Journal of the Balint Society

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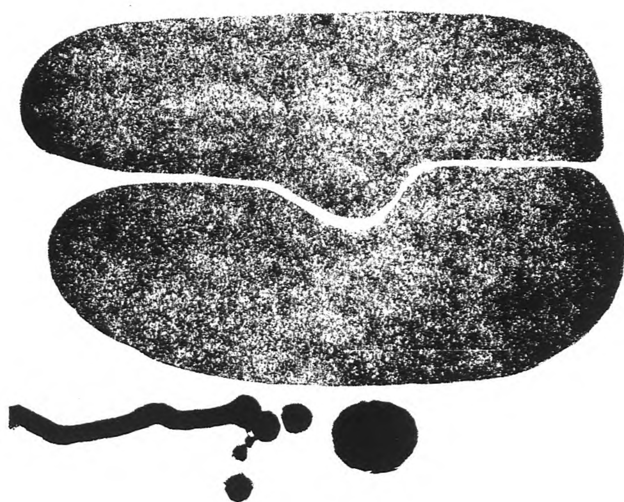

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Contents *Page*

Frontispiece: ... 2
The Balint Society ... 2
Editorial ... 3
Holding in General Practice, Sotiris Zalidis ... 4
The Erosion of Empathy in Medical Education, Clive D. Brock, Alan H. Johnson, Ronald P. Durand, Jon H. Levine and D. Bryce Downey ... 8
The Student Psychotherapy Scheme at the University College and Middlesex School of Medicine: its Role in Helping Medical Students to Learn about the Doctor/Patient Relationship, Peter Shoenberg ... 10
Student Psychotherapy Scheme and its Role in Helping Medical Students to Learn about the Doctor/Patient Relationship, Irene Bloomfield ... 15
A 'Bothersome' Patient, Joseph Saperia ... 19
A Plain Doctor's Guide to Balint-Work, Michael J. F. Courtenay ... 20
From my Bookshelf ... 22
The International Balint Federation, Jack Norell ... 23
Obituary: John L. Skinner ... 29
Reports:
- The Oxford Balint Weekend, September, 1992 ... 25
- Letter from the American Balint Society ... 27
- The South African Balint Society ... 28
- The Ripon Balint Weekend, May 1992 ... 29
- The Annual General Meeting, 1992:
  - Presidential Address ... 30
  - Secretary's Report ... 31
  - Council of Balint Society, 1992/93 ... 31

Announcements:
- 8th International Balint Congress, 1994 ... 18
- International 'Balint'Award 1993 for Medical Studies ... 24
- The Balint Society Prize Essay ... 31
- Future Meetings of the Society ... 32

Editor: Philip Hopkins
Assisted by Susan M. Hopkins

Demonstration of a Balint-group in front of an audience of over 400 at the First International Balint Conference, *The Doctor, his Patient and the Illness,* held on 23rd-25th March, 1972, at the Royal College of Physicians, London. Group-leader: Mrs Enid Balint. Chairman: Dr. Philip Hopkins.
Group members: Drs. P. Bernachon, B. S. Clarke, M. J. F. Courtenay, R. M. Fiskus, R. S. Greco, J. W. Hunt, A. Lask, J. Norell, L. Ratoff, G. Schithart, R. C. Veldhuyzen van Zanten.

The Balint Society:

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 Balint-groups in London. Residential Balint Weekends are held in Ripon in May, and in Oxford in September each year (see page 32).

The Annual General Meeting is held in June each year.

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 31), and the Journal is circulated each year to all members.

Editorial

Twenty Years of Publication

With this issue, the Journal of the Balint Society reaches its 20th edition. The first issue appeared in June 1971, with the now familiar drawing by Victor Pasmore on the front cover. Inside, by way of explanation, there was an article by Stephen Pasmore in which he related the appreciation of abstract art to the mental processes of a doctor listening to a patient[3].

The Journal's appearance is eagerly anticipated and it is read with enjoyment both at home and abroad. No other Balint Society has such a publication and its continuing vigour over such a long period represents a considerable achievement.

What do we know of the origins of the Journal and the intentions of its founders? From the very beginning, the Society's Foundation members ('The Old Guard', as Michael Balint called them) saw the publication of a serious journal as an essential part of the Society's functioning and provision was made in the constitution for an Editor to be one of the officers on the Council. In 1971, the first Editor, Dr. Max Clyne, together with Dr. Aaron Lask, wrote a paper for discussion at that year's Annual General Meeting in which they defined the purpose of the Journal as follows:

'The Journal will be the medium with which the Society will talk to the Profession. Michael Balint's life work would have been in vain if we were to restrict ourselves merely to talk to each other. The most important object of the Balint Society is the dissemination of its work, based on Michael Balint's teachings. The Journal is its instrument. This instrument must be of good quality, otherwise the Society will become an object of ridicule. It will be necessary, therefore, to present our thoughts in a language that is easily understood by other members of the medical profession, is free from esoteric jargon and vulgarisms, and of a style and linguistic level worthy of a scientific journal'[2].

How far has the Journal been able to meet these high expectations? Anyone who browses through the complete set of 20 volumes will find plenty of interesting material. The major papers are full of thoughtful and useful insights, amply illustrated with lively case-histories, often spiced with humour and generally written in good clear English prose. The more serious contributions are leavened with reports of conferences at home and abroad, book reviews, announcements, accounts of Annual General Meetings and, sadly, obituaries, all of which provide a documentary history of the Society and its development over the last 21 years.

The Society certainly has, in its Journal, a clear and articulate voice with which to address the Profession; but is the Profession listening? Although copies are sent to the medical schools and postgraduate departments all over the country, the Journal is not often displayed in postgraduate libraries and its circulation remains small. And yet, at the present time, there is considerable interest all over the world in the application of Balint-group methods to the training of family doctors.[1] At a recent International Balint meeting for students and family medicine teachers in Graz (Austria), copies of the Journal were devoured with great interest. At a national Balint Society conference in the United States of America this April, I was easily able to dispose of all the copies I had brought with me. Less happily, our journal seems to be very rarely quoted by authors in other publications. One notable exception was an influential paper by Scheingold in the Journal of Family Practice (1988) which cited the Journal of the Balint Society no less than 11 times![4] Dr. Scheingold's paper was written as a result of a long stay in England and a fruitful collaboration with Balint Society members, so it is rather special. Nevertheless, it amply demonstrates that there is material of importance and academic value to be found in the pages of our Journal.

Perhaps the time has now come for us to seek wider recognition and aspire to some authority within the medical academic community. One important step would be to have all original papers submitted to assessment by two well qualified referees, who could advise the editor on their suitability for publication. Secondly, all our members who are involved in academic general practice, or who attend meetings overseas should promote the Journal with the enthusiasm it deserves. And thirdly, if the Journal is to maintain its vitality, we shall need more contributions from our newer and younger members, recording their experiences and their ideas about Balint-training and Balint research. If these things happen, we may see the strength and influence of our Journal increase.

Meanwhile, we should salute Dr. Philip Hopkins, the Journal's Editor and moving spirit since 1974. Without his inspiration, dedicated hard work and unshakeable faith the Journal would not have survived. Under his devoted care, it has flourished.

JOHN SALINSKY

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Holding in General Practice*

Sotirios Zalidis
General Practitioner, London

I am a general practitioner, working in a busy, training group practice in Hackney. We have a multi-racial list of 10,000 patients with a 15% turn-over a year. We also have a substantial obstetric commitment which means that we are exposed to the whole spectrum of human troubles, from conception to death.

For the majority of patients, the knowledge that the surgery is there and that we are available, has a reassuring and regulating function. With this security, a large number of illnesses and emotional trouble sorts itself out in the ordinary home. Reliability and availability has to be tested of course.

In our work, we have to meet a great social need and pressure, and it is here that practice organisation makes this possible. One can say that this is holding on a social scale, but I may be taking the analogy too far.

Recently we had to introduce five-minute appointments and reduce the number of ten-minute appointments, in order to meet the increasing need of patients to consult us.

However, there are instances when being there is not enough. In order to facilitate the patient's healing tendency, a specific attitude is called for. This involves a special awareness of the patient's psychosomatic needs, a holding together of the somatic expression and the emotional need. It is a matter of clinical judgement whether you will meet the emotional need through attention to the physical complaint, or vice versa. This approach demands an integration, first of all in the doctor's mind, of psyche and soma. It is only by surviving the strain of disintegrating forces in the patient that you can set free the healing process in the patient. We have a model of this attitude in the mother/baby relationship.

There is a parallel between medical care and infant care. One can study, with great benefit, the analogy between the concepts of maturation and healing and between dependency and illness. In this context, I find Winnicott's concept of holding particularly relevant for understanding aspects of medical care.[1,2]

In infancy, when so much development is starting, two processes are fundamental: maturation and dependence. At first, the environment is essential and gradually becomes less essential. At this stage, one could speak of double dependence, meaning the lack of awareness of any dependence. This changes into simple dependence later on. The environment does not make the infant grow, nor does it determine the direction of growth. The environment, when good enough, facilitates the maturational processes. For this to happen, the environmental provision, in an extremely subtle manner, adapts itself to the changing needs arising out of the concept of maturation. Such a subtle adaptation to changing needs can only be given by a person who has, for the time being, no other preoccupation and who is identified with the infant so that the infant's needs are met as by a natural process. At this early phase, love is expressed in terms of physical care, adaptation and reliability meeting dependence.

In medical care, the concept of illness and of being ill brings immediate relief because it legitimises dependence. Encounter with an ill person in the professional setting moves the doctor into the position of one who responds to need, that is to say of adaptation, concern and reliability. This is a form of holding and it facilitates the healing process which is a regrowing process just as much when it concerns the mental self as when it concerns the body. It can not be artificially hurried.

The following two clinical examples demonstrate the relevance of the concept of holding in clinical practice.

One day after the evening surgery, a worried mother rang the practice to request a visit for her ill child. I spoke to her on the telephone. She said that her ten-day old baby was suffering from projectile vomiting after every feed and that in between feeds the baby appeared listless. She had to wake him in order to feed him. I was surprised by her use of the word projectile, which is used mainly to describe the vomiting associated with pyloric stenosis. I asked why she used the word projectile and she said that when he vomited, whilst lying in his cot, the vomit shot out of the cot! I went to visit her, with the possibility of pyloric stenosis prominent in my mind.

When I arrived, I was led to the parental bedroom where I saw his father sitting on a chair, bottle-feeding the baby. The mother was standing up and looking on with a pained expression on her face. I took the opportunity to use the baby's feed as a test feed and examine him for the sign of pyloric stenosis.

