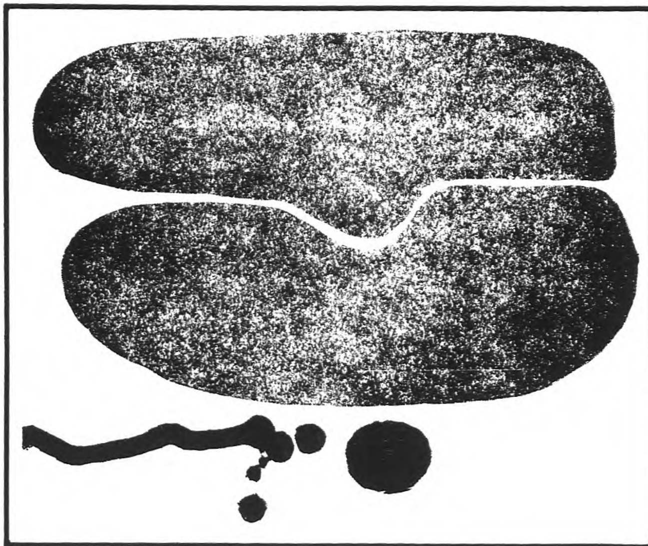
Journal of the Balint Society

1990



Vol. 18

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Editor: Philip Hopkins
Assisted by Susan M. Hopkins

Photograph by Dr Philip Hopkins

Dr Erica Jones
President of the Balint Society
1987-90

For New Readers:

The Balint Society was founded in 1969, to promote learning, and to continue the research in the understanding of the doctor/patient relationship in general practice, which Michael and Enid Balint started in what have since become known as Balint-groups.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group, and to anyone involved in health-care, established or students and trainees, who are welcome as associate members.

The Society holds regular meetings for discussions about relevant topics, as well as for lectures and demonstration-groups in London. The Oxford Balint Weekend has become a popular annual event, taking place in September at Pembroke College. (page 22) In response to local demand, other similar meetings will be organised from time to time throughout the country.

The Annual General Meeting is held in June each year, and is accompanied by an informal dinner.

The formation of new Balint-groups is under constant review, and the Balint-group Leaders' Workshop continues to meet throughout the year, and is also an excellent forum for Course Organizers for discussion of their work.

The Society is affiliated to the International Balint Federation, which co-ordinates similar activities in other countries, and organizes a bi-annual International Balint Conference.

There is an annual Prize Essay of £250.00p (page 4), and the Journal is circulated each year to all members.

Editorial

Do patients want to be 'Clarked'?

For the third consecutive year, our congratulations go to a British medical student for winning the first prize awarded in the international essay competition set by the Ascona Balint Centre. This time, it is Mr Jonathan Goldin, BSc. (Hons), of Manchester University, whose essay (see page 19), was selected from ninety entries sent in by students from many countries. (see page ?).

Once again, the teaching of the management and treatment of very ill patients in hospital, as well as the attitudes of those who are responsible for their treatment, are questioned. This time by a student in the early years of his training — while he is still able to observe the patient's *feelings* as a relevant clinical finding and indeed, to recognize the effect on his own feelings also. That is, before he has become dehumanised by his medical training.

Those same deficiencies have been pointed out by many others over many years and indeed, I experienced that *déja vue* feeling as I read Mr Goldin's comment, 'I found myself confronted with issues that pre-clinical medicine had ill-prepared me for, demonstrating the need for changes to be made to the medical curriculum . . .'

I remembered how, after several years' working in hospitals, and serving as an orthopaedic surgeon in the R.A.M.C. before entering general practice, I recorded in 1955, 'Every day I became more aware of the deficiencies in my training . . . I would seldom pick out a disease I could recognize in the patients who came complaining of a multitude of symptoms that would not fit into any of the disease pictures I had seen in hospital, or had read about in the text-books.'[2] I also remember the relief I felt when I met and heard other doctors admitting these same feelings when I attended Michael Balint's first Seminar.

Nevertheless, there has been some improvement since the development of Departments of General Practice in our Teaching Hospitals, especially where Balint-trained teachers are active,[3] but there is still relatively less interest shown by general practitioners in Balint's ideas in the UK, as compared with doctors in other countries, as indicated by their activities reported in this issue of the Journal.

The principal reason for the original establishment of the General Medical Council in 1858, was to establish and maintain the standard of medical education. Yet in its Annual Report for 1989, the Chairman of the Education Committee admits that there is truth in the allegation that students are still 'overburdened with factual information, which soon becomes out of date,' and that 'the surfeit of didactic teaching soon blunts the student's natural curiosity.[1]

Until, and unless there is an increase in the teaching about the relevance and importance of looking for, and treating the aetiological emotional factors involved in illness, many of our patients who we do not refer to hospital will continue to return for 'repeat prescriptions' for their recurring symptoms.

As for those patients who are referred from general practice to hospital, even if Mr Clarke gets his extra £3bn for the health service for his 'plans to create an internal market in health care, enabling more patients to be treated outside their own areas, which will need more computers . . .'[5] this is not likely to make people any the happier or healthier.

This madness, together with the 'new contract', which requires doctors to turn into profit-making dealers in a number of medically useless procedures, like screening newly-registered patients for conditions they are not concerned about, and visiting the over-75s to see if they have lost weight, or are incontinent, and ensuring that all the city-dwellers are fully protected against tetanus, will so limit the time available, that even those doctors who have been influenced by Balint have been heard to say that they no longer have the time to spend with their patients in the way they did until All Fools' Day 1990. Sadly, it may well take two and three years for the Government to realize that it has all been a disastrous blunder, by which time the health service will have become a complete shambles, and our patients will have lost even more confidence in us, their doctors.

There is no doubt in my mind that it is useless trying to negotiate any part of the new contract. We must show how our patients benefit from having adequate time with us, so that we can help them understand what lies behind their symptoms, instead of prescribing diazepam and similar drugs. In addition to the benefit for the patients, the saving of money spent on these drugs would be enormous, and this is more likely to be of interest to the Department of Health. Recently my prescribing costs were analysed by a neutral observer, using the figures provided by PACT. He found that my overall costs are 36% lower than my FPC average (and 54% below the national average). Furthermore, my prescribing costs for the central nervous system group of drugs are 55% below my FPC average, and his conclusion is that 'Counselling can cut benzodiazepine costs.'[4]

I would be very interested to know if members of the Society would like to research this topic. Please let me know your thoughts on this, and send me the PACT details of your prescribing costs, together with the average costs for your FPC.

P.H.

References:

1. *Annual Report, 1989.* p.16. The General Medical Council, London.
2. Hopkins, P. The general practitioner and the psychosomatic approach, in *Modern Trends in Psychosomatic Medicine*. p.3. Ed. D. O'Neill. London, Butterworth. 1955.
3. Hopkins, P. *Michael Balint: Training and Research*, Seventh Michael Balint Memorial Lecture. Journ. Balint Soc. 1985, **15**:4.
4. Pact Analysis: *Counselling can cut benzodiazepine costs.* Mims Magazine, p.43, 15 May 1990.
5. *Sunday Times.* 'Clarke wants £3bn. more for health service.' p.1, 13 May 1990.

The Balint Society Prize Essay, 1991

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme: 'Is it my nerves, doctor?'

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.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the 21st Annual General Meeting in 1991.

Entries must be sent by 1st April, 1991 to Dr. David Watt.

The Balint Society

(Founded 1969)

Council 1989/90

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

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

Manuscripts and communications for publication in the Journal should be forwarded to Dr. Philip Hopkins.

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

Psychotherapy for the General Practitioner*

Michael Balint

When introducing a new theory into medicine, it has become almost essential to demonstrate that the new theory is really not new at all, and everyone has been working in accordance with this for a long time, but without stating it. This contrasts with the frequently asserted view-point of the scientist that any conclusion can be arrived at only on the basis of objective findings about the correctness or otherwise of the theory. Why is there any need for subjective considerations in a debate that can be settled in an objective way? Obviously the fear of the new and unusual is the reason for this peculiar process. This method of introducing a new theory makes some concessions in form, and so it enables the reader to overcome his aversion and fear of the main thesis — thus it acts therapeutically against this fear. Naturally an article on psychotherapy can also use this form, since it can show the result of its methods immediately.

The statement that all medical activities inevitably involve some psychic effort is not a new discovery, however, and I should like to prove it with some examples.

Perhaps the most suitable example for this purpose is the 'grand round', because in such a case no participating doctor realises that he is participating in psychotherapy. What happens in this case from the patient's point of view? After lengthy discussions, well known doctors assemble. One after the other they examine the patient and then they go away into a closed room for further discussion and 'they decide what should happen to the patient,' while he is waiting anxiously in another room. After a while the whole company reappears and the most senior member tells him the decision.

The appearance of authorities, the mysteriousness and solemnity might be very effective especially for unsophisticated people — and in their heart of hearts many people remain unsophisticated all their lives. In such cases if often happens that the illness begins to improve before the prescribed treatment could have produced any effect.

We can explain similarly the frequent observation that certain illnesses are more benign and more susceptible to treatment in general clinics than in private practice. There are some people however, who mock the mystique of medical consultation, and the professor who appears in the ward with followers in white coats. Some people are hostile towards authority and understandably, the beneficial effect will be absent in these cases.

In understanding this, we discover the primary fault of every involuntary and unconscious psychotherapy; it cannot allow for individuality. It treats everybody in the same way without considering their characters, customs and temperaments. The consequence of this method will be the gradual self-selection of patients choosing their doctors. Patients who dislike the particular style of their doctor will look for another doctor. And so each doctor will acquire a certain 'clientele' for whom his style is appropriate and successful. For this reason, doctors find it hard to see that there are other strategies for treatment than their own. The 'brusque' doctor is equally short with everybody, the 'persuasive' one is equally kind to everyone on principle, the 'pedantic' is full of scientific terminology, and then there is the 'factual' one, and the 'comforting' one and so on. All these approaches can be appropriate if we apply them to appropriate patients. This success should set the psychologist thinking.

Why does one patient want 'brusqueness', another persuasiveness, and so on, and why is he more likely to recover with a particular doctor; does he recover only when the doctor strikes the right note? We cannot answer this question yet, but later we shall. Nevertheless, we can see that present opinion should be revised. We have learned in the clinic that the doctor's task is to find the correct diagnosis and prescribe accordingly; if he does this the patient should recover. However, it is a common experience that the correct treatment fails in the hands of certain doctors, while the same treatment prescribed by another doctor will be effective. Apart from the correct diagnosis and prescription there is a need for something further, that is, the appropriate psychological effect.

Each patient requires his doctor to play a role, and the good doctor senses this intuitively, and is able to play this role. He is able to comfort the patient who needs this, able to be authoritative when necessary, and receives the disclosures of the inhibited patient with tact, and so on, in thousands of variations. 'He knows a lot, but is not really a good doctor' — is the description of the doctor lacking in this type of talent.

So far, medicine has not dealt properly with these very important phenomena. There are two reasons. I have already pointed out one of them; that is, the gradual self-selection of patients to suit different doctors. From this follows the phenomenon that the doctor can 'be himself', and his few failures of treatment do not force him to analyse his methods. The other reason is less obvious, in that the requirement for playing a role can originate from the personality of the patient. The personality was almost completely *terra incognita* for psychology until recently, since psychological interests centred on the conscious part of the mind. There have been some discussions on the question of whether personality is innate or a result of environmental influence. But certain personality components have not been well understood since these components develop unconsciously.

However, psychoanalysis does not stop at the threshold of the mind, for in psychoanalysis consciousness is only a quality that is present in certain psychic contents and is missing in others.

This assumption is not new; Freud produced

* First published in *Therapia*, **III/5**, 148-153 (1926). Title of the original paper in Hungarian: A pszichoterápiáról a gyakorló orvos számára.

a new method for research into the unconscious. By this method it has become possible to show that the personality components have their own history. The forces of the individual's instinctual life play a major role on one hand, and the shaping effect of the environment, especially of education, is important on the other. This development proceeds as follows: certain instinctive drives are promoted by the environment, while others are prohibited, or permitted only under certain conditions. The child is rewarded in certain circumstances, while he receives punishment in others. Both situations will have a great impact on him. One involves a memory: 'if you do this, you will have a good time,' the power of the other is due to the fact that a strong, and in the child's eyes, justified desire remained ungratified. So it is understandable that everyone carries a pattern in their mind, and have no choice but to arrange their lives according to the pattern, without realising this. One strategy is to recreate the former pleasant situation again and again, another way is to avenge the injustice committed against the person, or perhaps to wrest compensation for it from the world.

Everyone becomes childlike again during illness. This explains why adults allow others, especially nurses, to treat them like small children. The food is treated like baby-food, words are used in the diminuitive 'have a little drinkie, a little nap . . .' and the use of the parental plural 'we are off to bed . . . how good we were today . . .!' One can see how the patterns of childhood will reappear vigorously in the patient's relationship with the doctor.

These fundamentally important processes were observed and described for the first time by Freud. This phenomenon was called transference — *Affektubertragung* — by Freud; emotions belonging elsewhere are transferred to the relationship with the doctor.

But of course people differ. How is it then that a doctor can achieve good results with people of very disparate social positions and cultural backgrounds? Using the new technology — why do different people get into the same transference relationship with their doctor? We have seen that the style of transference is determined by childhood experiences; the emotional life of the child is less complicated than that of the adult. So it becomes apparent that these patterns are more similar to each other than the people exhibiting them. And we can go further. Treatment can be divided into two types (as Ferenczi pointed out for the first time in his paper about hypnosis) — one is peremptory and characterised by force; pressurising and patronising the patient. The other is characterised by gentleness and tenderness, persuading, comforting, and so on.

Because of the patient's childhood memories, doctors belonging to the first type evoke the assertive father while doctors belonging to the second type the tender mother. Rigour and tenderness are memories that we been all experienced, even a person who lost a parent in childhood has had someone who was strict or tender with him; furthermore the person becomes acquainted with at least one of these two figures in the earliest period of our extrauterine life. It is clear then that these experiences have a powerful effect, and in this way there is a propensity in everyone to transfer these emotions that were formerly fostered by their parents, to some 'superior' person — and the doctor is often such a person for the patient, and to conduct the relationship accordingly. So transference finally will occur according to these very primitive patterns, and they will often be uniform.

