1969, he was a founder-member of the Balint Society and served as a most efficient and conscientious secretary from 1974 to 1980, when he became president for the next three years.

The first open Balint Weekend at Oxford in September 1980, followed a suggestion made by Cyril at a council meeting in 1979, and has now become a traditional annual event.

In 1985, Cyril delivered one of the most thoughtful Michael Balint Memorial Lectures,[1] in which he unwittingly demonstrated his humility, as well as his compassion for, and his deep understanding of his patients' need for more than the ministrations of an ordinary doctor — which he certainly was not.

From 1968 to 1984, he was a G.P. Trainer. His special interest in encouraging the formation of case discussion-groups for trainees as well as established practitioners, led to his appointment in 1973 as group co-leader at the half-day release course at the Academic Centre of the Whittington Hospital.

In addition to numerous articles, Cyril also contributed important chapters to two of the many successful books which have resulted from research carried out in Balint-groups. His chapters, *Types of Interview in General Practice: 'The Flash.'* in *Six Minutes for the Patient*[2], and *The Dependent Patient,* in *'While I'm Here Doctor.'*[3] are models not only of good, clear writing, but also of good, clear and deep thinking, and are well worth re-reading.

In addition to running his practice, and all the activities described above, Cyril helped in the foundation of, and acted as consultant for the Camden Bereavement Service, and also looked after many senior citizens for the Hampstead Old People's Housing Trust and the Guiness Trust. And still his boundless energy and enthusiasm allowed him to find time for other interests. He devoted much of his leisure time to listening to music, and to playing the clarinet in music ensembles; and to gardening.

Cyril enjoyed a very close family life, and is survived by his wife, Hilda, twin daughters Helen and Janet, and a grand-daughter Nicola.

Cyril's intense interest lay in people and how to help them, and on a personal note, I must add that my wife and I were his patients, and we will always be very grateful for the great help he gave us during my own lengthy, serious illness several years ago. We and all in the Balint Society miss him very much and will remember him always with great affection.

P.H.

1. Gill, C. H. Tensions in general practice: The Sixth Michael Balint Memorial Lecture. *J. Balint Society,* 1985, **13**,10.
2. Gill, C. H. Types of interview in general practice: the 'flash'. Chapt. in *Six Minutes for the Patient.* Ed. Balint. E. and Norell, J. S. London. Tavistock Publications. 1973.
3. Gill, C. H. The dependent patient. Chapt. in *'While I'm here, Doctor.'* Ed. Elder, A. and Samuel, O. London. Tavistock Publications. 1987.

Dr GEORGE BARASI, MRCS, LRCP, Dip.PSYCH.
1910-1987

Dr G. Barasi who died on 1st September 1987 was a general practitioner for 45 years in Archway, London.

He was born in Paris in 1910, the son of Jewish immigrants. They came to England when he was 5 years old, but his mother was widowed when he was 7. He matriculated when he was 16 — one of the youngest in the country, and he qualified at St Bartholomew's Hospital at the age of 21.

During the war, when his practice was depleted, he attended Birkbeck College and in 1944 obtained a Postgraduate Diploma in Psychology. In 1948 he married and had two children. In 1954 he underwent a serious brain operation, and made a remarkable recovery. Although he was never quite the same again, he was able to go on working until he was 70. For the last few years of his working life, he had to do all his visits on foot, as he was no longer able to drive. He was very caring and greatly loved by his patients; he always took unlimited time and trouble with them.

Dr Barasi took part in the research seminars at the Tavistock Clinic held by Dr Michael Balint and later by Dr John Kelnar, starting in 1952, studying the psychological implications in general medical practice. These resulted in Dr Balint's book, *'The Doctor, his Patient and the Illness'.*

Esperanto was one of his most absorbing interests. He travelled to many countries to Congresses, and in 1959 he wrote to Esperanto-speaking doctors all over the world, finding out what medical services were provided in their countries. The report of this project was compiled with photographs in Esperanto and English and shown at exhibitions.

He was a longstanding member of the British Medical Association and the Socialist Medical Association. He attended the Jewish Free Hospital and the Whittington Hospital for lectures, and the Horder Club which met at the Royal Northern Hospital.

In the last few years Dr Barasi became increasingly frail and he lived in a rest home in Muswell Hill. However difficult he found it to cope with everyday things, he always managed to continue with intellectual pursuits, and he retained wide interests, particularly in politics, philosophy, languages and medical developments. He continued to attend hospital lectures when his health permitted.