The baby looked healthy, was not dehydrated and as I was talking to the parents I observed that the mother had a towel wrapped around her neck. I asked what had happened. She said that her neck had been painful since the day of the delivery. It happened during labour. She was labouring on all fours, and kept turning her head to look at the clock on the wall just behind her. Her labours in the past had always been very fast, lasting about two hours, and the midwife in attendance said that the way she was going

*This paper was presented to the Greek Psychosomatic Society in 1989, and published in the *Annals of the Hellenic Psychosomatic Society*.

she would break her own record! The result was a very painful neck which became worse with every movement. Every time she had to pick up the baby, hold him and feed him the pain became worse.

The father was also very concerned. 'You are supposed to enjoy the first days with the baby', he said, 'but because of her pain, my wife has been very depressed.' By that time, I had completed the physical examination of the baby and I knew who the patient was. I explained to the parents that I could not find anything wrong with the baby, but that I did feel strongly that his mother should have urgent physiotherapy to her neck and that I would arrange domiciliary physiotherapy as soon as possible.

Then, I ventured the suggestion that it was possible the baby sensed the mother's pain and reacted with one of the limited ways at his disposal. The mother accepted this, to my relief, and seemed pleased for the recognition that her pain was important and needed treatment. I arranged daily, home treatment sessions and kept ringing daily to find out about the progress of mother and baby. By the end of the week, the baby had stopped vomiting and the mother was pain free and very happy.

D. Winnicott, in a discussion at a scientific meeting of the British Psychoanalytic Society in 1940, astonished his audience when he said that there is no such thing as a baby. This example illustrates very successfully the notion that when we see a baby, we also see someone who takes care of the baby. One is in the presence of a nursing couple. Also, this is one of the rare examples in which the factor that destroys the mother's pleasure in nursing her baby, is so easily recognised. This pleasure is very important.

Winnicott writes that the pleasure which you can get out of the messy business of infant care, happens to be vitally important from the baby's point of view. The baby does not want to be given the correct feed at the correct time so much, as to be fed by someone who loves feeding her own baby. The baby takes for granted all things like the softness of the clothes and having the bath at the same temperature. What can not be taken for granted, is the mother's pleasure that goes with the clothing and bathing of her own baby. If you are enjoying it all, it is like the sun coming out for the baby. The mother's pleasure has to be there, or else the whole procedure is dead, useless and mechanical.

In this case, the mother's pleasure in holding the baby and her relationship to the baby was spoiled by the painful neck which was interfering with the provision of good enough environment for the baby.

At this stage which is being discussed, it is necessary not to think of the baby as a person who gets hungry and whose instinctual drives may be met or frustrated, but to think of the baby as an immature being who is on the brink of unthinkable anxiety all the time. Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what this baby needs in the general management of the body, and therefore of the person. Love at this stage can only be shown in terms of body care. When the good enough care in this early stage is disturbed, the baby experiences an interruption of the continuity of his existence, an interruption of being. The place of being is taken by a reaction to impingement. In this case, vomiting and lethargy were such reactions. However, there is a positive aspect to this reaction. The baby's symptoms forced the mother to seek outside help which met the mother's needs.

One can only speculate about what might have happened to the baby, if his symptoms were not recognised for what they were. A reaction to the failure of the good enough environment. Could he have gone on to develop pyloric stenosis? There is some experimental evidence that is could have.

Graeme Taylor, in his book *Psychosomatic Medicine and Contemporary Psychoanalysis,*[5] mentions the findings from a recent study of hypertrophic pyloric stenosis. Several investigations have demonstrated a positive correlcation between maternal stress during pregnancy, especially in the third trimester, and the later development of hypertrophic pyloric stenosis in the infant. The administration of Pentagastrin to pregnant or newborn dogs, produces changes resembling hypertrophic pyloric stenosis. Dodge suggested that maternal stress leads to elaboration and transmission of a humoral factor such as gastrin, across the placenta from mother to foetus.

However, because persistent vomiting does not begin until several weeks after birth, Metzner speculated that experience during the postnatal period might interact with the predisposition proposed by Dodge, to produce the actual lesion. In a retrospective pilot study, Metzner identified and quantified stress factors in the pregnancies and postnatal experiences of eight mothers, whose babies later developed hypertrophic pyloric stenosis. The mothers were not only under stress, but were depressed and experienced a profound sense of incompetence concerning the caretaking of their newborns. As a result of their emotional unavailability, the mothers were not emphatically responsive to their styles, rhythm and needs, and the usual bonding and reciprocal regulatory interactions were not established. The ever increasing demands of the babies and the difficulty in quieting and soothing them, seemed to intensify the mothers' feelings or inadequacy. It was only after the infants developed vomiting and the mothers were forced to seek outside help that the mothers responded appropriately to their baby's needs. The diagnosis of hypertrophic pyloric stenosis rallied the mothers out of their depressions and they responded to their baby's needs with a new readiness not previously available to them. The symptoms of hyper-

trophic pyloric stenosis seemed to serve the adaptive function of drawing the mothers back into the bonding range.

Mothers, who have it in them to provide good enough care, can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task. Usually this task falls on the father. But there are circumstances when help beyond the family circle is needed. When the doctor is able to recognise and meet these needs, he can help re-establish the essential regulatory processes within the mother/infant relationship.

Many childhood and adult diseases may be conceptualised as disorders of regulation. The onset of illness sometimes has the adaptive effect of restoring an important interpersonal relationship, which is relied upon for its psychobiological regulatory functions.

The second case-history is that of a 30-year-old man who worked as a messenger in a big firm. Ten days after his mother was diagnosed as suffering from carcinoma of the ovary, and two days before her operation, he slipped as he was climbing a ladder at work. As he fell, he caught the left foot in one of the rungs of the ladder and his full weight hyperextended the Achilles tendon. He felt acute severe pain and after a while the tendon swelled up. Fate was particularly cruel to him because on the day of his mother's operation his flat was broken into and his best guitar was stolen. Before the injury he used to visit his mother every weekend. Since the injury, the pain was so severe that he stopped visiting his mother regularly and he gave up work.

The background of his mother's illness is important in this case. She had suffered from irritable bowel syndrome for twenty years and she was always terrified that she may have cancer. She had good reason to be frightened, because every female member of her family had died of cancer. The impression she has is that for a long time before the cancer was diagnosed, in each case, the general practitioner reassured the patient that her pains were 'all nerves'. She had several investigations over the years for abdominal pains which were all negative. One year ago, she presented to the trainee complaining of low, colicky abdominal pain. He referred her to the gastroenterology department, where she was thoroughly investigated for bowel pathology. During this time I saw her frequently, giving her support. When the investigations were finally completed, all the results were normal and she was sent home with a supply of anti-depressant tablets. Two days later her abdomen swelled up with fluid. An ultrasound scan confirmed carcinoma of the ovary. Her worst fears had come true and the doctors, as usual, made the diagnosis too late. Her husband was very angry and was talking of sueing the hospital.

Robert came to the surgery soon after his injury. He was angry and irritable. He saw our trainee who prescribed analgesic tablets. They did not work, so he returned to the surgery complaining bitterly. The trainee was upset by his behaviour and sent him to the hospital for pysiotherapy. It turned out that he was sent to the wrong department where they would only treat him if he had sustained a sports injury. After this experience he stayed at home. He wrapped his foot in a scarf, a friend lent him a pair of crutches, but by that time the pain was so bad that he was unable to walk, limiting him to staying in his flat. His father had to do the shopping for him as well as look after his ill wife who, by this time, had been discharged and was receiving chemotherapy at regular intervals.

I became involved with Robert one month after his accident, when he made a request for a visit. All he wanted, he said, was a sick certificate for work. I was very much involved with his mother's illness and was very moved by her misfortune. So I was intrigued to discover how her son reacted to this family tragedy and offered to visit him myself.

He opened the door, hobbling on one foot, supported by crutches. He is a slim man with thinning blonde hair and pox-marked face with a short beard, but looking younger than his age. He led me into the sitting room where he lived almost in squalor. It was dark, untidy and all the ash trays were full of cigarette ends. He spoke with some irritability and described his accident and his pain in great detail. 'I can't believe the luck of our family', he said, 'For the last couple of years we cannot stand on our own two feet'. I commented about the fact that his accident happened two days before his mother's operation. He looked at me angrily and said, 'Are you suggesting that my foot is psychosomatic?' That would be the ultimate insult. I felt that the patient's trust was at stake at this moment. 'What I am suggesting' I said, 'is that because you felt depressed about your mother's illness, you neglected yourself. Here you are, one month after your accident without any medical help.' He was able to accept this. He said that he gave up going to the surgery because he seemed to upset the doctor he consulted. 'I am sure the doctor can look after himself', I replied.

I examined his foot. His Achilles tendon was swollen and tender. I diagnosed post-traumatic tendinitis, gave him anti-inflammatory tablets and organised domiciliary physiotherapy.

I visited him again a week later. He was pleasantly surprised to see me. He talked with enthusiasm and at great length about his physiotherapy. He talked about the pain also in great detail. When I asked him about his mother's illness, he answered in the vaguest manner and changed the subject back to his pain.

The following week I rang him up to find out about his progress and gave him an appointment to come to see me at the practice in one week. My aim was to encourage his independence out of the invalid state, by offering a regular, weekly therapeutic relationship. At the same time, the home physiotherapy, which

satisfied the more dependent needs, was to continue.

He attended for his appointment at the right time to my great relief. After I listened to a very detailed account of his pain, I asked him to describe the change in his mother since her illness. 'When I visited her, she was wearing make-up,' he said; 'I could not really tell. I made an effort to cheer her up.' Then he looked at me with a broad, innocent smile and asked, 'Why?' He was obviously not ready to talk about painful feelings. He then attended every week, on the same day, at the same time; his pain and walking improved and he has now returned to to work.

When I met Robert one month after his injury, and listened to his story, I felt that his condition made sense only in relation to his mother's illness and his family's difficulty to talk about emotions. I felt that his injury was the result of accident proneness, which belongs to the depression class of psychiatric disorder. I felt that he used his physical pain to protect him from the emotional pain of mourning, which must have been much worse. But the most helpful idea for me, was that his fall represented a dramatisation of the loss of the internal holding mother. Also, an appeal to the environment to take over the holding function. His first attempt was not successful. The doctor became upset by his anger. His hate had to be met without retaliation and without rejection, unflinchingly. The doctor must survive the patient's hatred. He shared his father's anger about the inability to diagnose his mother's cancer at an early stage. So his pain, which was not improving, served also as a mutre reproach to the medical profession for their ineffectualness. After the second visit to the surgery, he withdrew and declined to have any home visits.

Is is helpful to think of withdrawal as a condition in which the person concerned, holds a regressed part of the self and nurses it at the expense of external relationships. Withdrawal, in the absence of a therapeutic person to regress with and to, becomes illness. It is the provision of a holding environment which alone can transform withdrawal with its sulking quality into regression. Regression has a healing quality, since early experiences can be corrected in a regression. There is true restfulness in the experience and acknowledgement of dependence.