Everyday practice is full of such cases that prove the therapeutic effect of these unconsciously but correctly felt transference relationships. These are very well known so it is sufficient to mention only a few of them. Saline solution given subcutaneously can be just as effective as morphine; patients with serious diseases feel better seeing their own doctor; new treatments often produce good initial results which diminish when the psychological effect caused by novelty is over. The finding that certain medications may need changing is explicable in the same way. Patients justify it by 'getting accustomed to the medicine,' but often they request new medication so often that there is no time to get accustomed to the old one. This is especially true for hypnotics and sedatives. Pharmaceutical companies know this, and produce successive new medicines under various names, although there may be no real need for them. In fact, certain preparations can hardly be distinguished from each other. Nevertheless, this is good business because of the aforementioned psychological effect. The well-known saying *ut aliquid fecisse videatur* masks an unacknowledged psychotherapy that can sometimes be successful — to the astonishment of the doctor. I will provide a historic example: Skoda, aiming to prove that even pneumonia will recover without any medicine, did not tell his patients 'you are not getting any medicine,' but gave distilled water saying that this was his medicine — evidently to avoid the unfavourable psychic effect.

So far we have seen that every treatment has a psychic component beside the objective one. We have seen also that the neglect of this component damages the effect of good objective treatment. A favourable transference relationship between doctor and patient is practically a precondition of a successful cure. Psychoanalysis is that science that recognised the significance of transference for the first time and is the only one to deal with it by scientific methods. For this reason it is correct to discuss psychoanalysis in the first place, all the more since Freud's work has shown what happens during a psychic treatment. Psychoanalysis can be distinguished from all the other treatments by two features. One is the revelation of the unconscious, and the dynamic comprehension of psychic processes connected with it. The other is the conscious and lasting use of the transference in a deliberate treatment plan.

We can experience any time the phenomenon that psychic contents, previously unconscious, may become conscious next minute. So none of my readers have been thinking of the theorem of Pythagoras, but now that I mention it, it 'comes to mind' at once. Psychic contents like this are able to become conscious without any difficulty. Psychoanalysis is interested especially in those contents, in that there appears to be some resistance against their becoming conscious. Such wishes, experiences, feelings and so on are called

repressed for two reasons: once they were conscious and the Ego was forced to suppress them because they were unacceptable. Since they did not lose any intensity from being repressed there is a need for permanent effort to keep all this in the unconscious, away from the Ego. Instinctual drives work in the same way, only the aim becomes conscious for the Ego, the origin however, still remains unconscious. This similarity was noted, and examination of these repressed psychic contents made possible by psychoanalysis, showed clearly that these repressed wishes, experiences, and so on, are derivatives of basic instincts which are inhibited by education for cultural reasons. This circumstance can explain the fact of experience, that repression refers primarily to sexual instincts.

The dynamic comprehension of psychological processes led to a new interpretation of symptoms and physiology of stimuli served as a model for this purpose. Freud did not regard the symptoms as the essence of disease. According to him the essence of disease is a conflict between the homogeneous Ego (and especially moral values, conscience, idealism and so on) and the repressed instincts striving for expression. Such a repressed instinct acts as a permanent stimulus, causes a permanently increasing tension which finally discharges through the symptom. Therefore the symptom is actually a reaction of the individual to a permanent stimulus. He is unable to get rid of it in any of the normal ways, thus it is an imperfect attempt at recovery. Therefore it is easy to understand the paradoxical observation that even the most embarrassing symptom often can be associated with gratification felt consciously by the patient. We can observe it especially clearly in illnesses appearing intermittently. The patient becomes nervous, excited before the attack, he is worrying, feels anxiety; and afterwards he relaxes, feels better and he is noticeably euphoric.

Beside this primary gratification the illness itself brings another benefit for the patient. In the struggle of life everyone strives to use his characteristics to his own advantage. The sick person always feels at a disadvantage compared with a healthy person (with good reason) thus is less scrupulous about his strategies. He soon discovers that his trouble is an excellent means for achieving certain 'gains.' The gain obtained in this way is called secondary gain by Freud as opposed to the primary gratification underlying the symptom. Certainly both the primary gratification and the secondary one are almost unconscious for the patient. The index of recovery is that the patient should be able to give up both types of pathological gain.

Psychotherapeutic methods can be distinguished from each other by the means they use to induce the patient to give up these gains. Psychoanalysis tries to achieve awakening of consciousness of the primary conflict between moral Ego and repressed unacceptable instincts and by so doing enables the patient to deal with the conflict on a higher level. During analytic treatment, the relationship between the doctor and patient relives everything that remained unresolved, or incompletely resolved during the course of the individual's development, and these aspects can then at last be resolved.

Using Freud's metaphor, we can say that problems appear to haunt the patient, and as in every ghost-story, the phantoms have to appear because they did not atone for their misdeeds, or obtain satisfaction from the wrongs committed against them. All these phantoms are conjured up by the doctor's presence with the patient. The doctor becomes that person against whom the wildest emotions rage, and then towards whom the most tender feelings are expressed. Of course the analyst does not forget for a moment that he is only a shadow here, that all these things are not directed against him personally, and he tries to regulate this process, studying the patient's resistance.

He strives to find, and demonstrate to the patient, that person and that situation against who, and on the occasion of what these emotions had their real meaning and power, and that they remained unresolved as a result of certain inhibiting circumstances. If these revelations are successful, then the phantom loses his terror, and goes to rest like a memory, for ever.

It is a separate group of practitioners which try to ameliorate the patient's situation and put him into more favourable circumstances. These methods have some value: 'you will receive all sorts of gain — just give up your sickness, or rather the gratification caused by the sickness!'

These methods give voluntarily all the secondary gain that the patient desires. This method is used very often in everyday practice, but doctors use it unconsciously. Advising bed rest serves this aim, and similarly, instructing others to 'look after' the patient, or adjusting the environment. Often the doctor suggests to a person who has a cold that he should 'stay in bed for a day and nurse himself.' I do not believe that he realises that his precription is actually a psychological treatment. However, almost exclusively, it is. He acts more consciously when he advises a patient to have more entertainment, a more varied way of living, or if he comforts the patient, or reassures him that his trouble is not so serious, and so on. Treatment in a sanatorium is the most well-defined form of treatment in this group. In this novel environment there is no effort in life, there is no work, no domestic conflict, no need to jostle for position; here everything is provided, and everyone attends to his needs.

Such an exchange can be successful only if the patient becomes 'better-off,' that is if the gratification caused by the sickness is not too great, or in other words the Ego did not repress too much material on the one hand, and if the gained relief is significant enough on the other hand. The latter explains why a treatment in a sanatorium often has a surprisingly good effect on poor people, while in rich people this good effect is rather rare and is accessible only by long-lasting treatment. Similarly one can hereby understand the good effect at the beginning; and later the decreasing efficacy of these methods. The patient learns that he gets these comforts only when he is ill. As soon as he recovers, there is a withdrawal of these comforts. This does not 'make sense' emotionally; so the patient takes back his old trouble, and obtains both the gratification caused by the symptom and the adaptation of his environment.

The psychic treatments belonging to the latter

group have advantages for the patient in reality, and aim to 'buy-off' the sickness in this way. The ones in the former group also offer an exchange, but they offer to 'pay' with transference gratification. All the 'suggestive' methods belong to this category. They can be characterised by the 'encouragement' from the doctor. 'If you believe me and you do as I tell you, you will recover.' Not only are the methods acknowledged as 'suggestive' to be included here, but almost the whole of physical therapy, and a number of so-called medicines too; in short, every method prescribed by the doctor with a similar statement to that mentioned above. These treatments can be easily distinguished from real medicine. Let us think of adrenalin given in the case of circulatory disorders, and organotherapy for disorders of the climacteric or impotence, or the difference between plastering a broken arm (physical treatment) and the galvanic treatment of a hysterically paralysed arm; in the first examples the doctor does not really need to speak much to the patient. as for the others, almost the whole effect of the treatment depends on the doctor's personality. This effect is in direct ratio to the power of the above-mentioned encouragement and to the *Aufmachung*. Sometimes the mystical characteristics of a treatment are the *Aufmachung*, while when the neurologist uses a thermal and electrical apparatus the scientific mystique and 'all the modern technical achievements' are the *Aufmachung*, as apparent in the brochures of many hospitals.

We can describe in these new terms that the main and perhaps the only factor in these treatments is the transference relationship between doctor and patient. Research can show that the doctor creates this relationship artificially. This can be studied also in simple situations where rows of machines do not intrude between doctor and patient, that is, under hypnosis. In one of these methods the patient lies on a comfortable couch and the doctor speaks with a soft, persuasive, monotonous voice, strokes the patient's face and hand with his hand, and 'coaxes' the transference from the patient.

The other type is the *Schreckhypnose*. The doctor fixes his eyes on the patient in a serious and intense way; the eyes of the patient are dazzled with a strong light. If he dares to move, the hypnotist shouts at him as if he would like to paralyse the patient's will. Every doctor working in this field uses one or the other treatment method — perhaps not in such an obvious form. By so doing the doctor takes over the role of that person who had the principle influence at the beginning of the patient's life.

In this way, he ensures that the patient relates to him as a child and looks up to him with unquestioning faith and boundless confidence as in the case of his parents in the past. The therapeutic effect is due to this mental reversion to childhood.

The patient prepared in this way is able to accept the 'inhibition' which is the actual active force of every suggesting therapy.

This inhibition might be a direct command as for example, in hypnotic suggestion, but might be a milder one like an encouragement, promise and so on; and clinical neurology applies it in this form. In both cases the intensity of transference connected with the doctor's personality provides the promise, command, or persuasion, and endows him with irresistible strength. In many cases the clinic even promotes this process by submitting the patient to some painful treatment. It is as if they were telling the patient 'If you misbehave, you will be spanked, with strong faradic current, and we will put you in a dark corner, behind a screen, if you behave well, we will like you.'

We can summarise these ideas in analytic terminology as follows: As long as the patient gains appropriate gratification in transference, he is ready to reinforce repression for the sake of his doctor to such a degree that thereby he blocks even the abreaction of repressed instincts through the symptom.

Thus the symptom disappears but the patient pays a triple cost for it: he loses the energey of repressed libido, loses the energy caused by increased repression, and the energy concealed in the unsolved transference is lost too. This wastage explains why patients treated by hypnosis become so diffident, powerless and disinterested. This increased repression claims a great deal of energy of course, and the patient is capable of coping with this only under the influence of a strong transference. This is the reason why 'suggestive' methods do not shrink from the use of bizarre techniques to enable this strong transference. This close relationship of blind faith is *conditio sine qua non* for for them.

After a successful course of treatment, this relationship does not disappear; in fact its strength increases. Recovered patients tell everyone about the power of their doctor — until their state changes for the worse, which often happens. So they return to their doctor, they forget the struggles of reality during their regression, and they leave again feeling better for a while. This is a frequent outcome for patients in 'suggestive' therapy. I do not deny that there are people who recover even after a single treatment, but this is exceptional. As we can see, this kind of treatment is similar to the former group of treatments in some aspects. Patients suffering from chronic illness get accustomed to suggestion as well as to the stay in a sanatorium, and most of them 'go on their pilgrimage' to their chosen place, or rather to their chosen doctor for ongoing treatment. This cycle — a few months of life, a few months of treatment — makes it possible to bear the trouble often for a long time, often for one's whole life; at the expense of much wasted energy, time and money. In other cases, the continuing treatment achieves less and less, after repeating it a few times, the illness does not yield to the most recent 'pilgrimage' and the patient leaves disappointed.

I have deliberately neglected the question of diagnosis and prognosis, which is very important. I have done so because we started with the premise that every medical activity has its psychological effect. In addition there is a practical point. All the straightforward treatment methods should be tried first, and only after the failure of all of these methods should we turn to some complicated ones. Full-scale psychological treatment is reluctantly undertaken, because of the contemporary training of doctors, and the clumsiness of contemporary psychotherapeutic methods. But this situation may not persist.

Under the influence of psychoanalysis, psychology

ought to find a place both in the education of doctors and in clinical practice, a very important place, maybe a paramount one. In the meantime, do not forget that organic and functional diseases are not separated from each other by nature, but by us, and if a patient can not be helped by organic treatments, let us consider that through the mind maybe we can reach the goal; and therefore may help the patient.

What can the general practitioner use from the ideas described above in his own practice? As we could see, psychoanalysis always aspires to treat in an aetiological manner, and its aim is to eliminate the primary conflict; whereas all the other psychotherapeutic methods treat the symptom only, their methods do not reach the essence of the illness. From this, it naturally follows that if the general practitioner is not successful with his treatment, and thus a special psychotherapy is indicated, then psychoanalysis is the treatment of choice; and other methods should be considered only in exceptional cases, when psychoanalysis is not practicable for whatever reason. This compromise probably means giving up the goal of complete recovery, so that is why it is important to give this careful consideration.

There is one more thing to mention at this point. Doctors following Freud discovered that a person who wants to deal with analysis of patients must get acquainted with his own subconscious for the first time, otherwise he is unable to observe those elements from the patient's material that can be linked to his — the doctor's — repressed unacceptable desires, memories, and so on. This discovery led to the requirement that a future analyst has to submit himself first of all to an analysis.

There were many others who avoided this self-evident requirement, they preferred methods which deviated from psychoanalysis and reverted to cognitive psychologies in a roundabout way. Jung, Adler, and Stekel are the leaders of these factions but still consider themselves analysts. It is worthwhile asking the doctor who considers himself to be an analyst whether he himself has been in analysis or not, and with whom. Neglect of this question is the reason for many failures in psychoanalysis.

Freud showed that the symptoms involved in the 'diagnosis' of neurasthenia are of a very heterogeneous nature. There are some cases characterised by emphasis on anxiety, while others are characterised by compulsive actions and thoughts. The first is called anxiety neurosis by Freud, while the second is called compulsive neurosis. He showed that they have independent pathology, and they have nothing in common with neurasthenia. Nevertheless, even the residual cases as so variable that it is recommended for the doctor not to categorise them as neurasthenia or psychasthenia. The doctor should not order cold-water cure or roborant at the first 'nervous' symptom, but must reflect that if he calls one 'nervous' it means for the moment that he cannot cannot understand this phenomenon on the basis of his former knowledge. He should not immediately offer sanatorium treatment, especially in chronic illness, but he should realise that every nervous symptom has its cause and purpose and origin in the patient's mind, and he should make an effort to understand them.