He is survived by his daughter Lyn, his son David and his ex-wife Dorothy Forsyth.

DOROTHY H. FORSYTH

The Dr Cyril Gill Bursary

When the news was broken of Cyril Gill's sad and premature death, a group of doctors who knew him, and admired his devotion to medicine as well as his professionalism, came together determined not to allow his memory to fade.

At this group's meeting, two aims were proposed:

1. A sum of money should be raised by inviting people to subscribe to form a bursary in his name, to sponsor two medical students for them to attend the Balint Society's annual Residential Weekend of Balint-groups at Oxford.
2. To print a collection of his publications, together with any reminiscences about him, as a supplement to this Journal.

Contributions will be gratefully received and acknowledged in the publication, at the discretion of the Editor.

Similarly, any letter, story, advice or key phrase relating to his work will be welcome.

Please address all correspondence to the Secretary or the Editor, whose addresses appear on page 35.

The Balint Society Prize Essay, 1989

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme: 'What Balint Means to Me'.
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 with margins of at least 25mm.
Length of essay is not critical.
Entry is open to all, except for members of the Balint Society Council.
Where clinical histories are included, the identity of the patients should be suitably concealed.
All references should conform to the usual practice in medical journals.
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 consist of the Balint Society Council and their decision is final.
All entries will be considered for publication in the Journal of the Balint Society.
The prizewinner will be announced at the 19th Annual General Meeting in 1989.

Entries must be received by 1st April, 1989, and sent to:

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

Please tell all your colleagues.

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 Dr. Philip Hopkins.

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

The Balint Society

(Founded 1969)

Council 1987/88

President:	Dr. Erica Jones	*Hon. Secretary:*	Dr. Peter Graham 149 Altmore Avenue East Ham London E6 2BT Tel.: 01-472 4822 01-505 1520
Hon. Treasurer:	Dr. John Salinsky	*Members of Council:*	Dr Michael Courtenay Dr Sally Hull Dr Paul Julian Dr Lenka Speight Dr Heather Suckling Dr Mark Sundle Dr David Watt
Hon. Editor:	Dr. Philip Hopkins 249 Haverstock Hill London NW3 4PS Tel.: 01-794 3759		

Extract from the Rules of the Society

Membership of the Society
Membership of the Society shall consist of Ordinary, Honorary and Associate Members.

(i) **Ordinary Membership.** Ordinary Membership shall be open to registered Medical Practitioners who have taken part in Balint-type seminars for not less than two years and who are preferably in General Medical Practice. The names of the first Ordinary Members of the Society (for the purpose of this clause describes as 'Foundation Members') are set out in the Schedule hereto. The Foundation Members prior to the first meeting of the Society have taken the following action:—

(a) Elected a President, a Vice-President, an Honorary Secretary, an Honorary Treasurer an Honorary Editor and two other members of the Society, who together form the first Council of the Society.

(b) Approved a list of persons as Ordinary Members of the Society.

(c) Approved a list of persons as Honorary Members of the Society.

Subsequent candidates for Ordinary Membership shall be proposed by an Ordinary Member of the Society and shall have previously attended at least one meeting of the Society as a guest. The proposer shall submit the candidate's name and qualification for Ordinary Membership in writing to the Hon. Secretary two months before the next General Meeting. Nominations for Ordinary Membership will first be considered by the Council and submitted by them for election at the next General Meeting.

(ii) **Honorary Membership.** Persons considered to be of outstanding merit by the Society shall be eligible for Honorary Membership. Subsequent nominations for Honorary Membership shall be proposed by the Council who will submit names for election at the Annual General Meeting.

(iii) **Associate Membership.** Associate Members shall be persons not possessing the necessary qualifications for election as Ordinary or Honorary Members. They shall have all the privileges of other members, but may not have voting rights.

All candidates for Membership of the Society, after election, shall receive a letter of invitation to join the Society. Membership, except in the case of Honorary Members, shall then take effect on payment of the Society's subscription.

Election shall become void in default of payment of subscription within three months. Ordinary Membership shall automatically lapse when no single attendance at an Ordinary Meeting is recorded throughout the twelve months following the Annual General Meeting or when the subscription has not been paid within three months of the Annual General Meeting unless the Council shall have accepted mitigating reasons.

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.

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