Return from regression depends on a regaining of independence and if this is well managed by the therapist, the result is that the person is in a better state than before the episode. All this depends of course on the existence of a capacity for trust as well as on the therapist's capacity to justify trust. There may be a long, preliminary phase of treatment, concerned with the building of confidence.

Robert's confidence in the medical profession was shaken. I felt that in the circumstances, to insist on discussing his emotions would be experienced as a refusal to nurse the regressed part of the self. This might force him to become demanding or manipulative, or remain withdrawn. Neglect of his foot injury, might also lead to muscle contraction and permanent deformity. A source of future litigation perhaps.

At this level of regression, psychological care has to be experienced in terms of bodily care. I decided that the most effective way of treating his injury and the accompanying mental state, was domiciliary physiotherapy. Our physiotherapist who incidentally, also treated the first patient, is a warm caring woman. She started visiting him three times a week for a combination of massage, ultrasound and stretching exercises. A very intensive treatment. The gadgetry she uses, can easily conceal a hidden aspect of the healing power of physiotherapy. That is the mothering, soothing attention to the body which is of an infantile order and meets the patient's dependence needs.

In parallel, I offered to see him weekly, at the same time and the same day at the practice. He found it very difficult to talk about his mother and his feeling about her. At no time did I make an interpretation to him. Nor did I force him to look at his emotions. He returned to work, the return to independence was complete. This became possible by meeting the patient's dependent needs and allowing for a short period of regression. It was only because he trusted the holding situation that he handed over the nursing of the regressed aspect of the self to the therapists and slipped over into becoming the infant for a short period of time.

In this paper, I have tried to show how the general practitioner works to provide care for the psychosomatic patient. Perhaps the essence of the physician's approach, is to exploit his capacity for physically handling the patient and his situation, in contrast with the psychotherapist, for whom touch is a taboo and who must therefore use a purely psychological approach to the same problem. Psychological care can be expressed in terms of physical care which is provided in a psychologically informed way.

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The Erosion of Empathy in Medical Education: A Comparison of Freshman and Junior Medical Student Responses to the Barret-Lennard Relationship Inventory

Clive D. Brock, Alan H. Johnson, Ronald P. Durand, Jon H. Levine and D. Bryce Downey. Medical University of South Carolina.

Introduction

It is well known that the effective delivery of health care depends not only upon a doctor's biomedical and technical knowledge but also upon his/her ability to respond empathically to the varying psychological, social and economic needs of each patient. A number of investigators[1,2,3] have reported a strong relationship between a doctor's responsiveness to a patient's concerns and that patient's satisfaction and adherence to medical management. Yet medical students receive little if any formal training to understand the doctor/patient relationship.

A patient comes to the doctor with a complaint and to paraphrase Michael Balint this presenting complaint represents the patient's interpretation of what is ailing him. However, the actual reason for the visit must always be determined and defined by the doctor. According to Mace,[4] patients usually discuss a wide range of issues, many of which are never identified by the doctor as possible causes of the presenting problem. Some of these unidentified issues are psychological or social in origin and doctors differ in their attitudes toward psychological and social problems, as well as in their abilities to establish an atmosphere in which the patient feels free to talk[5] A recent study indicated that doctors rarely permit patients to complete their opening statement.[6] The development of an appropriate interview atmosphere is important because, as Beckman and Frankel have reported, a doctor's behaviour has a major effect on the collection of historical data which in turn helps to determine the chief complaint.[7]

Doyle and Ware concluded that doctors could improve the interview atmosphere and patient satisfaction through better training in interpersonal and communication skills.[2] Survey research indicates that most U.S. medical schools have recently initiated courses in developing interpersonal skills, focusing mainly on interviewing.[2]

A critique of the research reveals disagreement about which interpersonal skills are most important to the interviewing process. Research in the field of psychotherapy has shown that empathy, genuineness and non-possessive warmth are important aspects of the physician/patient relationship, and empathy was found to be of particular importance.[10] Hogan[12] defined empathy as the intellectual or imaginative appreciation of another's condition or state of mind without actually experiencing that person's feelings. In a recent longitudinal study of entering freshmen medical students, Streit-Forest[12] reported that students with a higher capacity for empathy feel more at ease in situations where interpersonal skills are important, and are more open to accepting the interpersonal and emotional aspects of medical practice.

The purpose of this study was to determine whether a medical student's capacity for empathy was modified by medical school experience. The present study compared the empathic and other interpersonal relationship dimensions of entering freshmen medical students with medical students who had completed their third-year clinical rotations.

The study was designed to answer the following questions:

1. Is there a significant difference in the empathic levels of freshman and junior medical students?
2. Within each group are there demographic variables such as age, marital status, MCAT score, or sex, that could account for a difference in empathic levels?

Methods

The study included data from the Barret-Lennard Relationship Inventory. In a study comparing four instruments that measure interpersonal relationships for use in medical education, Jarski et al,[8] recommend the Barret-Lennard Relationship Inventory as the most suitable instrument for use in medicine. The test is of the pencil-paper type and can be administered in approximately 20 minutes.

Five dimensions of interpersonal skills are analysed and measure on the instrument's subscales: level of regard, empathic understanding, congruence, unconditionality, and willingness to be known. The test retest reliability is reported to be .89. Internal consistency has a reported split-half reliability coefficient of .86. The theoretical maximum score on the scale is 48 and the theoretical minimum score is minus 48.

The differences in the levels of empathic and other relationships between freshman and junior medical students were assessed by student's t-test. The second question was assessed by a multivariate regression analysis of the scores achieved on the Barret-Lennard Relationship Inventory and the previously identified

demographic variables. Freshmen were administered the Inventory during orientation and before beginning classes. Juniors completed the Inventory at the end of their last clinical rotation. Both groups responded anonymously.

Results

Eighty-nine of 142 junior medical students and 126 of 164 freshman medical students completed the Barret-Lennard Relationship Inventory. The respondents were proportionately similar to the total freshman and junior class populations in terms of sex, age, MCAT score and marital status.

A t-test analysis of the Barret-Lennard data revealed significant differences (p.8) between the scores of freshmen and juniors on each of the five dimensions of the Relationship Inventory, as well as a significant difference in the total scores for each class.*

The multivariate regression analysis considered several demographic variables which might have accounted for the differences in responses to the Barret-Lennard Inventory. After statistically allowing for these variables, significant differences between freshmen and juniors remained for all dimensions except 'willingness to be known.'*

Discussion

All five dimensions of the interpersonal skills measured by the Barret-Lennard Relationship Inventory changed significantly between the time students demonstrated significantly greater levels of regard, empathic understanding, congruence and unconditionality. The medical student's level of training was the major variable significantly associated with these differences. it seems paradoxical that the capacity for empathy, the factor judged most important to effective communication in a doctor/patient relationship should deteriorate during the process of a medical school education. Despite a curriculum that emphasizes courses in interviewing, clinical examination and clinical reasoning, as well as a traditional year of clinical experience the ability of the students to respond in an empathic fashion to patients seems to be diminished. A similar conclusion is supported by Johnson's five year study of the counselling skills and attitudes of Family Practice Residents from various medical schools throughout the United States.[13] Dubovsky noted that medical students developed problems such as declining humanitarianism, dishonesty, greed, cynicism, and a lack of independent thinking.[14] Such data support the judgement that the current curriculum does not support the students' empathic skills necessary to develop an understanding of their patients' emotional state.

Conclusion and Implications

The authors believe that it is important at the very least to preserve the levels of empathic skills that students bring with them to medical school. There are two medical schools that offer Balint-seminars to medical students in the U.S.[15] It seems that it is time to open Balint-training to medical students more generally. We hope that these data will encourage members of the Balint Society to re-evaluate their usefulness to this important group of trainees.

*Detailed Tables of statistical results available. Ed.

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The Student Psychotherapy Scheme at the University College and Middlesex School of Medicine: Its Role in Helping Medical Students to Learn about the Doctor/Patient Relationship*

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The British medical student starting his clinical studies is beset by various anxieties. Emerging from the relative freedom of the academic setting of his preclinical years at university, he now finds himself in a junior position without a clear role in the vastness of his teaching hospital. The patients he sees are, for the most part, in ward settings where high technology increasingly sets both the pace and the tone. In the middle of this, two issues are to the fore: first, the student's sense of his own clincial competence and skill and second, his sense of his capacity to relate to his patients. Many of the staff involved in caring for patients in this setting will be closely observed by the student, who naturally will seek to follow those with whose behaviour towards the patients he can identify.

The students often face early and later disillusionments and difficulties in this process, not the least of which will be related to the real limitations placed upon their own personal responsibility for the care of their patients, and the very short space of time they may spend on the same ward and in each of the other clinical settings. Other factors that may increase a feeling of disillusionment may be negative attitudes shown by some staff members towards certain patients and at a deeper level the severity of the illness, which may be really alarming to the student. Thus in certain significant ways they, the students, may have difficulty in identifying themselves not only with the doctors and the other members of the medical team, but also with the patient as they perceive the doctor/patient relationship in practice.

There is a real need for the student to have the opportunity to discuss freely his feeling about the patients in a learning situation that is not solely directed at the acquisition of factual knowledge, and to recognize that these feelings about caring for, being confused and despairing about patients, are real and worth talking about. These aspects of the doctor/patient relationship can and should be discussed by everyone who is involved in teaching medical students. The psychiatrist and psychotherapist can make a creative contribution here. In the Department of Psychiatry at the University College and Middlesex School of Medicine this is done in three ways: firstly, by means of a weekly one hour long discussion group which takes place on the medical wards with the first year clinical students, as part of the liaison psychiatric consultation service. I take one such group on a Gastroenterology Unit. Secondly, during the three-month psychiatry attachment which takes place during the second clinical year when students are attached to the Outpatient Department of Psychological Medicine they have the opportunity to see and clerk psychiatric outpatients, as well attending seminars on psychotherapy. Thirdly, by means of the Student Psychotherapy Scheme which I run within the Joint Department of Psychotherapy at University College Hospital and the Middlesex Hospital.

This scheme was begun in 1958 by Heinz Wolff and Roger Tredgold at University College Hospital in response to the challenge of Michael Balint's work with his first group of general practitioners. Just as Balint hoped to help general practitioners to learn more about their own ways of relating to their patients, so Wolff and Tredgold hoped that they could help the medical students, in their first clinical years, to learn about and value their capacity to relate to patients in a setting where continuity of care and its observation were at a premium. Thus they offered the medical students the possibility of taking on, at an early stage in their clinical studies, a psychiatric outpatient who had been carefully selected for long term individual once weekly analytical psychotherapy. This was under the supervision of one of the members of the Psychotherapy Department.