A doctor who is trusted by his patient may undertake the treatment himself, especially where there is some reason why psychoanalysis cannot be considered for some reason. This may not produce such a satisfactory result, but still may be superior to other courses of action, if the patient can form a strong transference relationship with his doctor.

What should the doctor do then? We can say it in two sentences: he should enquire, he should have patience, and then have the courage to listen. He should talk less, and what he says should rather serve to induce the patient to talk. He should not promise anything, he should not ask any suggestive questions and he should not try to amaze the patient with clever interpretations. It can be counter-productive when the patient has heard or has read something about psychoanalysis — all these efforts are pointless and they may be harmful.

On the contrary, he should allow the patient to pour his heart out and only if the patient becomes hesitant, should the doctor help him with benevolent encouragement. Otherwise he should act totally passively. Associations will come by themselves in the easier cases, and the doctor will need to add practically nothing to the material.

This method differs substantially from any other medical activity. In every other situation recovery depends on the doctor's personality and the doctor's knowledge. Here the doctor has a lesser role, the main activity being transferred to the patient. It is absolutely necessary for recovery on the patient's part that he should understand the psychological origins of his trouble. The doctor merely provides an opportunity for the patient to talk; the doctor must restrict himself to making only the most essential remarks. The doctor's role appears passive. But, it is very important what he says and how. Therefore there is great need for tact and talent in successfully using the method of questioning and listening.

If the doctor already has has some practice in this, he should ask the patient whether there is any obstacle barring his way to recovery, or in a more primitive form, why he does not want to recover?

He should ask this when a method that had previously proved useful, fails him unexpectedly, even where 'organic' troubles are present.

The doctor will not always get an answer, but when the patient replies to this question, the doctor will hear something that will lead him nearer to understanding the meaning of the illness both for the doctor and the patient. We should put the question in a particular form 'Why do you not want to recover? Perhaps you are annoyed with your doctor.' The doctor should not accept the first denial, that there is no real reason, but he has to insist that there may be some trouble and perhaps the doctor himself caused it. Almost in every case the patient reveals most of his doctor's mistakes very timidly and reluctantly at the beginning, mustering up his courage only gradually. This may be quite stressful, because the complaints of the patient are almost always justified, and the doctor should admit openly (not only to himself) that he was mistaken in certain cases.

Whoever has the understanding and willingness to admit this, and does not shrink from open and sincere discussion of his mistakes; who does not silence his patients when the patient tells him unwelcome things; for that doctor there is an open way after many struggles and after many unpalatable personal insights, to learn the greatest art of the medical profession: the tolerant management of transference.

* The Editor is grateful to Dr László Benedek, a psychoanalyst in Budapest, for his translation of Michael Balint's original Hungarian paper, and for additional help from Dr Anna Szabolsci, a general practitioner in London.

Current interest in Michael Balint

A study undertaken by the Royal College of General Practitioners, of general practitioners' use of post-graduate centre and practice premises libraries in the Vale of Trent faculty area, revealed that the five most frequently chosen books in general practice premises libraries includes Michael Balint's *The Doctor, his Patient and the Illness.*

Reference: 'Books for general practitioners', letter, *The British Journal of General Practice*, 1990, **40**:215.

Michael Balint and Consumerism in the Nineties*

Philip Hopkins
Family Doctor, London

I wonder, if Michael could be with us today, would we be discussing *The Doctor, his Patient and Consumerism?* What can we deduce about this from his and Enid Balint's work with us, and from his writings?

In the first place, would he have thought, and should we think of our patients as 'consumers'? According to the Shorter Oxford English Dictionary, a consumer is one who consumes, i.e. 'one who makes away with, destroys; uses up or takes up, spends, or wastes (time)'![24]

I have recently, perforce, been drawn to a new area of study — the subject of Economics which, I have discovered rather late in life, is about '. . . the satisfaction of material wants . . .' and that, 'it is people's *wants* rather than their *needs*, which provide the motive for economic activity.[25]

I have also learned that economists resist making value judgements, such as how much of any given commodity people *ought* to consume,[25] unlike those politicians who, like Alexander Pope's fools, rush in where angels, in this case the economists, fear to tread.[22]

It also seems that the term 'consumer' has mistakenly become synonymous with 'customer', meaning someone who buys 'consumer goods which are those commodities which satisfy our wants directly.'[25]

Indeed, I cannot help but wonder that we are to become the victims of our politicians' confusion in believing that our patients are the 'consumers'? Surely, the politicians are the consumers, since they, to use the market-place jargon, buy our professional services which they have decided should be provided for the public, who become our patients, and who, incidentally, appear to have little choice or influence over what these services shall be.

Announcements appeared in the national press,[2] in many cases, before the official statement of the new Terms and Conditions of Service soon to be imposed upon us, reached us.[12]

It seems that the politicians will require us not only to invite each new patient (with certain exceptions) to participate in a consultation, but we will also have to confirm this in writing! We must then ask specific questions about the patient's medical history and life-style, and carry out and record a number of measurements and other clinical examinations, whether they are clinically indicated or not.

None of this, of course, may be relevant to the patient's reason for wanting to see a doctor, and any possible counter-productive effect of all this is clearly not understood or considered by those who must be obeyed!

Furthermore, we will be required to invite all our patients who are 75 years old and over, to participate in a consultation and again, to carry out a list of specific assessments, without regard as to whether the patient wishes or requires any of this.

Similarly, there are many other regulations stipulating what must be done for various categories of patients, and what other services must be offered in terms of increasing the regular developmental examinations of the under-five-year olds — which the experts have long since decided are largely a waste of time, except for a carefully selected group of children, to ensuring that everybody is fully immunised against infections, including tetanus, which is not all that common with the present rate of our immunisation programme; screening more women for cervical cancer, irrespective of their sexual activity and their actual risk of developing this disease, and organising more 'health promotion clinics' and 'health check-ups,' even though there is little evidence to show that there is any value in such random screening.

From all this, it would appear that in spite of what the government is telling the public, we are not about to experience a growth in consumerism, but an increase in central economic planning.

This leads to another question we must ask: should we want to compete with each other by treating our patients like the grocer treats his customers who goes to his shop to buy a kilo of sugar? Or should we continue to encourage them to consult us for our opinion and advice about the treatment they need for their problems?

In the light of the Government's recent pronouncements,[13] and in view of our experience in our consulting rooms,[28] we must question whether we can accept that the services which our politicians have told the public, our patients, to expect from their doctors in the future, accurately reflect their needs?

It certainly does not agree with the findings of the recent survey carried out by the Consumers' Association, and published in *Which? Magazine.*[28]. Our patients made it clear that their first priority is for their doctors to give them adequate time to listen to them. Indeed, they have already shown that if the doctor does not allow them sufficient time, they will choose to see whoever does have the time they want and need — the Vocational Trainee or the Practice Nurse.

Of course, we learned from Michael and Enid that it is not only 'listening' that is needed. We must also 'hear' what the patient says or only half-says, and even what he does not say. More than that, we know that we must listen to our own inner reactions to our involvement with out patients, and become aware of our own feelings.

Michael Balint held that psychotherapy is not a treatment, however, but a skill — the skill of listening — and he helped us to learn to use it instead of asking questions.[6] It is interesting to note at the present time, nearly forty years later, that some doctors are re-discovering that it can be a useful approach when dealing with patients whose symptoms have a

disordered physiological function, rather than an underlying pathological cause to account for them.

Happily, general practitioners do not need the intensity of a personal psychoanalysis or psychotherapy like the analysand or psychotherapist, to learn this skill. Unlike other skills, however, it cannot be learned from attending lectures, nor by didactic teaching, or by reading books, but only by practical work under proper supervision.

Personally, I benefitted from attending Michael Balint's first group more than I did from any other form of postgraduate training. Its all important function is to provide a forum where doctors can freely discuss their problem-patients. This does not mean focusing only on the patient rather than on the disease, but also on the doctor and his developing relationship with his patient. In this way, it is possible to increase the doctor's awareness and sensitivity, and to discover how to tune in to the patient's real needs — and to help him to deal with them.

I wonder, therefore, what Michael Balint would have thought of the present trend of employing practice counsellors and psychologists? Although it is perfectly understandable in view of the increasing pressure from the Department of Health for doctors to spend more of their time on the administration of their practices, instead of training themselves to give their patients the sort of care they need, he might well have pointed out that it is simply a new way of diluting the doctor's clinical responsibility.

In turn, this can only lead to further interference with that other important factor in the doctor/patient relationship, the continuity of care. Balint's aims were clearly stated in *A Study of Doctors,*[7] to:

(i) 'expose the doctor to the full weight of his therapeutic responsibility, not allowing him any tacitly accepted way of escape,

(ii) contrast his individual ways of treating his patients with those of his colleagues in the group,

(iii) use the group-setting to demonstrate that any form of therapy entails a specific type of interaction between patient and doctor, the nature of which can be understood and its future development, and with it the efficacy of the therapy, can often be predicted.'[7]

Certainly, my experience over the past forty years in general practice has not revealed any change in our patients and their problems. Although there are some who are aware that they have emotional conflicts and problems which they bring to the doctor, there are still many who are alexithymic. They feel that they are ill in some way, but do not have the ability or the words to describe their feelings.

Hundreds of thousands of people go to their doctors every day with recurrent sore throats, coughs, headaches; feeling 'tired all the time,' yet cannot sleep at night; a variety of aches and pains; inability to eat, or eat too much; loss or gain in weight; bowels loose, or constipated; menstrual disorders — all sorts of bodily symptoms for whcih they say they *'only want'* a prescription for an antibiotic, a cough linctus, sleeping tablets, or some other pills, potions or tonics. And many of them get just that — Clark's Consumerism — what they want and ask for — a prescription.

Earlier this month, my receptionist buzzed me to ask if I could fit in an extra patient. 'A temporary resident — a young woman staying in a local hotel — on a business visit — says she feels very ill, awful — *only wants a prescription for an antibiotic for her sore throat* — will only take a minute.'

A few minutes later, a 25-year-old single woman, over-weight and over-bearing, sat alongside me, emphasising how ill she had felt for a week. She told me, 'I just want a prescription for penicillin,' adding, '. . . *like I always get from my doctors at home.'*

She could hardly allow me to examine her throat, but on my insistence she opened her mouth. I looked at her normal pharynx and noted her dry brown, nicotine-stained tongue and teeth. Yes, she agreed, she did smoke a lot, about 20-25 cigarettes a day. When I palpated her neck, I noted the tension in her neck muscles, as well as the absence of cervical adenitis.

When pressed to tell me a little more about the history of her trouble, she reluctantly told me that her throat has been sore on and off — since she 'caught something' on her summer holiday. Yes, she had been depressed, had gained weight, and was smoking more. And yes, she tended to do this when she was upset. The mounting tone of irritation in her voice increased. '. . . but what's that got to do with it? — *I only want a prescription for some penicillin.'*

Of course, I could have given her what she wanted, a prescription for penicillin, like her doctors at home 'always give her.' That would have been that. For me, that is. As she said, she 'only wanted a minute of my time — only a prescription.' Not my opinion or my advice.

Mr Clarke would have been so pleased with me — a satisfied consumer — only a minute of doctor-time. Then, 'Next patient, please'! Excellent 'through-put' — very efficient use of the doctor's time . . . but is it?

Mr Clarke might well say that it shows that we can happily go back to having larger lists and give our patients three or four minutes each . . . But does it?

I went through all that many years ago, and found the reverse to be true. So, after listening to, and examining my temporary resident, I sat back, paused for a few few moments, as I often do — then quietly said that I thought she sounded rather more upset and angry that I would expect for someone with 'only a sore throat.' Perhaps there was something else troubling her?

There was a pause. Tears started to roll down her face and, with all barriers down, she told me the sad story of her broken romance. Suddenly, she cried out angrily 'and we were on holiday.'

She nodded through her silent tears at my suggestion that perhaps she was not yet over the grief of losing her fiance. And yes, she agreed the 'tense feelings' in her throat had started on the way home, making it difficult for her to speak. I told her that I was encouraged by her accepting my use of 'tense feelings' instead of 'sore throat,' and yes, she could see the point I was making . . .

I apologised for being short of further time,

and invited her to come to see me again before returning home. She left without a prescription.

She telephoned three days later to tell me that she had completed her business in London and was returning home. She thanked me for suggesting it, but she did not need to come to see me again. Her throat felt better; she had reduced her smoking and was less depressed. She now realised how angry she was, and agreed she might look for psychological help when she is back home, but thought perhaps she might be able to manage on her own now she knew what her illness was about.

This example shows how patients like this can be helped to recognise how their feelings affect their body functions, by brief psychotherapy, which can be readily and effectively used by a doctor, and at the right moment, in the surgery. I am confident that by helping patients to understand 'what they are about' in this way, they can be prevented from developing into 'fat file' patients.

It is also an example of how little things have changed. By a strange coincidence, when I was searching through Balint's Tuesday-group transcripts for the record of the origin of our Society, I came across the following discussion which took place exactly 20 years ago, on 18th November, 1969:[1]

BALINT: This is how the enormously important dilemma in this case — and in all cases — what is the right thing to do. Let's say that if a patient comes with a sore throat, you wouldn't take a swab in every case to identify the micro-organism and find out what sort of antibiotic is the best for it, but you will give some wide spectrum antibiotic . . . The question is can we devise something of that sort which corresponds to this thing? We know that if we do a really proper examination lasting some time, then we can have a much safer and much more reliable basis on which to start our technical therapeutic procedure. Is this sort of thing acceptable or not? And this is why it is so important that we should follow up our cases . . . This will be enormously important for general practice if something of this sort can be devised.

HOPKINS: This is the core of the whole problem . . .

BALINT: . . . in this case.

HOPKINS: . . . in this case, and in all cases . . .

In another transcript I found a case-history which touched on a topic which we frequently discussed in the Tuesday-group: the difficulty of recognising unhappiness in our patients as another physical sign, and the difficulty which doctors have in accepting and dealing with it. This extract also demonstrates how Balint could be emphatic to the point of being authoritative at times, and also how relevant his comments are today as they were when he first made them.

A very difficult case-history involving a very depressed woman had been presented;[2]

BALINT: . . . now can I say something important? Whatever the doctor does, to my mind, is superficial and irrelevant as long as he avoids talking about the patient's unhappiness, because that is what really matters. The various other things you mentioned, like, where is the pain? When did it start? This is what I call superficial, or if you want, 'traditional medicine.' Ask questions, find a symptom for which you can prescribe a drug, and then you are all right, and the patient won't matter . . . The thing is, how to get, how to create an atmosphere, a climate in the surgery that will enable the patient to tell the doctor what he or she is really worried about . . . what makes him or her unhappy . . .[2]

We all know that a patient consults his doctor when he feels ill in some way and wants help. It does not follow that the help he thinks he wants, is necessarily the help he actually needs, and the doctor's responses are therefore critical from the first moment of the consultation, as they will influence his potential therapeutic effectiveness.

I believe that we should now be considering how we can prevent the impending re-organisation which is shortly to be imposed upon us, from interfering with that unique and most important relationship which develops between a patient and his/her doctor.

Try as we may, to create the right atmosphere or climate, as Balint described it, in the consulting room, it will be of little use if we are able to spend even less time in it with each of our patients, than some of us do already. Which seems more than likely if we are to accept that we must increase the size of our lists when our income is based on the new formula which proposes that at least 60% of the practice income must be derived from capitation fees.

Mr Clarke's consumerism is presented as a triumph of rationality, with the promise that everything will be graded, priced and displayed on a check-list, having all the features that a rational person is supposed to want and use as the basis for their choice of their doctor, as if people make choices for entirely rational reasons, consulting only their accountants to make sure they are getting value for money.

However, we are aware that the real experts who understand their consumers, know that nothing is as simple as that, and that actually there are much more powerful forces at work. The salesman and the advertising man have long since understood the message from the psychoanalyst, and have studied long and intensively how to deal with the consumers' subconscious desires, while appearing to cater for our rational egos. Politicians realise this, and use agencies like Saatchi and Saatchi at election time.

Maybe we should watch television more, to see consumerism at work as, for example, in the current advertisement for the Rover car. This makes minimal mention of rational material like petrol consumption and engineering features. The main substance of this short film uses the story of a man who drives in his Rover to the wedding of his ex-girlfriend, whereupon she immediately abandons the prospective bridegroom and elopes with the man who drives the Rover.

The real message of this advertisement goes straight to the libido, 'Drive a Rover and you get the woman,' bypassing all the other personality components. Perhaps we can beat them by joining them. It may be that now, more than ever, we need to have and to use our understanding of unconscious processes, to undermine the sterile 'price-check' style of consumerism that is being flaunted by the Government. For this, we will need all our ingenuity and Michael Balint's, to help our patients to gain the

insights required to achieve a deeper understanding of their real needs.

Indeed, we must also find ways to help our politicians to understand the real needs of our patients, and to follow their example of looking up to us, which, according to Mrs Edwina Currie, one of our many ex-Ministers of Health, they do, very much![11]

Mrs Currie's promise that, 'We will have a body of extremely well trained and competent doctors, being paid much better than they are now. And, hopefully, will be a lot healthier . . .;'[11] might have been more encouraging, were it not likely to be as false a prophesy as that made by Sir William Beveridge, who predicted in his famous Report of 1942, that the National Health Service will improve the nation's health so much, that the cost of running it will reduce progressively over the years![10]

While we can nevertheless be proud and happy to commemorate the foundation of the Balint Society twenty years ago, there is still much for us to do, if we are to develop further the work which Michael and Enid Balint started in the early Nineteen-fifties, and for which the Society was founded.

In my opinion, this will become more urgently required in the Nineteen-nineties because I believe that the increasing incidence of psychoneurotic and psychosomatic illness is more of a threat to our Society than are those diseases we are shortly to be compelled to seek out. This will be a shameful waste of our time which should be devoted to the real work of a doctor, which is, to paraphrase the well known adage, neither an affair of visiting octogenarians for annual check-ups, nor of sending for patients to attend for cervical smears or for innoculations.

Preventive measures have their place in medical practice, but they are not Medicine. The essential unit of medical practice is still the occasion when, in the intimacy of the consulting room or sick-room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor who he trusts. This is a consultation and all else in the practice of Medicine derives from it.

Historical note:

I suggested at the meeting of Michael Balint's UCH Tuesday-group on the 8th October 1968, that we should form a Society similar to that recently formed in France, and possibly meet with the French to discuss the possibility of forming an International Society of Balint-groups.[1]

We collected the names of the 231 doctors who had attended Balint-groups at the Tavistock Clinic up to that time,[13] and after further discussions, twenty-two of us met together on the 19th November 1969. Possible names for the Society were proposed and discussed at length, and by a majority vote, we decided to form The Medical Society of Balint Groups.[18] Subsequently I wrote to Michael Balint to inform him about this, and to ask for his consent to use his name in the title of our new Society.

Michael started the next meeting of the Tuesday-group on 25th November 1969 by saying that he had received a confidential letter from me, and was it all right to talk about it? Following my agreement, he went on to say, 'According to it, an underground movement has begun . . . reluctantly, I must agree to the suggestion . . . of course, with a great pleasure . . . and I wish this underground movement very great success.'[3]

A draft constitution for the Society was proposed and discussed at the second meeting of the Foundation Members on 24th February 1970.[19]

The final draft of the Society's Constitution was agreed at a further meeting on 28th April 1970, in the new Outpatients Building of University College Hospital. The Officers of the first Council of the Society were elected:[20]

My first very happy act as President of the Society was to propose that Michael and Enid Balint should be enrolled as Honorary Members. In his reply dated 1st May 1970, Michael wrote that he and Enid were proud and pleased to accept the honour of Honorary Membership of our new Society, and he repeated that he was pleased for us to use his name in its title.[4]

Just under five months later they, and thirty-six members and guests attended the inaugural meeting of the Society at the Royal College of General Practitioners on 29th September 1970. The subject was 'The Integrated Interview', and the first speakers were Dr Stephen Pasmore on 'Patient/Doctor Communication'; Dr Michael Courtenay on 'Time and Technique'; Dr Max Clyne on 'Diagnosis', and Dr Aaron Lask on 'Results.'[21]

At the second meeting of the Society on 26th November 1970, on 'Aspects of Repeat Prescriptions,'[22] Dr Max Clyne mentioned, by a slip of the tongue, the special meeting which we were arranging for his 75th birthday in the following year. Michael was sitting next to me, and his whispered comment expressed the delight this gave him.

On the next day, I interviewed Michael Balint for an article in *London Doctor*, a journal I was publishing and editing at that time.[15] I am very glad that I tape-recorded our discussion, because he died little more than a month later, on 31st December 1970.[16]

At the Council meeting on 12th January 1971, we agreed to change our name to The Balint Society, and to make the meeting we had been planning for his 75th birthday celebration, the First International Balint Conference.[11, 14].

This was held at the Royal College of Physicians on 23rd-25th March 1972 on the theme, *The Doctor, his Patient and the Illness*, which was the title of his first paper on this subject to be published in the British medical press in 1955[5] and which, of course, became the title of his book which is now an acknowledged classic in the international medical literature.[6]

*** Based on a lecture delivered at the Royal College of General Practitioners, on 21st November 1989, to commemorate the twentieth anniversary of the foundation of the Balint Society.**

Foundation Members and Officers of The Medical Society of Balint-groups

Dr Dorothy Arning	Dr Erica Jones
Dr James Carne	Dr M A Kalina
Dr L A Charkin	Dr Aaron Lask (Treasurer)
Dr Max B Clyne	Dr Margaret Macnair
Dr Michael Courtenay	Dr Frank Mallinson
Dr Stanley Ellison	Dr Marshall Marinker
Dr Paul Freeling	Dr Max Meyer
Dr Cyril Gill	Dr Shirley Nathan
Dr A J Hawes	Dr J S Norell
Dr Berthold Hermann	Dr Jean Pasmore
Dr Philip Hopkins (Chairman)	Dr Stephen Pasmore (Secretary)

Officers of the first Council of The Medical Society of Balint-groups

President: Dr Philip Hopkins	Vice-president: Dr Margaret Macnair
Secretary: Dr Stephen Pasmore	Treasurer: Dr Aaron Lask
Editor: Dr Max B Clyne	

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Empathy in the Doctor/Patient Relationship: A Theoretical View*

Ulla Holm, Clinical Psychologist, Sweden

Ten years ago, when I started to study the concept of empathy, hardly anyone in Sweden used the term or knew of it. Now it is a trendy word and as such, is exposed to distortions and used to denote a variety of meanings. So I will start to narrow down the concept of empathy by stating what it is not.

Empathy is not sympathy — sympathy is to like another person. Empathy has nothing to do with love. One can be empathic with a person one does not love or like, and unfortunately one can be unempathic with a person one does love and like. Empathy is not being kind or nice or good. I have heard this combination: 'He smiled an empathic smile.' Empathy is not telepathy. Empathy has nothing to do with extra-sensory power.

Empathy means to catch and understand another person's feelings. The central quality is often described as a sudden knowledge of, or insight into another person's emotional state. If this empathic understanding is used to guide behaviour one can talk about empathic behaviour. This includes not only verbal communication but all the actions, choices and decisions made in all diagnostic, treatment and nursing situations. Even the design of the premises and the routines adopted in the surgery are expressions of one's empathic understanding — or lack of it. If someone chooses to postpone a test because they can feel that the patient would not be able to endure it today — that is empathy. If the patient has to wait in the consulting room, undressed — to save the doctor's time — that is not empathy. Sometimes empathy implies putting one's foot down, setting a limit for a patient when it is understood that he needs such a response to feel at ease and secure.

When I speak to doctors about empathy, they often say 'we do not have time for empathy'. But it doesn't take longer to be empathic than to be unempathic. On the contrary, studies show that there is no correlation between the duration of the consultation and patients' ratings of doctors' empathy. In fact one study shows that if the doctor took care of, that is acknowledged the patient's feelings of, for example concern and anxiety, the consultation tended to be shorter. The patients were then more able to concentrate on the information given and taken in the interaction with the doctor. Many studies also show that compliance is much greater among patients who report that their doctors have been empathic. So it does not take longer to be empathic, but it certainly does take a mental effort.

If empathy means catching and understanding another person's feelings, how does the transmission, the communication of feelings come about? I will give a short survey of the mechanisms which seem to be involved in the empathic process. After that I will discuss the inner prerequisites for empathy and also the inner obstacles. This will be a basis for a discussion of how to increase the doctor's empathic capacity.

First the doctor needs to try to remember an occasion when she or he noticed that she was empathic, that she knew how her patient felt. Then she needs to consider how she got to know this, which mechanisms she used to be able to understand the patient's feelings.

I believe that many would say that the doctor used her perception, that she looked her patient over closely, listened carefully to signs of effects in his voice, perhaps even felt his muscular tension with her hands.

Some probably used their own experiences (to understand the emotional state of the patient). Perhaps the doctor asked herself: 'How have I reacted in similar situations and how would I react if I were in this patient's shoes?' The empathic ability seems to increase with increasing age (perhaps the only function that does). One reason for this is, of course, that one broadens one's experience as one gets older, that is, if one is an open-minded person.

Perhaps some did not use their own experience, but others' experience. Perhaps they have had other patients who have told them about how it feels to be in a situation similar to the actual patient. Or they have seen a film or a play, or read a novel or a textbook, and from these sources learned how people may feel in this kind of situation.

These three components — perception, one's own experience and others' experience — are cognitive mechanisms. They compose a judgement of the patient's feelings. They are not empathy, though. Empathy demands both cognitive and affective mechanisms so the doctor has to add the use of her own feelings.

Imagine the following situation: One meets a person who seems relaxed, secure, in a good mood. At the time you feel a pressure on your heart or an ache in your stomach, or wherever your feelings are situated. Because of this feeling one observes the other more closely and now one notices that her eyes are sad, in spite of her smile. With the help of actual feelings one has formed a hypothesis about the patient, perhaps that she is in despair, and with the help of the intellect one has evaluated and tested this hypothesis. To feel with (for) and think about — that his empathy. There must be a repeated oscillation, interplay, between an affective position and an intellectual, cognitive position. Of course this process is a very rapid one, although it takes a long time to describe it. It takes place mainly on a preconscious or unconscious level. The end-product, the empathic understanding, is conscious.

Now and then I meet the opinion that it is a bit dangerous to be too empathic. Too much empathy here would mean over-identification, lack of objectivity and a general letting loose of emotions. Such a view is based on the assumption of empathy as an entirely emotional affair. If you regard the concept of empathy as based on a balance and an oscillation between

intellectual and affective components, that leaves out the risk of too much empathy.

Now I am going to describe two important affective mechanisms involved in the empathic process. First I will give an example from a session where I supervised two psychotherapists. The male psychotherapist was reporting on his therapy with a pregnant woman, who was soon to give birth to her child. The therapist had reported on this therapy many times before. This time I had great difficulty in concentrating on his report. Instead I repeatedly found myself thinking about the other therapist present, a woman. I found myself thinking like this: 'What is her attitude to childbirth, to womanhood? Has she ever been pregnant, does she have children of her own?' When it was the female therapist's turn to report, she said, very sadly, that this was her last supervision session for a long time. The following week she was going to have an operation, which hopefully would lead to her being able to have a baby.

Was this telepathy? No, I think it was part of an empathic process. The female therapist signalled her feelings to me which aroused feelings in me which in turn aroused associations, thoughts in me. This prepared me to receive her feelings and her message. This is one important point with empathy, it makes you better prepared to deal with the other person's feelings. The mechanism involved in my example was probably affective resonance, a mechanism that is constantly in action in all our interactions. Without being aware of it, and totally automatically, we always imitate each other's affective expressions, the bodily posture, the gestures, the facial expression. This imitation generates in our bodies the automatic, physiological responses that are associated with the actual affective state in the other person. We experience an affect identical with the other's, but probably weaker. There is a saying that feelings are infectious. Affective resonance is the basis for this infection. If a person enters a room full of people they sometimes feel the feelings in the room gush up to them. Without being aware of it they have imitated the affective expressions of the people in the room and they feel a resonance of their feelings in their own body.

In this context, it is the associations, the thoughts that these resonance feelings evoke, which is important. Often we discard thoughts that are not directly linked to the situation. We believe them to be irrelevant and we discard them instead of using them to get ideas about our patient's emotional situation. If one knows about this unconscious mechanism, affective resonance, one can use it consciously. When I meet a patient and I do not understand her feelings, afterwards I try to imitate her way of sitting, her facial expressions, her gestures. Sometimes this has helped me to catch her feelings and to understand more of her way of handling them.