Usually the student would see the patient for at least a year. As such, it represented a tremendous commitment in time as well as emotion on their part. Not only would they see their patient for 50 minutes each week, usually in the evening, but also after each psychotherapy session they would spend up to an hour making a careful process recording which they would then discuss with their psychotherapy supervisor and the other student therapists in a weekly one to two hour supervision group. This also meant that the student would be given permission to take time off from his current medical attachment to attend the supervision (although usually the supervision also occurred in the evening time). So this scheme required the cooperation of the physicians and surgeons in the hospitals involved in our teaching programme. The patients receiving this psychotherapy from the

* Paper read to the Society on 29 October, 1991.

medical students were reviewed at the end of their psychotherapy if they felt in need of further help.

Over the 32 years this scheme has been running, it has been enormously popular with the students who volunteer to join it, often in much larger numbers than there are vacancies for supervision. About 30% of an annual intake of students may volunteer but we can usually only take on some 10-15% because of limits on our numbers of supervisors. In the past, the students have not been selected but, with the increasing numbers of students (with the formation of our new medical school), we are planning to interview the students to select those for whom supervision vacancies can be offered. A joint study, funded by the European Economic Council, was made of our scheme and another one started more recently at the University of Heidelberg and a book was published evaluating the changes in the students and their patients, entitled *First Steps in Psychotherapy.*[2] Incidentally this book also contains articles evaluating Michael Balint's work with general practitioners.

What sorts of patients are selected for our students? These are psychiatric outpatients referred to the Department of Psychotherapy for assessment for long term individual or group psychotherapy in our department. Most of our referrals come from local general practitioners and from within the Department of Psychiatry but some also come from other specialties within the hospital especially from gynaecology, endocrinology, gastroenterology and the Department of Nutrition. Many patients seen in a National Health Service Outpatient Psychotherapy Service are likely to have quite severe psychopathology e.g. eating disorders, severe character disorders (e.g. schizoid personalities). Their motivation to have analytical psychotherapy may be limited even though their actual need for it is very great. Paradoxically, with some of these patients, the possibility of seeing a young and interested person may make relating easier rather than more difficult. A student with all his enthusiasm and eagerness may make good initial contact. On the whole, I have increasingly avoided giving the students chronically sick patients and those patients with too great a self destructive potential, whose suicidal threats may be too big a clinical responsibility for student, supervisor and myself, as Head of the Psychotherapy Service to take. Also patients with paranoid, borderline and body image disturbances (dysmorphophobias, eating disorders) tend not to do so well with students. To a certain degree, equivalence of age can play a positive part and it may be easier for initual mutual positive identification to occur when the student sees someone his own age or younger. Where the patient has come from a socially deprived background, as is regrettably increasingly the case, because of increasing levels of poverty in our health district, the student often finds it easier to identify with the patient as someone who is a potential victim of social injustice.

Does the patient know that the psychotherapist is a student? As a group of supervisors and students, we have differing views. In all the supervision groups, this is one of the first questions the students raise. Each group consists of three to four students and a psychotherapy supervisor. On the whole, a Socratic approach to supervision is adopted, that is, the students are encouraged to learn from their own discussion. In some supervision groups a decision is taken that it is better that the patient should be clear from the outset of his therapy that he is seeing a medical student; in others the professional status of the student is not disclosed any more than it would be for any of the multi-disciplinary team of professional staff doing psychotherapy in our department, i.e. so as to enhance the possibility of a transference being made by the patient to his psychotherapist. In a supervision group there are likely to be old as well as new students. This helps the self-learning process for the students and results from the fact that students may not only join this scheme at different times during their second or even third clinical year, depending on the length of time they can commit themselves to seeing their patient. I will have told all the patients that I place on the waiting list for this scheme that they will be seen for a minimum of a year to a year and a half. The students are now expected to tell the patient from the outset of therapy exactly how long they will be seen.

What other issues are raised in the early days of the supervision process? Many of the issues that come up for discussion, concern the student's realistic anxiety about his clinical competence to undertake such a psychotherapy. Where there are more experienced students in the group, who are already bringing and presenting thier process reports, the new student will be immediately within a culture in which he can see and learn from these others. He can share his anxieties with the more experienced students, who will tend to identify with him and at least reassure him that they too were anxious at the beginning. The students are likely to have very little idea of what individual analytical psychotherapy consists of, let alone in what way we view mental illness and emotional disturbances. I invite them to sit in on psychotherapy assessments and I take them for a more formal tutorial on psychotherapy to introduce them in a somewhat more didactic way to a few of its principal concepts. As well, books like *The Words to Say It* by Marie Cardinal about individuals' personal experiences of psychotherapy, are helpful reading for the students.[1] Before any plan is made for the student to take on a patient, they are allowed to come to the supervision group for a number of weeks. In this way they can learn what such a commitment may involve before coming to a final decision to take on a patient.

In some cases, the student may decide in

spite of his initial enthusiasm that, at this point in his training, this is not for him. In one case a student asked for help for himself. In other cases the supervision may be concerned that the student will be too defended or too out of touch, by virtue of his personal problems to help the patient. However, this has been rare in our experience. If all goes well, the student will then write to the patient to offer him an appointment to discuss the possibility of working together. I emphasize the tentativeness of this initial meeting so that the student is aware that not only is he choosing him or her. Very occasionally the patient does reject the student psychotherapist. In my experience this has happened early on with two patients. Both of them had had, on reflection, faulty psychotherapy assessments where I had missed more severe psychopathology, e.g. borderline character traits. Sometimes it does happen at a later stage that the patient, for a variety of reasons, decides to discontinue his therapy with the student. In all cases the patient is offered the possibility of returning to see either myself or one of the original assessors for consideration for psychotherapy with someone else in our department.

So each week, the students (usually two per week in a group of four) will present their process reports on their 50-minute psychotherapy sessions. This usually gives rise to a lot of discussion amongst the students about the clinical material in the session. The supervisor may or may not say a lot. Our department is made up of analytical psychotherapists of different orientations, most are Freudian and a few are Jungian. There are ten supervisors in all. So that at any one time some 30 to 40 medical students and their patients will be in the scheme. The supervisors' basic attitudes are especially important for the students: their reliability, punctuality and attentiveness in the supervision will be vital points of identification for the students. I am a Freudian and my own approach is to say very little about psychotherapeutic technique or psychology at this initial stage or at even later stages. I am interested that my students should learn mostly from their own experiences with their patients. Also I want them to see that I too am learning about their patients in this way, rather than making assumptions prematurely about underlying psychopathology or meaning in the sessions. The first thing I want to know is that my students can really listen to and be with their patients. How do they deal with awkward situations? How do they deal with the negativities, hostilities and mistrusts of their patients? Inevitably people tend to wonder whether the process of supervision becomes more of a psychotherapy for the student than a way of helping the student to do psychotherapy with his patient. In a very few cases the student has already commenced a personal analysis or even more rarely is contemplating training as a psychoanalyst. I try to look at my students' feelings in relation to their patients as opposed to themselves in the supervision, so as to allow the counter-transference to be discussed only as of relevance to the patient rather than to become a way of self exploration (which is so seductive for these very young therapists).

Jane is a medical student in my present supervision group. She is a lively, chatty person who has a degree in the History of Science. We were discussing which of two possible patients she might take on for treatment: one was a young unemployed male artist with depression and passivity as his main character difficulties. The other was an over-lively chatty 20-year-old female writer embittered by the problems of growing up with two parents who got on very badly together. Jane said she would rather see the girl because her parents also had a difficult marriage and as with the girl she too had a mother who had been a refugee from Germany. I felt her identification with her patient's situation was too intense and that it also would become an invitation to discuss her own problems if she saw the girl. I suggest that she consider seeing the less attractive passive male which she relucantly accepted. A tendency to over-identify with the problems of the patient is an early problem for the psychotherapy student, as it is for the other medical students and the freshly qualified doctor. Here is an example of how one student learned to handle her own difficulties in this area.

Anne was a first year clinical student in my supervision group some years ago. She is now training to become a general practitioner. She was an intelligent and also a lively participant in the supervision group. She was keen to let me know of her previous reading in sociology and psychology. She chose to work with a depressed 28-year old Greek Cypriot patient called Katerina, who had difficulties with being overweight, and in finding a boy-friend. She had tragically lost her mother at age 20-years in a car crash and she was living at home with an invalid father. Anne would report to our supervision group in her lively way about equally lively sessions with Katerina. The sessions often seemed initially to be devoted to themes of how Katerina was trying unsuccessfully to lose weight. Anne gave her, from time to time, various pieces of somewhat gratuitous advice which the group commented on in a critical but friendly way. By her own admission, she was behaving like an agony aunt, although her patient seemed to like this well enough. At the same time, it was clear to me and becoming clear to Anne, that Katerina was actually quite controlling of Anne. At times there seemed to be difficulties for Anne in retaining her own boundaries, as for example when she found herself going down in the lift with Katerina. One day Anne came to the supervision in a quieter mood. She told us how Katerina had, in her last session, come with her from the waiting room to the consulting room and deliberately sat down in Anne's chair. Anne had asked her to sit in her own chair and this led Katerina to change chairs and then to explain that she had only wanted

to see what it would be like to be Anne. I was impressed that Anne, after such a relatively short time, had been able to recognize and deal creatively with her own and her patient's difficulties in establishing boundaries in the session. Gradually her approach to Katerina evolved into one of listening and commenting as opposed to actively advising.

Often the students are puzzled by the differences between supportive and insight-oriented analytical psychotherapy. In some cases their work with the patient is likely to be mainly supportive as a result of a deliberate decision on my part: one student was a rather sweet but less mature person than the other students and seemed likely to be less sophisticated in her understanding. I decided to give her a rather immature over dependent young woman crippled by Ollier's disease. This is a condition in which there are painful and unsightly enchondromata. She was under threat of having to have an amputation of her right foot. It was a helpful experience for both the student and her patient, but not one which led to any greater understanding of the seemingly intractable psychodynamics of the patient's secondary gain from her physical symptoms, or of her overly close attachment to her mother. However it did provide this patient with very necessary psychological support during a real physical crisis in her life when she was threatened by even greater invalidism, as a result of the proposed amputation, which in fact never took place. In most cases we hope to help the student to learn something about the process of analytical psychotherapy and the ways in which it can help a patient to arrive not only at a deeper understanding of themselves but also help the patient to begin to work through some of the unconscious conflicts that have arrested their personal development. In reality in a year or a year and a half the deepest psychological changes will not have occurred. However very often this initial experience of psychotherapy can lead the patient to consider having further help in a non-time-limited psychotherapy (either individual or group). Within this year or so of psychotherapy the patient does usually not only form a good working alliance with the student, but also manifestations of the transference are likely to occur. In this way the student can begin to learn at first hand how a medical patient can project previous expectancies of past relationships on to present day figures such as his doctor. I do not believe that it is feasible or even desirable to expect a student to arrive at a deep theoretical or practical understanding of the implications of the transference. Nevertheless, I hope that by the end of his work with his patient he will appreciate its potential for affecting the dependency needs of each patient he is likely to see in future medical situations.