The last mechanism in my review is projective identification. This mechanism always deals with unconscious feelings, feelings that we do not allow ourselves to have. Instead we dump these feelings into another person. We accomplish this by behaving in such a way that we evoke these intolerable feelings in the other person.

A bit tricky, isn't it. I'll give you an example. Imagine two children, brothers, alone at home during a dark and stormy night. It most certainly would be a loss of prestige for the elder brother to feel afraid of the dark and so he represses all such feelings. Instead he makes his younger brother feel afraid. That's very easy. Now the older boy can enjoy his own forbidden feelings acted out by his little brother. One often sees this happen, or may be one of the characters in this type of drama.

If we return to the doctor/patient relationship; one should think about the feelings which might be difficult to tolerate for a patient. Feelings of dependence, of humiliation, submission and helplessness are often part of the emotional pattern of the patient. For quite a few people such feelings are dangerous and forbidden because they do not fit their self-image. One way of getting rid of these feelings is to dump them into the doctor. Try to remember a time when one felt completely incompetent and helpless in the interaction with a patient, who seemed rather confident and competent. Perhaps this patient had managed to dump her intolerable feelings of helplessness on to the doctor by behaving in a very demanding way, by refusing and rejecting all the doctor's (good) clever proposals and advice.

Or imagine a seemingly sensible, logical and coherent patient. The doctor has a growing feeling of confusion and chaos, which she cannot quite understand. Perhaps this patient unconsciously, and in a very subtle way, makes her feel his inner chaos by means of projective identification. These are well-known phenomena for many people working with patients. If they are used in the proper way they constitute an important source of understanding the patient and are a very important component in the empathic process. But there is always a risk of acting out the projected feelings instead of using them to understand the patient's feelings.

Well — what should the doctor do when she suspects that her own feelings of, for example, helplessness originate from the patient? First she has to remember that these feelings are intolerable for the patient. You cannot say 'I feel very helpless so I gather that you feel helpless too.' Of course the patient would deny it and think that the doctor had gone mad. Instead she could acknowledge her own feeling only, and say 'Now I have given you a lot of proposals for your treatment but you do not seem to fancy them. Frankly, I feel rather helpless about how to proceed, but perhaps we can think of something together.' By that, the patient is shown that feelings of helplessness are endurable and also that they do not need to be a reflection of the total truth of the situation.

To handle a situation like this the doctor either has to be rather free from conflicts of competence/incompetence and helplessness. Or she has to have a good supervisor or be a participant in a Balint-group, which can help her to sort out the feelings involved in the interaction.

This leads to the question of personality prerequisites for empathy. It helps to have a clear identity, knowing what one's limitations are. Otherwise one cannot differentiate one's own feelings from the patient's.

Another important ego function involved in

empathy is affect tolerance. It concerns the ability to tolerate, put up with one's own feelings without being overwhelmed by anxiety or having to repress one's feelings.

The doctor has to develop a containing function, an ability to feel and to keep, contain within herself the patient's difficult feelings and experiences without leaking out her own anxiety. Of course she must tolerate her own feelings to be able to contain another person's feelings.

Those were the prerequisites of empathy. Now let us look upon the obstacles and what to do to reduce them in order to increase the empathic capacity.

1) The first kind of obstacle consists of deficiencies in the basic identity development. This is the most devastating obstacle to the empathic capacity. It means that a person cannot change flexibility between different positions of closeness and distance. He either finds himself in an uncontrollable state of emotional over-identification, or in a purely intellectual position without being able to catch the affective signals. Or he may be too occupied with his own faltering self-esteem to be able to take an interest in another human being.

The main way to reduce this obstacle might actually be to undergo psychotherapy or psychoanalysis.

2) The second kind of obstacle is to be found in most of us. It consists of unconscious conflicts, which activate rigid psychic defences. Such conflicts lead to 'blind spots' which make the doctor unaware of certain feelings in herself and in others. Or she distorts the feelings. For example, if she has a conflict about feelings of aggression it's very hard to catch aggressive feelings in an undistorted way. She could say 'I'm not angry, just tired and hungry.'

Reducing this obstacle has to do with self-knowledge, with increasing the doctor's awareness of her blind spots and the defences she tends to use when provoked. It also has to do with the working through of conflicts. Partly this will happen in everyday life where the doctor is continually exposed to conflict loaded situations. This is another reason why empathy increases with increasing age. One needs time to process your conflicts. But above all one needs somebody else, a supervisor or a Balint-group to help one to become aware of tender spots and distortions.

3) The third kind of obstacle is lack of awareness of affective signals and lack of knowledge of affects as transmitters of information. I am sorry to say, this obstacle is often a result of the training of professional helpers. The students seem to unlearn knowledge about feelings and the holistic approach which they had from the start. There are studies which show that the empathy of medical students decreases during their medical education.

This obstacle has to do with the myth that in order to be unbiased, objective, one has to discard feelings. So one tries to pretend that one has no feelings which of course is a catastrophe for both the ability to be objective and for the ability to be introspective and empathic. I think that this obstacle can be reduced with the help of a Balint-group where the doctor's own emotional experiences come into focus.

4) The fourth obstacle to empathy consists of lack of motivation. I think that this is the most important reason for lack of empathic behaviour. If the doctor works in a system that gives no credit or prestige to an empathic approach to patients, then her motivation is bound to decrease. If her working conditions are bad, if she feels that she is not treated with empathy by her superiors, then her motivation to treat patients with empathy will probably be missing. The Balint-group is one part of this system that can contribute to starting a parallel empathic process between, on the one hand the doctors and the leader of the Balint-group, and on the other hand between the doctors and their patients. The conclusion is that to get empathic doctors, the doctors have to be treated with empathy.

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* Paper read at the Seventh International Balint Conference in Stockholm in August 1989.

An Account of a Student/Patient Relationship During Medical Training

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Medical practice is an art as much as a science and it is unfortunate that at Medical School the latter tends to be emphasised at the expense of the former. An important part of the art lies in knowing how best to communicate with one's patients and it is becoming increasingly acknowledged that the way in which doctor and patient interact can have a significant influence on the outcome of a patient's treatment

This past term has been my first in clinical medicine and even the limited practical experience I have had, has brought home to me some of the demands doctors can face in their relationships with their patients. These demands can be particularly great when the patient's problem stems largely from difficulties they are having in their psychic life. Psychological factors are a widespread cause of 'dis-ease' in patients but this is a fact that is still poorly addressed in medical education today.

In this paper I should like to describe my experience of a relationship with a patient suffering from anorexia nervosa, a relationship which I found particularly challenging and demanding and one which gave me much food for thought. I have to say that I found myself confronted with issues that pre-clinical medicine had ill-prepared me for, demonstrating the need for changes to be made to the medical curriculum — some possibilities are discussed towards the end of the paper.

When I first saw *L.*, a 19-year-old patient on the renal ward on which I was working, I was quite taken aback by her physical appearance. She was extremely emaciated with hollow eyes, sunken cheeks and protruding bones. I was shocked to see someone who looked like a famine victim on a ward in a South Manchester hospital. I asked one of the doctors what was wrong with her and was told she was suffering from anorexia. Obviously this was a disorder I had heard much about but I had never been in direct contact with anyone suffering form it.

I was told that *L.* should have been receiving treatment on a psychiatric ward but had been transferred to our ward after her condition had deteriorated to such an extent that she needed careful medical treatment to keep her alive. When she had put on some weight and was not in quite such a desperate physical state, she would be transferred back to the psychiatric ward from whence she came. In the event, she spent about three weeks on our medical ward, initially being fed intravenously but later orally. During this time her physical condition improved to the extent that she was eventually returned to the care of the psychiatrists.

Having obtained permission from the firm's registrar, I introduced myself to *L.* as a student-doctor and asked if I might speak with her. I was pleasantly surprised to find her quite cheerful and fully alert mentally, despite her physical appearance. I remember feeling that it would be highly inappropriate to get out my notebook and pen and conduct a full history and examination. These had previously been thoroughly carried out by more than one doctor and I decided that a more informal approach would be a far better way of establishing some degree of effective communitcation. I also recalled something Balint[1] once wrote: 'If the doctor asks questions in the manner of medical history-taking he will always get answers — but hardly anything more.'

Although *L.* was aged 19, her emaciated condition made her look a good deal older, and she was covered in a purpuric rash. Despite her wizened appearance she projected a somewhat childlike persona. She had a huge teddy-bear beside her, which she invested with human attributes, and she spoke with a childlike enthusiasm at having someone take an interest in her welfare.

L. was very eager to talk about herself and told me that she was the youngest of five sisters and had been brought up in Ireland, running away from home some years previously to escape what sounded like a tragic upbringing. She spoke of sexual abuse from her father, threats of being hit by an iron bar by her mother if she informed the police, and then went on to say that 'hundreds' of other men had also abused her. When I questioned this, she said that what she really meant was that there were about seven or eight of her father's friends who would regularly abuse her. I was not sure how much of this was actually true and felt it was important to be aware that much of what she said could be the result of unconscious fears and fantasies, intermingled with what was unquestionably an unhappy childhood.

She went on to tell me how, on arriving in England, she had struggled for a couple of years but had eventually been lucky enough to win a competition to find a promising young model. She had been catapulted into a highly lucrative career as a model and had enjoyed her new-found wealth, but after a time had begun to find the job extremely stressful. She had started to worry about her weight, asking people with whom she worked whether they thought she was getting fat. They all reassured her that she looked fine, but when one agent suggested she might 'tone up' her thighs a little, this was the catalyst she had been waiting for to begin dieting rigidly. Over the course of about 18 months her weight fell from 8.5 stone to 4.5 stone, and she was eventually admitted to hospital.

I listened to her story largely without interruption, as she seemed to have a strong need to talk to someone. It gave her the opportunity to express her feelings, which seemed to act as a sort of emotional catharsis; for example, when she told me that she was not sure whether she wanted to live or die. Her fears

* First Prize winner of the Essay competition arranged by the Ascona Balint Centre.

and anxieties clearly needed to be expressed and worked through before she would be able to recover and I felt that simply listening to her was of some therapeutic value.

L. told me that I was the first person who had actually sat down and really listened to her since she had been in hospital and she seemed to appreciate this. When I asked her about the care she had received from the psychiatrists she said that there had been several of them looking after her, but that they had always seemed too busy to spend time with her. One of the consultant psychiatrists had taken charge of her case, but her consultations with him had always felt rushed and were often interrupted by telephone calls.

In the last week of term before the current Christmas holidays, *L.* was transferred back to the psychiatric ward and I hope that when I next see her she will be feeling more positive about the treatment she was receiving.

When the time came for me to leave our first meeting, *L.* urged me to come and see her again. I agreed and left with the impression of a frightened, confused and lonely young woman who desperately needed help. I went to speak to the house-officer about her but he had little advice to give me since her problem was 'psychiatric' and not 'medical'. As far as I know, however, she only received one visit from a psychiatrist during the time she was on our ward.

When I returned home I looked up what I could find on the subject of anorexia, but found little as regards treatment for patients with this eating disorder. I had got into the habit of looking up the various 'diseases' that patients were suffering from on the ward and although one can learn a great deal in this way, it can also lead one to the erroneous belief that the vast majority of patients' problems can be neatly categorised, allowing a particular treatment regime to be instigated. Of course life is not this simple in many cases and *L.* was one of the patients I saw last term who brought this home to me most strongly.

I decided that the best I could offer *L.* was support and a sympathetic ear, while she received the physical treatment that was immediately necessary to keep her alive and build-up her strength. As a medical student I had more time than the busy doctors on the ward to spend with *L.*It is interesting to note that both my fellow students and myself have frequently found that patients turn to us to talk about their fears and anxieties more readily than to doctors. This is probably not only due to the fact that we have more time to sit and listen to them, but also because they feel less threatened by us due to our more junior position. As I shall discuss towards the end of this paper, future medical training needs to address this more than it does at present, raising the awareness of students and preparing them better for demands of this sort, which they will all face in clinical medicine.

Although I felt I could offer *L.* some support, I was only too well aware that the psychodynamics of a patient with anorexia were highly complex, far from fully understood, and that I did not have the experience, nor was I in the position to offer *L.* the depth of help she needed.

I remember on one occasion trying to rationalise with *L.*, not really expecting it to work but in an attempt to understand further how she saw herself. I placed my forearm next to hers and asked her if she could see how thin she was, but she said she could see nothing abnormal. When she looked at herself in the mirror and compared how she looked now with photographs of how she appeared when she was at her more normal weight, she said she could see no difference. It was clear that *L.* had a seriously distorted view of her body.

On another occasion I was with *L.* at lunchtime, supervising her eating. I vividly remember her going through the painstaking task of removing all the batter covering her piece of fish before she picked at the actual fish inside. With some help and encouragement from me she ate most of the fish as well as some vegetables and fruit salad. At the end she said she felt 'bloated' and guilty about eating too much, but I tried to assure her that in reality she had eaten very little and did not need to feel guilty about 'stuffing' herself. She asked me in her childlike way whether I was sure she did not need to feel guilty and when I said that I was quite sure she seemed relieved.

During the course of our several meetings *L.* often seemed to push me into a position of parental authority and I have read that regression is common in patients suffering from anorexia. It involves the emergence of infantile patterns of behaviour in the patient, which may be illustrative of their inability to manage life and pain (either physical or emotional) in a mature way. It is interesting to note that Balint[1] has written about patients who adopt the foetal position in a large number of painful conditions. He also observed that others are willing, or even demand, to be washed and fed well beyond the stage that is objectively necessary. I tried to respond to *L.*'s regressive tendencies by not treating her as a child, but was aware that her emotional problems were such that she found it very difficult to assume a greater degree of responsibility for herself.

Looking back on our conversations, there were times when *L.* appeared to over-idealise me, exemplified by comments such as 'you're the only one who understands me'. She sometimes seemed to expect me to have answers to all her problems and I had to be careful not to place unrealistic demands on myself. I remember one of the consultants coming up to me, commenting that I had spent a lot of time with *L.* and asking me what I thought about her. We spoke for some time about *L.* but had to agree that it was very difficult to know how to treat her problem. I told her that it was difficult for me to understand why she was suffering from anorexia and that she must not expect me to provide solutions for her difficulties.

On reflection, I feel that to some extent I was the subject of *L.*'s transference behaviour. In many ways the relationship between doctor and patient mirrors that between parent and child, and the patient can repeat infantile conflicts and needs in relation to the doctor.[2] Patients may project onto their doctor all kinds of magical expectations, hopes and fears that are intrinsically irrational; with this irrationality stemming not only from a confusion between past and present but also between fantasy and reality.[3]

There were times when *L.*'s attitude towards me suggested that fantasy and reality were being somewhat

confused and I had to be wary of this. On our last meeting before the Christmas break, *L.* said that when she was better we would have to go out for dinner together. I was unsure how to react to this but smiled and said 'let's see you get better first'. I had to be careful that the reality of our relationship as a 'professional' one was made clear, yet I did not wish to appear cold or unfriendly by rejecting her offer. I had to maintain an adequate 'emotional distance' from *L.* to avoid becoming over-involved emotionally, but this did not mean that I should become detached or aloof. I must say that I would have welcomed the opportunity to discuss some of the difficulties I encountered in my relationship with *L.*, perhaps in a group with fellow students under the guidance of an experienced medical practitioner.

This brings me to the question of medical training. As has been exemplified in this paper, students face numerous demands in their relationships with their patients, for which they are often poorly prepared. I have heard it said that at graduation the medical student is the best informed but most poorly educated of all graduates. One of the problems is that during their time at medical school students are not encouraged to give enough thought to their relationships with their patients. Medical education consists largely of learning facts and being taught to 'act' with little time for students to pause for reflection. The doctor/patient relationship is a complex affair and involves far more than simply the patient presenting themselves to the doctor with a complaint, and the doctor making a diagnosis and dispensing treatment. It is first and foremost a relationship between two human beings, with feelings and emotions therefore playing an important part in the interaction.

One step forward would be to introduce into the curriculum discussion-groups, led by experienced doctors, on psychological and emotional as well as ethical aspects of medical practice, as described by H. H. Wolff et al.[4] Students should be encouraged to think about issues they will face in clinical practice from an early stage in their training, and by that I mean right from their first year at medical school. Furthermore, during their clinical years, students need a forum to discuss difficulties they might encounter in their relationships with patients. This could also take the form of discussion-groups, under experienced supervision, which would need to meet at regular intervals throughout the year. Through being given the opportunity to explore their relationships with patients in this way, students' own levels of self-awareness will hopefully be raised, which in turn will enable them to understand their patients better.

As well as by means of discussion-groups, students can also become more aware of how to communicate effectively with their patients by taking part in role-playing exercises. In this way, different situations can be encountered in a teaching environment. Similarly, if students are videotaped interacting with patients (or people acting the part of patients), they can observe their own behaviour objectively and learn from their mistakes. For example, it is hard to establish a good rapport with a patient if one avoids making eye contact with them and videotapes can demonstrate this clearly. Such techniques are not new to the training of doctors, but their use needs to become more widespread.

In conclusion, therefore, medical students' relationship with their patients can be extremely challenging and demanding. If effective communication is to be established, students need to pay close attention to psychological and emotional aspects of their relationships with their patients. It should not be forgotten that the *quality* of relationship between doctor and patient can have a significant influence on the therapeutic outcome. If changes could be introduced into the curriculum whereby medical training addressed such issues more directly and more effectively, then I believe it would be deeply beneficial for all concerned — doctors, students and patients alike.

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Balint Weekend at Oxford:

14th-16th September 1989

With Balint Aforethought

It was with great trepidation, despite a feeling of honour, that Mary Keany and I accepted the news that we had been chosen to receive the Cyril Gill Bursary to attend the Annual Balint Weekend at Oxford.

For a few weeks prior to the scheduled weekend, we debated at length what possible relevance our attendance could have, and whether or not we would have anything to contribute. We spent much time discussing what the weekend would be like, who the delegates would be, and whether they would all have long beards and balding heads, since isn't that what psychoanalysts are supposed to look like? We conjured up scenarios of how on uttering a few syllables, our words would be taken and lengthily but exactingly dissected so that our Elektra complexes and bed-wetting phases as children would almost certainly be exposed for all to see.

How wrong we were. From the moment we took the wrong turn and drove the old banger gleefully through the gates of Christchurch College, we had a growing feeling that this was going to be an enjoyable weekend. The porter was very polite and redirected us to Pembroke, a less austere yet still very auspicious college nestling in a quiet corner of Oxford.

Being undergraduates at one of the (concrete and) red-brick universities we had the feeling as we walked through the stone-walled and leaded-glass quadrangles that we were being given a taste of forbidden fruit and addressed each other as 'Charles' and 'Sebastian' in true thespian fashion. With Mary having been up all of the previous night delivering babies, and I having been busy until evening on my medical firm, we were too late for the opening formalities and so missed Mrs Enid Balint-Edmonds' address to the company. In fact we were too tired to socialise in the bar that evening but appeared in the Dining Hall next morning for the traditional English breakfast, refreshed yet a little apprehensive.

In the first session our respective groups made us feel exceedingly welcome and encouraged our participation with sincerity. I worried at first that my contribution would not be acceptable due to my lack of knowledge of Balintian theories, but I soon relaxed and subsequently gave my own opinions with confidence. Because of the strength of our initial misgivings it took the course of the first morning to make us realise that we were among some very down-to-earth people as opposed to the ethereal academics we were expecting. As the morning progressed it was refreshing to discover that the sessions were centred around the discussion of the delegates' personal experiences and feelings. By revealing to the group their worries, fears and mistakes people exposed to us their personalities. Yet these exposures were not dealt with harshly or judgmentally, but in a sensitive and constructive fashion.

Mary and I found this framework particularly welcome since it provided a stark counter-point to the atmosphere in medical school of fierce competitiveness and to the student ethos that it is a failing to reveal the chinks in one's confidence-armoury. By the end of the first morning my impression of Balint-groups had begun to develop in a positive direction.

Saturday afternoon was given over to recreation. For the benefit of the overseas visitors and the British newcomers to Oxford, John Salinsky followed tradition by braving the inclement September weather to take his walking tour of the city of dreaming spires. Having cast a wary eye skywards after lunch we renamed the tour, 'drizzling spires', and retired to our rooms where we toasted our toes by the fire and reflected upon what life must have been like in 1624, the year to which Pembroke College dates.

The second sessions commenced with a greater energy. Everyone seemed to have been enthused by the morning session to contribute and present their own cases. At times when the subject matter threatened to capsize and sink our moods the more experienced Balintians leading the sessions gently guided us onto an even keel, and the discussions continued with renewed vigour. Due to the natural evolution of trust in the groups, by the end of the second session Mary and I both found that we had volunteered to present cases of our own in the final sessions, which we would earlier have imagined to .be impossible or even irrevelant due to our not being practising doctors.

On Saturday evening we were treated to a formal dinner in the Dining Hall, a very awe-inspriring venue with its glistening silver and glowing candelabra. The setting lent the evening the potential to be a solemn, pompous affair especially since the room gave one the impression of being in church with its vaulted ceiling and stained-glass windows. However, from the moment the food was served along with a different wine for each course, an aura of conviviality pervaded those assembled and the dinner was a relaxed and most enjoyable occasion.

Sunday morning's breakfast was a more sparsely-populated event, delegates apparently choosing to indulge their hangovers with an extra hour in bed rather than with fried egg, fried bread and sausage. Mary and I breakfasted in order to build up our strength for the third and final session of the weekend. As the morning progressed I began to talk about feelings of guilt I had about a patient I had nursed some years ago before starting medical school. The group explored many areas of my emotions and unearthed feelings I had complexed without resolving some time ago. The experience was an exhausting one and though I did not feel completely unburdened at the end of the session, I was left with a feeling of relief and a conviction that I could come to terms with the problem in time.

At the end of the morning I found to my delight that Mary had had a similar experience. Her group also, having welcomed her contribution, helped her work through a problem she had encountered in her capacity as a clinical student. She, like me, had felt assured that though we were presenting matters from a different prospective, all relationships with patients

bring problems for the participants, whether qualified or not, thereby helping to confirm our opinion that Balint can be useful for students as well. We also believe that any doctor, not only bearded and balding ones, and not only general practitioners and psychiatrists, could benefit from sharing in the Balint experience.

We agreed that the weekend had been very valuable and enlightening and found that we had independently reached a decision to join Balint-groups as soon as we become eligible and also perhaps to sample the hospitality of Pembroke College on a future occasion!

Carole Anne Tallon

Balint Weekend at Ripon:

18th to 20th May 1990

Feedback from the annual residential Oxford Balint Weekend suggested that a venue 'North of Watford', might draw more interested doctors into trying on Balint-work for size. Consequently, the Council of the Society arranged a meeting in Ripon in May 1989.

The venue was the College of York and St. John, which had been used for the local Regional Trainers' Courses, and had hosted a meeting of Course Organisers from all over England and Wales. It is set in extensive park-like grounds, with very comfortable, though limited accommodation for extra-mural activities. The food is excellent, and the wine-cellar must be among the best in the land, with wines of high quality, yet at reasonable prices.

Fifteen doctors registered for the weekend, with a substantial Scottish contingent, and the rest from northern practices, mostly in Yorkshire and Lancashire. The Council had arranged for three groups, so had provided for three pairs of group-leaders. One of these was unfortunately laid low at the last minute, but his place was taken by a local psychiatrist who, though unfamiliar with Balint-work, turned out to be a 'natural'.

Thus, there were three groups of five doctors each, with a group-leader and a co-leader. It was decided that there would be no 'fish-bowl' demonstration-group as has been customary at the Oxford weekend. Each group, therefore had five sessions with time for each doctor to report two case-histories, with a final plenary session before lunch on Sunday.

This seemed to work very well, although in one group there were dramatic comings and goings (literally) by one member, but it is unlikely that this was due to the balance of an initial demonstration-group.

The plenary session was the most productive that any of the leaders could remember having taken place at Oxford. This may have been due to the relatively small number of doctors attending.

One Scottish doctor reported how a short description of Balint-work by Philip Hopkins, in conjunction with the registration form set out in a freebee medical paper, had so captured his interest, that he had uncharacteristically filled up the application form then and there!

The general message was that they had enjoyed the Balint experience, but they castigated the Balint Society for presenting an image of esoteric practice instead of the down-to-earth work which lay at the core of what Balint-work is really about.

The leaders were only sad that the name of Michael Balint seems to bring some British general practitioners out in a rash. The Society must address itself to this problem without delay.

Mike Courtenay

The Seventh International Balint Conference:

Stockholm: 7th to 9th August 1989

I was extremely fortunate to be able to attend the 7th International Balint Conference which was held in Stockholm, Sweden from 7 - 9th August 1989. This trip was made possible by the generous sponsorship of Abbott Laboratories.

The Conference was attended by about 150 delegates — about half of whom were from Sweden itself. This number was considerably smaller than previous International Balint Conferences I have attended, but in spite (?because) of this, it was the most successful Balint Conference I have ever attended, in terms of both organisation and content. It was a great pleasure to meet with many old and new Balint colleagues from no less than 13 countries and 5 continents, from as far afield as Australia, Canada and Yugoslavia.

It has always been my contention that the main value of Congresses is the informal contact between delegates. One notion that this visit served to dispel was the stereotype of the Swedes as cold, remote 'icebergs'. This was not my impression at all. While not perhaps particularly demonstrative by temperament, they impressed me deeply with their hospitality, quiet warmth and genuine interest — I cannot remember being made to feel so 'at home' at any other Congress I have ever attended. (This feeling was increased by my wonderful hosts — Gregor (Psychiatrist) and Barbaro Katz — in whose home I stayed, who told me that their daughter had spent some time in South Africa. Earlier a great-uncle had been hosted by the S.A. Government, when he spent some time in prison at the Castle after deserting the ship on which he was a sailor, at the turn of the century!).

Apart from the Conference itself, it was a real joy to be in the beautiful city of Stockholm, 'the Venice of the North'. We had the opportunity to see the city by boat; to visit the fascinating 'old city' built by the Germans in the 13th Century, and to see several places of interest such as Skansen (which featured numerous exhibitions of the history of Swedish life, such as the glass-blowing works, pottery, old homes, etc.) and Millesgarden, home of the great sculptor, Carl Milles, rightfully dubbed the 'Swedish Rodin'!

On to the Conference itself. Before the first session started, we were treated to a display of Swedish folk music and dancing by a folkband, which included a local Balint doctor and which was due to tour Zimbabwe very soon.

The first morning session was devoted to papers on 'Sympathy — Empathy. Its importance in the doctor/patient relationship and in Balint-work'.

There was a particularly good paper by Ms U Holm, a psychoanalyst from Sweden. She drew a distinction between feeling empathy towards a patient and liking him/her, and stressed the importance of doctors' self-understanding in the development of empathetic responses to patients.

The morning of the second day dealt with 'the meaning of the prescription in the doctor/patient relationship'. Frequent references were made to Balint's concept of the 'drug, doctor'. Dr M Gregor of East Germany argued that since prescriptions were an inevitable part of the doctor/patient interaction, it was important for doctors to understand *why* they were prescribing particular drugs. If this were done, the issuing of prescriptions could have a beneficial psychotherapeutic effect and need not merely be regarded as a 'necessary evil'.

The third and final morning had as its theme 'The everyday situation for the patient, the doctor and Balint-group in different countries'. It was in this plenary session that I delivered a paper on 'Balint work in Developing Countries'. I stressed the point that properly trained Balint doctors were less likely to prescribe unnecessary drugs or order unnecessary investigations and were therefore likely to practice more *cost-effective* medicine, which is a crucial consideration in developing countries.

The afternoon sessions were divided into large Balint-group demonstrations (in German, English and French) and thereafter in smaller groups for Balint-group case discussions. I was honoured to be asked to lead one of the English-speaking groups with Dr John Salinsky of the United Kingdom.

It was with considerable sadness that I left the Karolinska Institute (home of the Nobel Prize Committee), at the end of a most stimulating and worthwhile Conference. I was also sorry to leave this lovely country, which enjoys one of the highest standards of living and social security in the world. What a joy to be in a city in Europe unravaged by war and with practically zero unemployment!

The next International Balint Conference is to be held in Zagreb, Yugoslavia in 1993.