At least they will have an appreciation from this experience of the immense value of the continuity of care and the affect that breaks in this continuity can have on the doctor/patient relationship. They will learn to warn the patient well in advance of holiday times or other breaks and of the time of ending of the psychotherapy and to anticipate anger as well as sadness in the face of these separations, as being significant reactions to loss. Here is an example: Joanna was a bright and thoughtful, rather sensitive student who had been seeing Vivienne, a somewhat hysterical picture-framer unhappily married to a television producer. The psychotherapy was now well into its third month. Joanna's initial anxiety that the sophisticated Vivienne at 30-years old would find Joanna at 20-years old immature and inadequate as a psychotherapist, had proved to be wrong. My own hypothesis and anxiety that Vivienne might throw a rather violent tantrum at the somewhat gentler Joanna had also not been born out.

On the contrary, Vivienne attended very regularly and was finding that Joanna could help her to begin to feel less driven by anxiety and despair. Vivienne's background, although materially wealthy, was one of quite significant emotional deprivation. Her mother had been quite severely depressed during Vivienne's early childhood and her father had always been an artistic recluse. However when Joanna went away for six months to do a paediatric attachment in California, although she had warned the patient well in advance of this break and had tried to look at potential separation anxieties which were vigorously denied by Vivienne, this young woman managed to break the furnishings in her kitchen and to smash a lot of the crockery. Her general practitioner had been called in and Vivienne had been referred to another consultant in our department. When Joanna returned from abroad she was dismayed to find that Vivienne had been diagnosed as being psychotic by this consultant, Dr. X. Vivienne was now behaving in a dismissive way towards her saying that she really wondered if Dr. X, who she was continuing to see, was not really the better therapist. I was struck by the fact that the previously shy Joanna could openly voice her irritation and annoyance with Dr. X for interfering with her work with Vivienne. Also I was impressed that she could see that possibly Vivienne had been acting out her rage at Joanna for going away and in the course of this had now found another parent-figure. Now Joanna saw in this negative transference less her own failure towards her patient as her missing therapist, but more her patient's intense dependency needs that had emerged in relationship to her, in this repetition of her childhood experience of a lack of love from her depressed mother. Vivienne some months later came to the end of her psychotherapy with Joanna but now she was able to acknowledge at least some of her anger and hurt with Joanna for ending this psychotherapy after only one year. She could also make reparation and show her gratitude by giving Joanna an old and beautiful engraving of two people standing beside a folly in a landscaped garden, a symbolic representation of all that this therapy had meant,

which was not lost on Joanna, or the other students in supervision.

Some of the students who join this scheme have gone on into careers in psychiatry or even psychotherapy, but we are at pains to introduce this option of doing psychotherapy to each new intake of students as a means of gaining an insight into the doctor/patient relationship rather than as a training for a potential psychotherapist. Many of the students in our scheme going on into general practice and some into internal medicine, surgery or obstetrics. I find that they have mostly become more caring and more aware of how to vlaue their own and their patient's sensitivities and of the value of continuity of care and the ways in which they can be disrupted. This personal development sometimes contrasts with that of other final year students who may have lost their earlier enthusiasm and interest in the doctor/patient relationship in their search for a professional identity.

I will finish with a quotation from a summary of the psychotherapy done by another student called Fergus with a female graduate suffering with a depression which had followed the break-up of her relationship with her fiancé. Each student is expected not only to write to the general practitioner and/or the referring psychiatrist and psychotherapy assessor about the ending of the psychotherapy, but also to produce a full psychotherapy summary on his patient's progress and prognosis. We then discuss this summary in the last supervision. Here are Fergus' comments on the transference and the counter-transference that arose during his work with Anita.

Transference /Counter-Transference

'It became clear after only a short while working with Anita that I had become the ideal mother: I was someone to whom Anita could talk openly about boyfriends, sex, work, play, without fear of criticism or rejection. I was not like her friends, who she had to be careful with in conversation, not wanting to upset them by saying something she was thinking but knew would annoy or irritate them. Every session I would be there waiting for her, there was no fear that I would reject her in the same style as Dragan. Unlike her mother, I would not turn away when the subject of sex was brought up, or criticize her binges or her weight.

And Anita clearly wanted my approval. For every session she turned up on time, and never missed even one. She would tell me jokes or stories to make me smile, and in this way she felt that I had accepted her. From such a position it is difficult to imagine her becoming angry with me, and indeed she never did, or at least never felt able to show that openly to me.

As the sessions were drawing to a close, another transference emerged towards me as Anita's partner. Near to the ending Anita brought dreams of Dragan, the man she loved and placed her faith in. Along with these came the image of arms without a body which held her as she fell asleep at night. She thought of all the things that this sensation had given her: comfort, worth, security and realized that they were the same sensations she had felt from being 'held' in the therapy. It seemed quite possible that those arms had been mine — although in bed, the transference was not overtly sexual — recalling Anita's background as far as such things were concerned, it seemed likely that such a transference would be possible. Alternatively in another fantasy, she had met me, Mr Bone, the person in the future outside the therapy and we had hit it off and become friends. She thus expressed a clear desire that I was more than anything her friend, but that even outside the confines of the therapy, I would be able to accept and acknowledge and enjoy her for the person she was.

As for my feelings towards Anita, she wanted to and did make me smile. I found her a warm and friendly person — gentle and kind. Her tears made me often feel like comforting her, a response I am sure she would have welcomed from her mother. I never felt a sexual attraction or desire to be close to her in that sense, but more a feeling that she would be a good friend and someone who would put themselves out to help others. My impression was also coloured by the fact that I sympathized with a lot of what she had to say about subjects such as politics and religion. She also showed an underlying keenness about psychotherapy which made me feel content about my role as therapist. She was always telling other people how good therapy was, constantly trying to work things out on her own, writing things down in books. It seemed that she was working hard for the therapy and this made me feel that it was worth working for her.'

In conclusion, I should say that our psychotherapy scheme can help medical students in many ways to open their eyes to the potential significances of the doctor/patient relationship. However, they are at a point in their personal and professional development at which major clinical responsibility has not yet occurred. When this occurs, the picture is likely to change and former clinical sensitivities may be suppressed by the newly qualified doctor in order to handle the demands that this new clinical responsibility brings. With these thoughts in mind, we have started a new discussion group for the Senior House Officers to review their psychological problems with medical patients. So history is perhaps repeating itself.

(This paper was originally presented at Grand Rounds in the Department of Family Medicine at the University of Ottawa, Canada, in Spring, 1990.)

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Student Psychotherapy and its Role in Helping Medical Students to Learn about the Doctor/Patient Relationship*

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At first sight, this topic seems to have very little to do with general practice. Our reason for bringing it to the Balint Society, is that it is concerned with the training of future doctors. This kind of training is still fairly unique in Medical Schools. Although holistic and patient-centred medicine is now more widely accepted in principle, the teaching of skills in this area is still uncommon, nor is it very effective unless it can be acquired through example and experience. If teachers pay little attention to psychological aspects of illness, it will be difficult for students to recognise and accept their importance.

The scheme

The scheme, whereby students could elect to take on one patient for psychotherapy under supervision, started at University College Hospital in 1958. There were naturally some anxieties and doubts about it. There was concern about what would happen if a patient were to have a psychotic breakdown or committed suicide whilst in treatment with a student, and what if the student himself became seriously disturbed and broke down? Such occurrences might have jeopardised the scheme badly and damaged the reputation of the department and the hospital as a whole. It might also have reinforced the resistance to this whole area of psychological treatments and approaches to medicine.

The risks were recognised and acknowledged, but it was felt that the advantages of the scheme far outweighed the risks. We tried of course, to select patients carefully, so as to minimise the risk of breakdown or suicide, but I will say more about this when I come to the section on selection.

As for the risks to the students, there were a few who came up against weakness in their own personalities. Some went into therapy themselves, a few dropped out, but on the whole, it seemed preferable that weaknesses should emerge at this stage rather than after qualification, when it might be harder to seek the necessary help.

Format of training

Students were warned in advance about the commitment they were undertaking in time, energy and responsibility. They had to allow one hour per week with their patient and another one-and-a-half hours for supervision, plus writing up notes. Most of this work had to be undertaken during the student's free time, so as not to interfere with any other aspect of their training.

The seminars consisted of four or a maximum of five students who met once a week with their supervisor in order to present their work with their respective patients. Everybody was encouraged to take an active part in the process, commenting on each other's presentations and asking questions. This meant that they learned from each other, about each other's patients and about different problems and psychopathologies. The format of the seminars was in some respects similar to that of Balint-groups, but there were also important differences. Students see their patients weekly for twelve to eighteen months and during this period, they get to know four or five patients very well, whereas patients presented in Balint-seminars might have been seen on one occasion only, or over a period of many years. In spite of the considerable amount of extra time students had to invest, very few opted out of the scheme because of this. They often felt that in the rest of their training, they were very much at the bottom of the medical hierarchy, often feeling useless and getting in the way when the real work was being done. They also felt that they were not valued on the wards. This depended of course, very much on individual consultants, but it meant that when they joined the student psychotherapy scheme, they were very appreciative of the opportunity, of making a real contribution to one patient's welfare and to have an ongoing relationship with their supervisor, who was a member of the Psychological Medicine Department staff. All of this compensated for the investment in time and effort.

Once students had elected to come into the scheme, they were invited to join one of the groups some time before taking on a patient of their own. This helped them to get some idea of what they were letting themselves in for. Even more important, it was the beginning of the learning process. It enabled them to share some of their anxieties and doubts with the others who had tackled the same difficulties when they started.

Selection of students

Until recently students were not selected but

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volunteered to join the scheme. It did happen on occasion, that a student joined in order to resolve some problem of their own. He or she might not have been conscious of this motive, but strong feelings can be triggered off in the student through the process of therapy, and these may be difficult to contain. However, the group as well as the supervisor offer support and insight, which generally make the situation manageable. Supervisors vary in the extent to which they allow the airing of personal difficulties, but it is always important to maintain boundaries between supervision and therapy, and supervisors have to bear in mind that the group should not be turned into a therapy-group for the students, Michael Balint had very firm views on this and would not allow the airing of personal difficulties or interactions within the group at all. This was important and necessary at the time, so as to reduce the suspicions among some sections of the medical profession of what members of Balint-groups got up to.

Increased self-awareness and insights gained about particular characteristics of a student's way of handling a patient, of dealing with crises, feelings of grief, anger, anxiety or rejection do frequently have therapeutic effects however, and can help members of the group to tackle blind spots, prejudices, difficulties with authority figures or with peer relationships.

Difficulties

It does happen occasionally, that student and patient cannot get on, and the patient may stop therapy. This can be traumatic for both, but may be very hard when it happens with a first patient. At times like this the group can be particularly helpful. Somebody else may have had the same experience, and everyone will try to understand what went wrong, and what can be learned from it. The supervisor may also point out that drop-outs even occur with very experienced therapists, and this may lead to a useful discussion of ambivalence in patients and students alike.

Students are naturally worried about their inexperience, and fear that this may cause harm to the patient, but although mistakes may be made, they can generally be redeemed after discussion in the seminar, and the student's strong motivation and enthusiasm frequently compensate for lack of experience.

Selection of patients

Our aim was naturally to select patients for the students who had the capacity for change and insight; people who would not present with gross pathology, such as psychosis, paranoid or suicidal tendencies, obsessional neurosis, character disorders or severe psychosomatic conditions. This is still the aim, but sometimes the severity of patients' pathology emerges only after they have been seen for a while. Also, the majority of patients referred to the department in recent years have, on the whole, been people who are quite severely damaged or disturbed, and do not meet the ideal selection criteria. To our relief and surprise, students nevertheless often do remarkably good work with such patients. I have already mentioned their strong motivation and enthusiasm, which were important ingredients in patient's improvement. Other reasons were their care and concern for the patient and the help and support from supervision and fellow students plus their increasing skill and confidence.

There can, of course, be over-confidence too, and although this may cover up the opposite such as feeling of inadequacy, it can nevertheless impair the student's capacity for empathy and sensitivity and their willingness to learn from patient or supervisor. Learning from patients is essential for all of us.

Mirroring

Sometimes what happens in the therapy is mirrored in the supervision. An example may help to illustrate this. Bob's patient, Celia, had great difficulties with authority-figures both within and outside the therapy. She disregarded the few rules regarding punctuality, regularity of attendance and informing Bob when she was going to miss an appointment. On a number of occasions, he rushed to get to the department from some distance away, only to find that Celia had decided not to come. He re-enacted his patient's rebelliousness in his own attitude regarding the rules of supervision by querying and at times breaking them. One of the rules was that students should avoid contacts with their patients outside the therapy. Bob did not accept this and took Celia out for a drink on at least two occasions. He had convinced himself that this would help her to feel better about the therapy and make her more co-operative. He thus displayed very similar reactions to authority and its rules to those of his patient. In looking at what it meant to Bob to be defiant toward me and what I represented, (his mother was a psychoanalyst) he was able to get a better understanding of what was happening between himself and his patient.

Anxiety of the beginner

Students frequently express considerable anxiety about their lack of experience and their inadequacy. They often wonder whether to tell the patient that they are not yet qualified. I described another example to show how such questions can be dealt with constructively and creatively, in my chapter on Anxieties and Difficulties for Student Psychotherapists in the book, *First Steps to Psychotherapy.*[1] Roland, a 22-year-old student who was at the end of his first clinical year had chosen a 42-year-old married woman from a list of three patients. He was very conscious of the gap in their ages and his lack of life experience compared with those of his patient, Vera. Roland felt that it was almost a matter of honour to tell Vera that he

was not yet qualified. He was also worried, that Vera was not getting the best help available and felt guilty at having so little to offer. The group suggested that he was offering himself and his willingness to listen, and that Vera had probably never had anyone before who was prepared to do this. Other students shared their own experience of how they had felt at the beginning, and how they had come to realise that it was not a good idea to have rules about telling or not telling, because it would mean different things to different people and might be right in one case but unhelpful in another. I told the group about a former student who had informed his patient at the beginning, that he was still a student, but his patient had persisted in addressing him as doctor throughout the therapy.

Similarities and differences between Balint and student psychotherapy groups.

1. Selection

At the time I participated in Balint-groups, candidates were very carefully selected. This reduced the early drop-out rate quite considerably. Students who participate in the psychotherapy scheme at University College Hospital select themselves — as mentioned earlier. Patients presented for discussion in Balint-groups were chosen by the presenting doctor when I was a participant. The only exception was during a period when we were looking at repeat prescriptions, when patients who turned up at a particular time had to be presented for research purposes. Selection of patients for the student scheme is by members of staff who do the initial assessments. Students may be given a choice of two or three patients on the waiting list, but they only have a restricted choice.

Psychotherapy patients will be seen weekly for a period of 12-18 months, whereas patients presented in Balint-groups may be presented after one consultation or may have been seen over a period of many years and any number of consultations in between those extremes.

Students' groups consist on average of four members, whereas the Balint-groups I attended were much larger, with up to ten or twelve participants. I have so far mentioned differences between the groups, but there are also overlaps and similarities. In both groups participants learn to listen with understanding and empathy to the patient's feelings and to what lies behind the symptoms presented. The relationship between doctor and patient is seen as fundamental in both situations.

The students' experience of the training

Psychotherapy is still regarded with a measure of suspicion by some members of the medical profession as well as by many prospective patients. The reality of the experience the students have, helps to reduce the stereotype and poor image of the psychotherapeutic approach and may encourage them to participate in Balint-groups later on. The aim of the scheme is not to turn medical students into psychotherapists, but to give them some of the basic skills I have mentioned, and to help them in whatever branch of medicine they take up.

I would like to quote an extract from one student's assessment of her training. 'The group was very important from the outset for its reassuring effect — we were all in the same boat, even though at the beginning we felt like the blind leding the blind. Students tend to lose confidence in the presence of their superiors. We were inhibited by our fear of saying the wrong thing, of making fools of ourselves. We waited apprehensively for criticism from each other and from our leader — but none came. We were thus encouraged and became more expansive. I am sure our inhibitions would have remained much longer had we been alone. Amazingly quickly a sense of unity of the group was established. As each of us experienced feelings of hopelessness or inadequacy, the other group members were quick to rally round with encouragement, even when feeling lost themselves.

However within the group we remained individuals, and a spirit of competition tended to creep in. The groups provided an incentive to report clearly and consisely. Theories about our patients were never dictated to us. When all the possible disasters are considered, the group system works admirably well.

This group spirit is a very important ingredient of the total learning process. It does not have to be made explicit, as it would be in a therapy group, but I am convinced, that in the groups, in which it operates, it not only facilitates learning, but is also a way of modelling something about the nature of the relationship between teacher and student, doctor and patient and peers. It models something about listening with attention and respect for the other and with an attempt to understand without judging or pre-judging the other. All of this is, of course, a bit of an idealised position. We all do the things we do not really want to do, when somebody is irritating, infuriating or frustrating, but in the group this can be acknowledged and often something can be learned from it.

Questions we are left with:

One of the questions is 'how lasting is the impact of the training?' It has sometimes seemed to me, that during the pre-registration year, students forget everything they learned about good listening, unconcious motivation, not taking things at face value, not being judgemental etc. We have to remember, of course, that during this year they are very over-worked and very dependent on their consultants for good reports and recommendations. The question is to what extent they later recover the lessons from their time as student psychotherapists. Their choice of medical or surgical speciality will, of course

play some part in this, but we are at the moment primarily concerned with those who become general practitioners.

Another question is therefore, whether the training improves the students' eventual ability as general practitioners, and here you are more likely to have information than we are!

The third question is why this scheme, which has worked so successfully at University College Hospital and in Heidelberg has not been taken up elsewhere? Other hospitals have tried but not kept it up. One important feature at University College Hospital was the enthusiasm of the pioneers and the co-operation of the hospital staff at all levels. Without this co-operation the scheme cannot succeed.

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THE AMERICAN BALINT SOCIETY

The American Balint Society will host the

8th International Balint Congress

in Charleston, South Carolina

on 22nd-25th OCTOBER 1994

In order to obtain further details about the Conference, will all those interested in attending, please inform as soon as possible:

Mrs Odessa Ussery
Office of CME
Medical University of SC
171 Ashley Avenue
CHARLESTON, SC 29401-9904
United States of America

A 'Bothersome' Patient*

Joseph Saperia
General Practitioner, Leyton, London

Mrs France, aged 55 years, was married with two grown-up daughters. She presented to me at monthly intervals either with palpitations or pruritus vulvae. Repeated examinations of her heart, breasts and vagina were always normal, and my close familiarity with her breasts and vagina helped neither of us. Referral to consultants was of no avail, in spite of the common hospital belief that a complete physical examination is often a potent and effective therapeutic act.

How the problem was resolved

My recent attendance at a Balint-type seminar for general practitioners was providing interest and benefit, and I decided to apply my newfound knowledge and technique to Mrs France — I asked her about her childhood. The story unfolded slowly at first and then the floodgates opened.

She had been the youngest of 10 children. She was unwanted and neglected in favour of the children of her old sisters, who often visited her home and who were welcomed with open arms; this was in marked contrast to her own acceptance or, more correctly, her lack of acceptance.

When she was 9 years of age, her father, who was often away from home as a sailor in the merchant navy, finally left home and, about the same time, she started to be abused sexually by her maternal grandfather. Protests to her mother were dismissed as nonsense, and this formed yet another link in her mother's chain of rejection.

Over a series of planned consultations we discussed her early days, the ultimate rejection by a father who left her, the mother who told her that she was not wanted and who subsequently dismissed her, the sexual abuse by her grandfather and the lack of consideration by her siblings. The psychological damage had left her unhappy, inadequate and insecure — a person who benefited little from marriage and the bearing of children. She suffered further degradation by her husband who subjected her to anal and oral sex. Previously, she had denied fervently any sexual problems and, on the contrary, had professed to a full and happy sexual life.

Gradually, the old symptoms lessened and, instead of being someone who made my heart sink, Mrs France became a patient of interest who slowly gained both insight and self-respect.

A recurrence of the problem

Mrs France returned to see me recently, saying that she had suffered a recurrence of her former symptoms and, on consideration, she realized that this had followed the receipt of a letter from her daughter who was on holiday in the Far East. She appreciated that she was envious of her daughter's way of life, and that she felt sad as she contrasted the lifestyle of her daughter with that of her own early years. She understood the situation and knew she would feel better if we talked about her feelings.

What a difference from the old consultations with Mrs France when I had listened abjectly to her symptoms and subjected her to a useless and humiliating physical examination.

Lessons to be learned

Unrecognized emotional illness is common, and the opportunity for detecting it in general practice is great. The 'bothersome' patient is asking silently for the emotional component to be uncovered, and the onus is on the general practitioner to do this. The ability to seek out the psychological reason is a skill to be learned and applied, just as much as the interpretation of an electrocardiogram or an examination of the abdomen. The need to be circumspect in approaching these issues is of equal importance, whether the matter is physical or psychological.

*First published in UPDATE, 1 May 1989

A Plain Doctor's Guide to Balint-Work

Michael J. F. Courtenay
Retired General Practitioner

Although the name of Michael Balint is widely known in connection with the seminars for general practitioners conducted by himself, his wife Enid, and other colleagues back in the 1950s and 1960s, their work seems either relegated to history or shrouded in a frightening mystique. Young doctors today seem either unaware that Balint-work is still alive, or frightened by their perception of it as something very esoteric.