STANLEY LEVENSTEIN

Annual Balint Meeting of Swedish Doctors:

Järvsö 1st to 3rd February 1990

The meeting was held in a traditional hotel in a ski resort not far from the Baltic coast north of Stockholm. 44 doctors attended, including GPs, psychiatrists, gynaecologists and an orthopaedic surgeon! The meeting began with a huge traditional Swedish meal, after which I gave a talk on a Balint doctor's approach to sexual problems in general practice. This was then discussed in small groups. The whole meeting was conducted in English!

The next day there were two demonstration group meetings (the inner group were *ad hoc* groups nominated by the organiser, Benkt Abom), each followed by discussion in small groups, while the leaders' group discussed my work with the demonstration group. There was a third demonstration group meeting on Saturday morning, again followed by small group discussion, followed by a plenary meeting, which was virtually administrative — including a gift of a traditional white linen shirt to me (no interpretations please!).

The groups worked very hard, with amazingly straightforward cases on the Friday morning session, followed by horrific cases in the second. The cases in the last group were all about the difficulty of saying farewell! This was a gift to the group-leader, of course.

In parenthesis there was a splendid dinner on the Friday evening, followed by impromptu self-entertainment by each of the three groups, all in English(!), including 'Ten little GPs' and a song entitled 'Michael, row the group ashore'. I responded by telling a long shaggy-dog story. The meeting was a tonic to me.

MIKE COURTENAY

International Balint Meeting:

Szeged, Hungary: 6th to 8th April 1990

The 20th annual meeting of medical students and doctors on the work of Michael Balint took place from the 6th to 8th of April 1990 in Szeged in southern Hungary. For the last 19 years this meeting, called the 'Ascona Balint Model', has taken place in Ascona, in Switzerland. While the hospital there is being rebuilt the meeting can travel around — next year to Freiburg, West Germany, and in 1992 to Graz, in Austria.

More than 250 doctors and students from West Germany, Austria, Hungary, Romania, Yugoslavia and England gathered to discuss the doctor/patient relationship, and to try to gain more understanding of it. Led by distinguished psychoanalysts and doctors from all over Europe, including London GP Dr Jack Norell, President of the International Balint Federation, small groups worked as Balint-groups for five 1½ hour sessions over the weekend.

In addition there were lectures and seminars on various topics such as maternal depression and its effects on the children, by Dr Cox from Guys' & St Thomas' and Suicide in Hungary (Hungary has the highest suicide rate in Europe).

Sessions and groups were organised in Hungarian, German and English. However, the problems encountered by doctors all over Europe were the same and new insights were taken by all. Perhaps most profound for the group from Neumarkt in Romania, recent scene of racial atrocities against Hungarians. These students and doctors were experiencing the ability to meet and talk freely with other Europeans for the first time, coming from medical schools where scientific journals were banned. But Balint meetings always seem to bring a sense of freedom to the doctors who attend, the ability to express and discuss their *feelings* and *emotions* in order to help them help their patients.

The awards to medical students for the best essays based on their personal experience of relationships with patients, were not presented as usual at this annual meeting. Instead, they were awarded in Ascona at the end of April, during the Symposium on the Promotion of Interpersonal Relationships, organised by Professor Boris Luban-Plozza.

Once again the first prize was awarded to a British medical student, Jonathan Goldin from Manchester University, whose essay was judged the best of ninety entries. A full account of his essay was given (see page 19). The second prize was awarded to Zorana Abramovic of Yugoslavia, whose essay was also quoted, together with others from Belgium, Holland, Hungary, Italy, USSR and Yugoslavia.

The ideas conveyed in many of these essays were most impressive, considering that the students had only begun to share the experiences of established physicians. Yet their thoughts were remarkably similar to those we had taken years to develop. Evidently Michael Balint has influenced not only our response to patients, but also the way we help and encourage students to learn from patients, and from each other.

DAVID WATT
JACK NORELL

Report from the South African Balint Society

Dr Jane Eyre receiving the South African Balint/Fisons Travel Fellowship Award for 1990.
Left to right: Dr Savile Furman, Dr Jane Eyre, Ms Jenny Price and Mr Lawrence Camfer (Fisons).

1989 saw three of our members travelling overseas to represent our Society. In May 1989, I presented a paper at the WONCA Congress entitled 'Doctor, Are you Listening?' This was in a Workshop session where the other participants were Philip Hopkins, Jack Norell, and Roger van Laetham of Belgium. The paper was based on my own experiences after being exposed to Balint-training. The inspiration for the paper came to me after reading the book entitled 'While I'm Here Doctor'.

Stanley Levenstein went to Stockholm in August 1989, where he delivered a paper on 'Balint-Work in Developing Countries'. He stressed the point that properly trained Balint doctors were less likely to prescribe unnecessary drugs or order unnecessary investigations, and were therefore likely to practise more cost-effective medicine which is a crucial consideration in developing countries.

Dr Basil Michaelides, the 1989 recipient of the South African Balint/Fisons Travelling Fellowship Award, attended the annual Balint Weekend at Oxford. He commented that the cases presented were very similar to the type of problems seen in South Africa. However, the different State medical systems influence patients' expectations in Britain and Finland. He also noted that the Balint movement has the same problem in the U.K. as it has in South Africa, that it is centred mainly in London.

The Annual Balint Weekend Workshop was held in Cape Town from 9th - 11th February 1990 under Dr Stanley Levenstein's able leadership. There were 20 delegates from all over the country. The weekend was a resounding success. Extremely interesting cases were presented and discussed in the group setting. New members who had never been exposed to Balint-work previously found themselves at home very quickly and very sensitive issues were dealt with in a trusting environment. At the Cocktail Party on the Saturday evening, Dr Basil Michaelides proposed the toast to the South African Balint Society and the International Balint Federation.

Jane Eyre was selected as the recipient of the South African Balint/Fisons Travel Fellowship Award for 1990. She qualified in 1950 and did her internship in Johannesburg. She then went to the U.K. initially for 6 months, where she worked at King George V Hospital. She started training in surgery, but changed to general practice where she was from 1955 until 1967, when she returned to South Africa. When she entered general practice in the U.K. she felt she knew nothing about people and was lucky enough to join one of Michael Balint's groups in London. Jane spent 4 years in one of his groups and continued with seminars at the Tavistock clinic.

Since her return to South Africa in 1967, she has attended most of the International Balint Congresses. She started a group in Durban in the early seventies and comes annually to Cape Town for the Workshop. She will use the Award to travel to the Annual Balint Weekend at Oxford in September 1990.

At the 11th A.G.M. of the South African Balint Society we were informed that a new student-group was being started in Johannesburg under Dr Naomi Arnheim. Stanley Levenstein reported on his Vocational Trainee-group that he runs in Cape Town. I am co-leader of another group in Cape Town which has now been meeting for a year. There is also another Balint-group in Johannesburg, and one in a hospital setting at Medunsa Medical School.

Stanley Levenstein and myself are also involved in setting up a Counselling Service for parents of drug-abusers and suspected abusers. We have undertaken this community counselling project in conjunction with Lifeline, pharmacists, social workers, psychologists and other people interested in combatting this problem.

We intended having another Workshop in Cape Town during February or March 1991 and would welcome any Balint member from the U.K. to come and join us. See you there!

SAVILLE FURMAN

Foundation of the American Balint Society

6th May 1990

On the 6th May 1990, I was present at the birth of the American Balint Society in Seattle, Washington. This is how it happened. Last October I visited the Department of Family Medicine in Charleston, South Carolina, as the guest of Dr Clive Brock, the Clinical Director. Clive, who comes originally from Cape Town, South Africa, is a great Balint enthusiast and is now running Balint-groups for the family medicine residents (or trainees, as we would call them) in Charleston. He and a colleague called Ron Stock recently published the results of a survey of Balint activities among the 381 family medicine training programs in the USA. They found that 66 of them offered Balint-seminars as part of their training. Furthermore, it was clear from what the leaders said about the function of these groups that we would recognise the great majority of them as the genuine article.

In May 1990, I visited another hot bed of American Balint-training 3000 miles further West at Santa Rosa, a pleasant town of 100,000 people in the heart of the Californian wine country. The director of family medicine training here is Dr Frank Dornfest, another ex-citizen of Cape Town and another fervent advocate of Balint-work. His enthusiasm had evidently been communicated to many of his colleagues including both doctors and clinical psychologists. One of the enviable features of American family medicine training is the presence of large numbers of friendly 'Behavioural scientists' who are very much part of the medical team and make a great contribution to the education and support of the residents.

The Santa Rosa program runs three Balint-groups for residents, one for faculty members and one for local family doctors as well as a leaders' workshop. I was able to take part in three of these groups and was delighted to find that I felt very much at home with their style of working. I hope they felt the same about me!

A few days later, Clive, Frank and I met up in the Sheraton Hotel, Seattle, along with 900 other MDs and PhDs for the Annual Conference of the American Society of Teachers of Family Medicine. Clive and Frank had negotiated permission from the conference organisers to hold a 'Balint Theme Day' to which anyone with an interest in, or curiosity about Balint was invited.

The theme day was organised and facilitated by Dr Alan Johnson, a Jungian therapist and family medicine teacher who works with Clive in Charleston. About 90 people turned up for the morning session and I started things off by giving them a short talk about Michael and Enid and the history of the Balint movement in Britain and Europe. We then had a fish bowl group (just like Oxford!) followed by a discussion which I chaired with some difficulty because of the forest of eager hands requesting permission to speak. In the afternoon, the numbers thinned out, but we still had enough people to run four groups, each led by two relatively inexperienced leaders with a more senior leader present as an observer. This led to a plenary discussion about leadership issues which was lively and constructive. I noted again, that it was difficult to tell who was a doctor and who was a psychologist, because everyone had the same identification with 'family medicine'.

The climax of the day came after tea when there was a unanimous decision to found an American Balint Society to co-ordinate and foster Balint-work and leadership training in family medicine programs around the country. Frank Dornfest was elected as the first president and it was decided to adopt the Constitution of our own Balint Society, after suitable Americanisation of the language where appropriate. The society will apply for affiliation with the International Balint Federation and we look forward to welcoming Frank as their representative at the next International Meeting in Helsinki in August 1990.

John Salinsky

Obituary

Dr ELIZABETH M F MITCHELL, MB, ChB

2.1.1917 - 17.9.1989

Dr Elizabeth Mitchell died on 17 September 1989 at the age of 72.

After qualifying from the University of Aberdeen in 1939, Betty joined the Royal Army Medical Corps, where she met her first husband who was a general practitioner in east London. When she was widowed soon after the birth of her son, she faced the problems of single parenthood by working in many hospital and community health posts until 1951, when she was appointed medical officer at Harrods.

She became an active member of the Society of Occupational Medicine, and held the post of secretary for some years in the 1960s. After her retirement in 1979, and coming through the great shock and trauma of losing her husband, Howard, so soon afterwards, she came to do some work at the Dympna Centre, a Roman Catholic Counselling Service. She was like a young student, eager and ready to learn new skills. Her profound interest in people and her total acceptance of them, made her a natural counsellor and healer.

I first met Betty when she joined a Balint-group at University College Hospital. She stood out among the members of the group from the beginning, being spontaneous, human and irrepressible without ever pushing herself into the limelight.

The first time she was due to report a case-history, she was a little anxious beforehand and had a dream in which all her case-notes were blown away across some green hills. She asked Michael Balint if she could tell her dream to the group as it seemed relevant. 'Certainly not,' he said sternly, and that dream has stayed in my mind as it was so characteristic of Betty, but although she felt admonished, this did not put her off Balint.

She was a great advocate for Balint-groups, and was quite passionate in their defence when she came across critics who had no personal experience of them. 'Balint-groups,' she would tell them, 'have completely transformed my approach to patients. Before I joined a Balint-group, I was often bored by the repetitiveness of complaints, but afterwards every patient became a small drama, and I was never bored again.'

When some members of the group expressed doubts about being able to find time to talk to so many patients who seemed to be managing all right on simple prescriptions, and wondered how they would ever finish their surgeries, Betty said, 'Curiously enough, I found that I actually had more time after I started talking to my patients more. People did not keep coming back, and I learned how to allot time more efficiently, just giving longer appointments to those who needed them, at the end of the surgery, and because it became so much more interesting, I had more energy for them.'

Betty could get on well with people from any culture, creed, social class or educational background, even when there were great language barriers, as in her last work situation at the Medical Foundation for Victims of Torture, as happened with those who came from many of the countries which practise oppression. Betty's genuine kindness and feeling for others, especially for anyone in need or in pain, was remarkable. She spared no effort to help wherever she could, and it gave her great pleasure to be able to do so.

I do not remember her ever saying anything nasty or judgemental about anybody. She knew a great deal about art and literature and was a stimulating companion. It was always a great treat to be with her, whether to go for a walk, to see a film or play, or to share a meal. She could really enjoy the small things of life and be immensely appreciative. She asked for very little for herself and gave much.

When she was told that her cancer was inoperable, her reaction was astonishing. She said that she experienced a great sense of freedom, because she was now going to enjoy whatever was left of life to the full. Every minute would be precious, and I believe she did just that — enjoyed herself without any sense of guilt.

Betty faced death uncomplainingly, with great courage, serenity and strength. When, during the last few weeks, she lost the use of her right arm, she tried to teach herself to write with her left hand, because writing letters and keeping in touch with friends was so important to her.

Betty was a very special human being, and I feel very privileged to have known her. I shall never forget her and believe that everyone she came into contact with, will treasure the experience and feel richer for having known her.

She is survived by her son, John, who is a doctor at the King's Fund College, and two grandchildren.

Irene Bloomfield

From My Bookshelf

The ever growing number of books about the psychological aspects of medicine and medical practice has almost become overwhelming. Apart from the limited room on my bookshelf for current books, the shortage of time to read them all has seriously reduced the number of books which can be reviewed. However, there are some which just have to be recommended:

Psychological Management for Psychosomatic Disorders, J W Paulley and H E Pelser. (Pp. 335. ISBN 3-19298-0) London, Springer Verlag. 1989. (£35.00).
Although there is nothing new in the idea that a great deal of illness is associated with the effects of the emotional state on body function, this still seems to have little effect on the treatment of the many patients in this category.

Too many patients are still sent away with the hospital specialist's words ringing in their ears, 'We've done all the tests and there's nothing wrong.' Back they go to their general practitioners, to ask why do they still have their symptoms? There may be no answer, if the doctor has not been trained to recognize depressive/anxiety states, or perhaps has some intuitive empathy.

If any book can help doctors to treat these patients more effectively, here it is! Written, as it is, by two highly reputable and experienced hospital consultant physicians who, according to the Foreward by Professor J J Groen, (Emeritus Professor of Medicine and Psychobiological Research in the Universities of Jerusalem, Israel and Leiden, The Netherlands), combine the use of modern techniques with human understanding and psychological management of their patients in the practice of internal medicine.

They are just as concerned about their patients who suffer from illnesses in which emotional stresses play a major aetiological role, as they are about their patients with diseases involving gross pathological changes.

They invited six other specialists from The Netherlands, West Germany and Britain to contribute chapters on the psychosomatic aspects of dermatology and obstetrics and gynacology.

The book covers the whole field of internal medicine, and some eighty disorders are covered, system by system, in eleven chapters on clinical medicine. Guidance is offered throughout on the psychological managements for psychosomatic disorders in some detail.

There are added chapters which define the terms used in describing the general methodology of psychosomatic practice, at the beginning of the book, together with general descriptions of somatopsychic presentations, profiles and associated hypotheses and various aspects of the psychosomatic approach in medical practice.

There are numerous clinical case-histories with *verbatim* transcripts throughout, with excellent summaries wherever they are required. Some might appear to be rather didactic, but accepting the intention to guide the lesser experienced clinicians, I welcome this approach and am pleased to recommend this book to any doctor who feels the need to improve his management of those patients who frequently are so difficult to manage along more traditional lines.

My main criticism of this otherwise excellent book, is that although mention is made of 'the research and teachings of the Balints and others,' and 'the value of brief psychotherapeutic intervention in general practice' is recognized, the subsequent discussion suggests that the authors are not as intimately familiar with the Balints' work as they might be.

I have been using Balint concepts in my practice for thirty-six years, and I have never found it to be incompatible with a medically scientific approach. In fact, it is only by having a good grounding in scientific medicine, that I have dared to go ahead with whatever psychological treatments I have thought appropriate for any given patient.

Of course, we all know that reading books is not the same as exchanging ideas and attitudes in a Balint-group discussion, and is unlikely to lead to any change in the doctor's personality, but to be realistic, there are many doctors in Britain who have not had, nor are likely to have any experience in a Balint-group for some time to come, as long as general practitioners are obliged to spend their time carrying out routine 'check-ups' and un-selected screening of unproven value, and to use up their time in endless form filling and reports of dubious worth.

This book will be a very useful addition to all practice libraries, as well as the libraries in all Academic Centres.

The Ailment and other Psychoanalytic Essays, Tom Main. Ed. J Jones; (Pp. 256. ISBN 1-85343-105-2) London, Free Association Books. 1989. (Hardback £27.50).
Tom Main is a distinguished psychoanalyst. For many years he was Medical Director of the world famous Cassel Hospital in Richmond, and was largely responsible for the development of the therapeutic community which was established there. He was analysed and supervised by Michael Balint, who asked him to take over the work he had started earlier with doctors from the old Family Planning Association.

When, in 1974, the NSH took over the work of the FPA doctors, it did not take on their psychosexual training, so Tom Main and the other trainer practitioners started their own Institute of Psychosexual Medicine, of which he is the Life President, to carry on the work. Tom needs no introduction to members of the Balint Society, who invited him to give the third Michael Balint Memorial Lecture in 1978, and elected him to be an Honorary Member of the Society.

There is a most illuminating Introduction by Eric Rayer who, we are told, facilitated the plan to produce this book, together with a short explanation by Tom Main's eldest daughter, Dr Jennifer Jones, (who is also a psychoanalyst), about its origin.

The first half of this book contains some of Tom's reflections on his development of the therapeutic community in the Cassel Hospital, in eight of his best known papers. One of them, *The ailment,* although

primarily of interest to those working in institutions, has much in it to interest general practitioners and others too. The description of his work with groups made up by members of the hospital staff, makes fascinating reading. It shows the groups to be made of very much the same stuff that Balint-groups are made of, training and research, as exemplified by the description of how discussions with the nurses about their giving so much sedation to patients, led to its reduction almost to zero.

The second half of the book contains another eight of Tom's papers, concerning training in and applications of psychoanalysis, which illustrate how psychoanalytic thinking can be fruitfully directed in other fields. They include one of his earlier papers, *Clinical problems of repatriates,* (1947) which is about the difficulties faced by the returing soldiers and ex-prisoners of war in adapting to conditions at home.

A later paper, *A fragment of mothering* (1958) reflects on how much of the literature on the subject of maternal parenthood is infant — rather than mother-centred, and describes the sorts of problems that can arise at this stage of development, and some of their consequences.

Happily, the Third Michael Balint Memorial Lecture, given in 1978 by Tom Main, *Some medical defences against involvement with patients,'*[1] was selected out of over fifty of his papers for inclusion in this book which I can enthusiastically and sincerely recommend to anyone who is concerned with patient care, whether in the community or hospital setting, and also to all those who are interested in the application of psychoanalysis to other fields such as general practice, marriage guidance, family planning, probation work or in the setting of community or hospital psychiatry.

Obsessional Thoughts & Behaviour: Help for Obsessive Compulsive Disorder, F. Toates. (Pp 192, ISBN 0-7225-2195-2) Wellingborough, Thorsons Publishing Group. 1990. (Paperback £4.99).

It does not take very long for the vocational trainee general practitioner, or indeed any doctor entering general practice, to discover the difficulties in knowing how to deal with the large number of patients whose presenting symptoms do not fit the neat diagnostic labels he learned about in medical school (a topic mentioned elsewhere in this Journal, and frequently in any medical journal which deals openly with such matters!). He soon finds out that the patient suffering from a compulsive-obsessive disorder, presenting with his obsessional thoughts and behaviour is the most difficult of all. And a doctor with a list of 2000 patients might expect to find that he has about forty such patients. Fortunately not all will be so severely disturbed as Dr Toates bravely admits to have been earlier in his career.

Because Dr Toates has not only been a victim to this debilitating disorder, but he is also a well known experimental psychologist at the Open University. He has therefore been able to research the subject most comprehensively in order to produce this excellent book, which is designed to help his fellow-sufferers to realize that they are not alone with their troubles, and to find the professional help they need, and perhaps to come to terms with what can, and what cannot be done for them.

Dr Toates starts by warning his readers that this is not a DIY book on how to cure obsessions in twelve easy lessons, but rather a *User's Guide* to the obsessional personality and disorder. He then describes, in a succint and very graphical autobiographical account of his childhood, already marred by a number of fears. His early life in a small village four miles outside Cambridge. The brief references to his 'highly strung' paternal grandmother, his asthmatic father who suffered from 'spells of depression', his mother who used to 'come over funny', and his sister who was 'petrified of spiders', all brilliantly set the scene.

He takes his readers (and I think there should and will be many) through a rapid, but brightly illuminated career through childhood and school in his village; off to work after 'O' levels; serious studies, recognition by a kindly employer who volunteered financial assistance to help him through university; success, and on into the academic world of psychology, until his obsessive thoughts and compulsive behaviour became too much for him.

His search for help — the doctors who let him down; decline; and the one who tried to help him; the slow way back to normal.

Then follows an outline of some of the features of this disorder, together with a very helpful, though brief description of the available treatments, and their success-rates, with suggested ways in which sufferers and their families can help themselves.

In the last chapters, Dr Toates looks at some famous people whose lives can illuminate the understanding of obsessions: Samuel Johnson, Soren Kierkegaard, Hans Christian Anderson, and others, including George Borrow and Woody Allen. All examples of beautifully potted biographies.

Some wise and intelligent concluding remarks follow, and finally there are eleven pages of wide ranging references and, my only half-hearted criticism, a rather poor index.

I am including this book in this short selection from my bookshelf, not only because I believe that we doctors should know what our patients are reading, but because I found it to be compulsive reading!

Also because it contains one of the best accounts of a very serious and debilitating medical disorder that I have seen for a long time. I strongly advise the publishers to produce a hardback edition, (preferably with an improved type-face and better quality paper which it deserves) if only to ensure that all libraries will put it on their shelves too!

Philip Hopkins

From the 20th Annual General Meeting held on 20th June, 1989

Secretary's Report

The year's activities began in September 1988, with the annual residential Balint Weekend in Pembroke College, at Oxford. As always, this was very successful, although there were only 42 delegates, including several from overseas, and a medical student who had been awarded the first Cyril Gill Bursary.

The weekend started with a demonstration group after dinner on the Friday evening, led by Dr John Salinsky and Ms Antonia Shooter. Four groups subsequently met on four occasions over the weekend, with Saturday afternoon free for the brave and adventurous to walk through the rain on John Salinsky's now traditional tour of the sights of Oxford.

The usual problems were raised during the final plenary session on the Sunday morning: Where are the group-leaders for those wanting to start Balint-groups 'North of Watford'? Can there be other Balint Weekends outside London, like Oxford and Ripon? Some doctors objected to the eponymous title of the Society, and discussion became surprisingly heated! (see Journal Volume 17, page 35).

The series of evening meetings, held at the Royal College of General Practitioners, began in October with Mr John Schlapobersky's address on 'The Pair and the Person: Group-analytic Psychotherapy for Couples in Distress'. This work has led to Relate forming marital-therapy groups for those with difficulties.

The second meeting in November, proved to be very popular with an excellent attendance for a joint meeting with members of the Institute of Psychosexual Medicine. Each organisation presented two case-histories for discussion. There was much agreement, and it was felt that the meeting had been very worthwhile in bringing together the two groups with many similar ideas, and method of working.

Dr John Sklar, a psychoanalyst working in a National Health Service setting in Cambridge, talked with us at the third meeting in March 1989, about his group for psychiatrists-in-training, which he leads along Balint lines. It is invaluable for those who take part, providing as it does a learning experience which is otherwise completely lacking in the rest of their training.

The eighth Michael Balint Memorial Lecture, 'Making Sense of Medicine', given on April 25th by Dr Michael Courtenay, was a profoundly thoughtful address, based on his long experience of Balint-work. He also discussed where progress may still be made. (see Journal Volume 17, page 5). This was the best attended meeting of the year.

The meeting for May was replaced by the Society's organisation of the first residential Balint Weekend to be held in the north of England. It was held in the College of York and St John, in Ripon. There were 15 delegates, divided into three groups, each with two co-leaders, who met throughout the weekend, without an initial demonstration group.

Most of those attending were new to Balint-work, and their response was very positive, and all comers enjoyed the weekend very much (see page ??). A second Balint Weekend will be arranged for May next year.

The Balint-group leaders' Workshop continues to meet regularly under the chairmanship of Dr Erica Jones.

The Council was pleased to announce that the Balint Society's Prize of £250.00 for the best essay for 1989, on 'What Balint Means to Me', was awarded to Dr Jack Norell (see Journal Volume 17, page 20).

The Council was also happy to congratulate Dr John Norell on his nomination for election to the Presidency of the International Balint Federation for the coming session.

Congratulations were also offered to Dr John Salinsky for his nomination for re-election to the Treasurership of the International Balint Federation.

The membership of the Society is in a state of flux. Six new members joined during the year, but we may well lose some members in our efforts to bring members' subscriptions up to date.

It was with great regret that we learned in the spring of this year, of the death of an old and much revered member, Dr David Morris (see Obituary Notice in Journal Volume 17, page 37). The Society has expressed its condolences to his widow and family.

DAVID WATT

PROMOTING PATIENT-CENTRED MEDICINE:

The Ascona Model to further the doctor/patient relationship

Award for Medical Students 1991

Medical students are invited to submit an essay based on their personal experience and relationships with patients. An award of 6000 Swiss francs, donated by Pharmaton Ltd., Lugano, will be made to authors of the best entry, as judged by adjudicators drawn from the Psychosomatic Societies of Austria, France, Italy, Switzerland, West Germany; the International Balint Federation, as well as student representatives.

The essays will be judged on the following criteria:

1. Exposition: The fresh presentation of a truly personal experience of a student/patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. Reflexion: A description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialties, and working routine within different institutions.
3. Action: The student's perception of the demands he/she felt exposed to, and an illustration of how he/she then actually responded.
4. Progression: A discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Four copies of the essay, each containing the author's name and address, should be posted, **not later than December 31st, 1989,** to the following three representatives:

1) Prof. Dr Boris Luban-Plozza
   Piazza Pedrazzini
   CH-6600 Locarno, Switzerland
2) President Dr J. S. Norell
   50 Nottingham Terrace
   London, NW1 2QD, G.B.
3) Prof. Dr Paolo J. Knill
   Lesley College Graduate School
   11 Mellen Street
   Cambridge, MA 02138, USA

The presentation of prizes will take place in Ascona.

All information can be obtained from: Documentation Center Balint, CH-6612 Ascona, Switzerland.

Programme of Meetings of the Balint Society for the Twenty-First Session

1990-1991

The following meetings will take place at the Royal College of General Practitioners, 14, Princes Gate, London, SW7, on Tuesday evenings at 8.30 p.m., preceded by coffee at 8 p.m.:

DR BRYAN LASK, Consultant Psychiatrist, The Hospital for Sick Children, Great Ormond Street, London:
The child speaking with his body: understanding, and treating physical symptoms. 16 October 1990

DR ANTHONY RYLE, Consultant Psychotherapist, St. Thomas' and Guy's Hospitals:
NHS relevant psychotherapy. 20 November 1990

DR SOTORIOS ZALIDIS, General Practitioner, London:
Short psychotherapy in general practice. 12 February 1991

DR HAROLD STEWART, Psychoanalyst, The Tavistock Clinic:
Why regression in psychoanalytical psychotherapy: An overview.
The Ninth Michael Balint Memorial Lecture: 12 March 1991

The Oxford Balint Weekend, 1990

will take place at Pembroke College, Oxford: on Friday at 6 p.m. 7 September 1990
to Sunday at 1 p.m. 9 September 1990

THE OXFORD BALINT WEEKEND 1991 — dates to be announced.

The Ripon Weekend, 1991

will take place at the College of Ripon and York St John, North Yorkshire on Friday at 6 p.m. 17 May 1991
to Sunday at 1 p.m. 19 May 1991

The 21st AGM and Annual Dinner

will take place at the Medical Society of London date to be arranged in June 1991

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

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