In actual fact Balint-work is an extremely practical approach to common areas of difficulty encountered in the clinical work of general practice, and if there is anything esoteric about it, it is only that the group-leader must be experienced in the perception of what lies underneath many of the facets of the doctor/patient relationship in the daily work of general practice. From the point of view of the general practitioner members of a group, its only demand is that the personal dimension of human exchange be restored to the professional's practice of medicine.

A Balint-group consists of about eight general practitioners and a leader. Sometimes there may be two leaders acting together. Such co-leadership may exist because of a policy decision on the part of the leadership, or because one leader is in the process of learning the skills required as a leader. The raw material of the group is the presentation of case-histories of patients who individual doctors are currently treating in their practices. There is no pressure for group-members to present any particular kind of case. It is important that this should be made clear as an idea persists that cases of psychological problems are preferred by leaders of Balint-groups. It is true that the Balints may have begun their pioneering endeavours forty years ago, with the expectation that it would be that kind of case on which light would be shed consequent to the experience of psychoanalysts. In Balint's first book, *The Doctor, his Patient and the Illness*,[1] the concept of the general practitioner as 'psychotherapist' was addressed.

But in the second decade of his work with general practitioners Michael Balint realised that the idea of formal psychotherapy was a foreign body in their work. He is on record as saying on one occasion during a seminar: 'Why can't one of you present a patient with a cough?' In fact he had come to realise that the nature of the presenting symptoms were irrelevant to any difficulty which might arise in the work of a general practitioner with a patient, and this his new approach to patients in the setting lent itself to establishing 'two-person' medicine. He had come to understand the work of the general practitioner so well that he gave the impression that he would be quite able to do a locum, though he would probably have strenuously denied such a capability.

What then are the kinds of case most appropriate to present? In a word, one in which one has got stuck! Stuck, meaning in the words of the O.E.D., as 'unable to go further'. This will range from 'heartsink' patients[5] to those in which the presentation does not seem to make sense to the doctor, so engendering a feeling that one has lost one's way.

There are, of course, two sides to every relationship, and although there are difficult patients, there are difficult doctors too.[4] Proceedings of a study day for general practitioners arranged on the subject of managing the difficult patient concluded 'that there was a triad of factors involved in every case of the difficult patient — the doctor, the patient and the interaction between the two.'[3] Balint-work seeks to illuminate the latter as its primary focus. Inevitably, studying the relationship will shed light on the personalities of the protagonists, but it is the declared policy of Balint-work that the privacy of the doctor's personality must be protected by the leadership even when his professional work is under scrutiny, although inevitably conclusions about personal issues may be drawn by the members of the group, and most importantly by the presenting doctor himself.

This dogma has been challenged, because some people have said that exposing the doctor's personality is the most direct way to improving his performance. Be that as it may, a group which does so explicitly will not be an orthodox Balint-group, even though the original training method was aimed at 'a considerable though limited change in his personality.' This apparently rigid position is the only thing that has remained immutable; as developments in every other sphere of the work — the study of the professional work of a doctor with a patient — are strongly encouraged. More sensitive observation by a better calibrated instrument is at the growing point of current endeavour. It is, therefore, one of the primary duties of the leadership to see that all the members of the group are protected from over-zealous intrustion into their personal worlds by other members.

In purely practical terms the doctors will be invited to present a case. It is taken for granted that every member will have a case ready, though in practice this will not always be so. It is useful for those who wish to present most urgently to be identified, so that the time can be judiciously apportioned by the leader, as with a meeting lasting from between an hour and a half and two hours, there is a considerable time constraint. Inevitably from time to time there may be only one offer initially, but it is

frequently observed that this case sparks off reverberations in the minds of others, giving rise to further cases by association. Sometimes a case makes such demands on the group that it will consume all the time available, in which case the excluded presenters must be remembered at the next meeting.

Presentations are made without the use of the patient's notes initially, although notes can be used for reference to answer factual questions which may arise. The idea here is not to make it difficult for the presenting doctor, but to allow the doctor to highlight those aspects of the case which are *felt* to be most important. Even though other members may disagree with this assessment, it is the only way to indicate what *that* doctor is arrested by, and also to appreciate, in due course, what has been *excluded* from the presenter's perception. So called 'negative findings', according to Michael Balint, can be just as important as the 'positive' ones.

The discussion can range far and wide, and technical clinical judgements are as acceptable, though rarely as useful, as observations on what is going on between patient and doctor. But the issue is not in terms of 'why did you do that?' or 'why didn't you do so-and-so?' but rather on what that patient brought which made that doctor react in this way. Of course, it may be something in the doctor that determines the reaction, but, as has been already stated, this must be approached in terms of the presenter's professional, rather than private, self.

The most valuable work by group-members is occasioned by their flights of imagination liberated by their own, individual, reactions to the story as presented, taking into account the fact that all the participants may have found themselves in a very similar position in relation to a problem of one of their own patients, and at the same time *every member of the group will bring their own personal and professional characteristics into play in consideringthe case.* It is this universe of imaginative thinking which gives life to the group, allowing the patient to be viewed from many different angles, and so better understood in the light of that particular doctor/patient relationship. It is on this substrate that the leader may exert leadership skills — reinforcing those aspects which seem most productive, and allowing the others to die by selective neglect.

The other dimension of the work in Balint-seminars is their life over a period of time. This allows follow-up reports of the cases presented to be re-discussed. These will demonstrate the effect of the group-work on the management of the cases, and chart the progress of the individual doctors in terms of their capacity to change and develop in the course of their work.

It will also reveal whether the doctors have reccurent problems with certain categories of people as patients, and help to liberate them in order to pay attention to a wider spectrum of patients in their practice. This dimension is unfortunately absent in the context of weekend meetings of the type promoted by the Balint Society at Oxford and Ripon.

In the words of Michael, 'If possible, the aim should be to create an atmosphere in which anyone can speak unhurriedly, while the others listen with a free, floating mind, in which some silent is tolerated and time is allowed for everyone to find out what he really means or what he really wants to say. Unexpected things can be said and examined at times without any drama, while at other times they are allowed to cause mirth, surprise, embarrassment, or even pain. But, whatever the group's reaction, the emotions emerging both in the reporter and in his audience must be accepted and evaluated as expressions of unconscious processes activated by the report'.[2]

It is from the consideration of these emotions that a new understanding can be gained which may allow the doctor (and patient) to be freed from the log-jam of difficulty. This kind of situation occurs on a daily basis in the general practice setting, and that is why Balint-work is in the last analysis, *even though it is a new kind of work*, essentially liberating.

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From my Bookshelf

THE SOCIAL HISTORY OF THE UNCONSCIOUS: Vol. 1. The Archaeology of the Mind. George Frankl. (2nd Edition, in Paperback. pp. 212. £8.95. ISBN 1 871871 166). London, Open Gate Press. 1992.

This recent addition to my bookshelf seems to have come at an opportune moment. As so often is the case, several different wars are being waged as I write, in August 1992. It is noticeable that the most viciously contested of them appear to be based on ethnic, almost tribal conflict, rather than on ideological issues.

Why do we so often hate 'the others'? What unconscious material determines genocide? George Frankl has presented us with some fascinating and powerful explanations.

George Frankl was born in Vienna where he studied philosophy and psychoanalysis. Forced to emigrate by the Nazi invasion of Austria, he continued his studies in England and Canada, and returned to live and work in London in psychoanalytic practice for the past 35 years.

He describes in his Forward how, while helping a number of individuals as a psychotherapist, he became impressed by how society mass-produces neurotics and moreover, shows unmistakable signs of a profound neurosis in its structure and behaviour. He goes on to say in his Introduction that 'It is obvious that our civilisation suffers from a disease which we seem unable to understand or to cure'.

In this book, the first of two volumes of what clearly is a monumental work, he applies psychoanalytic techniques and insights to archaeological findings and traces the psychological development of the human species from its beginnings. He goes on to examine why men came to build walled cities, the motivations for kingship and the worship of gods, for hierarchic social structures and the development of property.

He goes on to show the long continuing conflict between matriarchy and patriarchy and, in particular, he describes the nature of patriarchal paranoia, that fatal disease which was and continues to be the source of warfare. These are only some of the issues Frankl addresses, and if his conclusions are taken up and explored further, they must surely lead to the transformation of some of our fundamental concepts about our social existence and about ourselves.

For me, this book has joined that group of books which make for compulsive reading — a book that is difficult to put down until it has been read from cover to cover — and one which should be in every doctor's personal library. I cannot wait for the second volume!

PSYCHOSOMATIC DISORDERS IN GENERAL PRACTICE. Eds. B. Luban-Plozza, W. Polinger, F. Kroger. Translator, George Blythe. (3rd, revised and enlarged edition, in Paperback. Pp 255. ISBN 3-540-54556-5). Edition Roche, Basel, Switzerland. 1991.

Michael Balint wrote in the Foreword to the first edition of this extremely interesting and well constructed book, that it is intended for the doctor who, '. . . although properly educated in traditional 'illness-centred medicine', feels ill at ease in face of the many patients whose case histories cannot be understood and whose complaints cannot be helped on the basis of what he has learned.'

The authors start with a critical view of the usual procedure for patients with psychosomatic conditions: from the first step of a physical examination, which produces no evidence of any organic disease, followed by the well meaning doctor's 'reassurance' for the patient that he has found 'nothing wrong'. Depending on how well the doctor knows the patient, he might try to 'advise' him how to live or behave, perhaps gaining praise from our political masters, but achieving little more.

The next step of prescribing some symptom-suppressing or controlling medication usually follows, also with little effect unless it is to bring the patient back with a complaint that the tablets did not agree with him in some way.

The authors question the justification of this approach in medical practice, although they are careful to point out that taking a psychotherapeutic approach with these patients should not be *instead of* the accepted clinical assessment, but should complement it.

The book is divided into twelve sections, on psychosomatic groundwork, psychosomatic disorders, psychoautonomic syndromes, psychosexual disorders, psychosomatic aspects of dentistry, the psychosomatic patient after onset of middle age, the cancer patient with an unfavourable prognosis, aspects of anxiety, masked depression, the psychosomatic approach to the patient, rudiments of treatment and psychopharmacotherapy.

Each section contains a full and clear systematic analysis of the many aspects of the topic in focus, including the importance of the doctor's attitudes, and many other essentials of Balint's ideas. The description of Balint-group work is particularly good.

The very full Index helps the reader to find his way around this excellent work, which can be highly recommended to every doctor, Balint-trained or not, and whether working in general practice or in hospital. The added bonus is that the book is available free, on application to Roche.

PHILIP HOPKINS

The International Balint Federation: Past, Present and Future

Jack Norell
President of the International Balint Federation

The International Federation was created in 1975, just five years after Michael Balint's death, and is devoted to the sharing of experiences, reviewing of ideas, and the continued development of the Balint philosophy.

Michael Balint's first groups were held at the Tavistock Clinic's old premises in Beaumont Street, London W.C.1. Later groups were held by him at University College Hospital, and by other psychoanalysts at the Tavistock Clinic.

After his death in 1970, the activities of the Balint Society led to various groups developing outside London, although never being comprehensively available throughout the United Kingdom.

Even more significant was the spread of his ideas throughout Europe and across the world. As a result, formal Balint Societies now exist in most of the western European countries, and there are some in eastern Europe and the other continents. (Table 1)

Table 1.
Countries with National Balint Societies:

Belgium, Denmark,	Hungary, Yugoslavia,
Finland, France,	Argentina, Japan,
Great Britain, Italy,	South Africa,
Sweden, Switzerland,	United States of
West Germany	America.

An even larger number of countries that do not have national Balint Societies are nevertheless closely represented by their own various medical associations. (Table 2)

TABLE 2.
Other countries associated with the Balint movement:

Austria,	Portugal, Rumania,
Czechoslovakia,	Spain, Algeria
Greece,	Mali, Zaire,
East Germany,	Australia, Brazil,
Iceland, Israel,	Canada,
Luxembourg,	Hong Kong,
Netherlands,	Mexico,
Norway, Poland,	New Zealand.

The first and fourth International Conferences took place in London in 1972[3] and 1978[4]; others have been held in Brussels, Paris, Cologne, Montreux, Budapest and Stockholm. The next was to have been in Zagreb in 1993. And in 1996 we shall have a special International Congress in Budapest, to celebrate the 100th anniversary of the birth of Michael Balint.

The Federation's former presidents were Dr. Pierre Bernachon of France, and Dr. Jacques Dufey of Switzerland. Michael Balint's widow, Enid, has been Honorary President of the International Federation from the very beginning. (Table 3)

TABLE 3.
Officers of the International Balint Federation.

President:	Dr. Jack Norell, London, U.K.
Vice-Presidents:	Dr. Michele Lachowsky, Paris, France.
	Dr. Margareta Stubbe, Schlopweg, W. Germany.
Secretary-general:	Dr. Roger Van Laethem, 42 rue des Bollandistes, B-1040, Bruxelles, Belgium.
Treasurer:	Dr. John Salinsky, Wembley, U.K.

The president of the International Balint Federation has been invited to these medical meetings in 1992:

March:	Dubrovnik,	Croatia.
	Budapest,	Hungary.
April:	Graz,	Austria.
	Ljubljana,	Slovenia.
	Ascona,	Switzerland.
May:	Kolobrzeg,	Poland.
	Varna,	Bulgaria.
June:	Montreal,	Canada.
	Vancouver,	Canada.
	Transylvania,	Rumania.
September:	Skane,	Sweden.
	Kiel,	W. Germany.
November:	Nantes,	France.
December:	Seville,	Spain.

A comparison of the family doctors in Belgium, Britain and the Netherlands has recently been carried out. The study revealed differences in the levels of disease-centred and patient-centred attitudes, and these contrasts were attributed to the kind of doctor/patient relationship that existed in those countries. The Belgian doctors were thought to be acting competitively because they did not possess registered patients. The defensive way that they practised helped to maintain the traditional doctor/patient authority, which their patients expected. The Dutch doctors were regarded as being more patient-centred as a result of some recent advance in educational activities, and were displaying tolerance towards all their patients. Yet they were considered reluctant to interfere with patients' health behaviour, or to adopt any active

approach in preventive medicine. The British doctors seemed to be spending relatively short time in face-to-face contact with their patients, which made it harder to be patient-centred. They were considered rather less patient-orientated, because of social class differences; *upper-class* practitioners were thought not to be able to relate all that well to *working-class* patients.[2]

Of course, even neighbouring colleagues in the same area can differ greatly in their attitudes towards patients. However, the sharing of such experiences and varied approaches, is just what the International Balint Federation likes to contribute, in order to provide the opportunity for the good review of original ideas, and the further development of the Balint philosophy.

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International 'Balint' Award 1993 for Medical Students

For 20 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verità' (the mountain of the truth) in Ascona. With their function as university influence, they are known under the name for 'Ascona-Model' (WHO) and their main purpose consists of Balint teamwork. This means an examination of the doctor-patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. An award of Sfr. 10'000.-- donated by Sandoz-Wander Pharma AG, Berne, will be made to authors of the best description.

The criteria by which the reports will be judged are as follows:

1. Exposition. The presentation of a truly personal experience of a student/patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. Reflection. 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 specialities, 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 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.

Three copies of the composition, each containing the author's name and **full address** should be posted, not later than **January 31st, 1993** to the following representative:

Prof. Dr. med. Dr. h.c. Boris Luban-Plozza, Collina, CH-6612 Ascona.

The presentation of prizes will take place in Ascona on 24th April 1993, Monte Verità.

All information can be obtained from Foundation of Psychosomatic and Social Medicine, CH-6612 Ascona.

Balint Weekend at Oxford:
20th-22nd September 1991
Three Students' Experiences

I first came across Michael Balint's work when I was at Cambridge studying for my Part II in Social Psychology. The doctor/patient relationship and its importance in all branches of medicine had not been touched on at all during my pre clinical medical course and so the opportunity to explore it at this juncture was most welcome.

I was not made aware of the existance of the Balint Society, however, until over a year later, when a letter advertising the Oxford weekend was sent to my medical school. None of my contempories had ever heard of Michael Balint and very few expressed any interest at all in the idea of a weekend discovering what the society did. Eventually, and not without some trepidation, I set off for Lincoln College, Oxford, alone.

The weekend consisted of five sessions in a group consisting of ten people. Each session began with a member of the group sharing the experience of a patient he or she was finding particularly difficult or interesting to cope with. The group tried to help the presenting doctor explore his or her feelings towards this patient in an attempt to make future management easier and more successful. Also included in the weekend was a guided tour of Oxford and a special dinner on the Saturday night. The weekend ended with a Planary session where all were invited to join in a discussion about the weekend, the society and the future.

My first impressions of the weekend centred very much around how good it was to be away from London, and how nice the food was! My second, was how committed all these people were to the Balint Society and that they really believed that Michael Balint's work and the work which has followed on from that, is of fundamental use in the day to day practice of medicine. I think the third thing that stuck me was that all the doctors there were general practitioners — is Balint any less relevant to hospital doctors? I don't know.

My final thought about the weekend, I am afraid to say, is a sad one. If Balint is so useful to doctors and so beneficial to their patients, then why are there so few Balint groups in operation today? The answers I was given to this questiond ranged from lack of leaders to lack of interested general practitioners. Most people I asked ended up blaming medical education somewhere along the line. I am quite sure that the majority of medical students graduate without ever hearing what the Balint Society has to offer them, and they begin their lives as practicing doctors, undoctrinated by hospital consultants that any feelings which you experience in relation to your patients are unprofessional and should be suppressed.

I don't know if or when this will change. All I can do is be grateful that I am one of the lucky ones, I have been given permission to feel things for my patients and I have begun to learn how to use these feelings both to my patients' benefit and my own.

CAROLINE BELL
5th year Medical Student
St Bartholomew's Hospital Medical College.

What a great time — well worth attending! That sums up my experience of a Balint weekend. However I expect further elaboration would be enlightening.

I guess it is sensible to start at the beginning. Preparation! Like any good girl-guide I aimed to be well prepared. Step one: Send off for an application form: That promptly arrived and I duly sent off my cheque. However on further perusal of the form I noticed each person was meant to bring a case for discussion! Help! A short phone call to the secretary reassured me that students were not obliged to do this — but apparently tended to find they were as capable as the doctors as presenting. The second step was to read Balint's book, *The Doctor, his Patient and the Illness.*

In no time at all I was trundling along the M40 towards Oxford. A sense of excitement mixed with fear rumbled in my stomach. I wondered what my first conference would be like. Would a Balint experience enhance my view of general practice? I hoped so.

The first evening consisted of a demonstration group. A mixture of experienced Balintians and first attenders joined two group-leaders in a circle whilst the rest of us watched. One brave chap eventually broke the silence to present a patient. As the case unfolded his humour began to relax the audience. A discussion was opened to the floor. Insightful comments flew around — some seeming more to impress colleagues, some to develop understanding of the case. However we got a flavour of what was to come. The mystery of what happens in a Balint-group was starting to evaporate.

The weekend's four sessions began on Saturday. Seven doctors and two students formed my group. The two presenting doctors for that meeting were decided and work began. In the discussions I saw nuances of consult-ations. I saw how the feelings generated in the doctor can be used to understand his patient. Analysis of the patient's consulting pattern helps discover what he wants from his doctor, what the patient really needs. It's not about digging up relics of his childhood nor probing a sexual history. No, it's about understanding real people as they present now, to their doctor.

On Saturday afternoon I began to regret

my hasty volunteering to present a case if needed. Succumbing to speak in a threatening silence has some drawbacks! But I was also keen to try to better understand the lady I'd been seeing for weekly psychotherapy. Here was my chance to understand how she reacted to me, to gain insight into the therapist/patient relationship on a first hand basis. I wondered whether I was "doing the right thing". (Don't I ever learn? There's no "right thing to present" in Balint-groups!) Eventually I heard my voice stop — pause — then the group leapt in with comments I seemed to be given quite a bit of practical advice (unlike most of the presenting doctors but apparently like most of the other students). However encouragement also abounded and I was helped to understand the dynamics of "my case".

I'm pleased I attended the Balint weekend. I'd go again. The groups were both stimulating and enlightening. I shall join my second general practice attachment inquisitive towards patients reactions and searching for ways to understand them better. Balint-groups currently are for general practitioners but the Balint philosphy can be applied to all of medicine. Embryo doctors from all specialties can learn from such a weekend. There is much to gain if you are open enough to receive it.

JANET BUTLER
4th year Medical Student
St George's Hospital Medical School.

'Hey, Susannah, have you seen this notice about the Balint Society weekend?'
'The *what* society?'
'Well, apparently, it's a group of doctors who look at the role of the doctor as a therapeutic agent. Don't you think that sounds interesting?'
'Hmm. We could always write and find out more.'

That is how Susannah Denny and I came to attend this year's Balint Society weekend in Oxford. I really had no idea of what to expect, even though I had read part of Balint's 'The Doctor, his Patient, and the Illness' over the preceding weeks.

At the end of the first evening, having watched the demonstration group and listened to the comments afterwards, I was slightly apprehensive about what was to come over the next two days. On the negative side, this first evening strongly reminded me of the things I had disliked about my psychiatry attachment last year. These were the trying to find a reason/cause for everything, the idea that there is sex behind it all somewhere, and people saying "I hear what you are saying", which, to me, had come to imply "but I'm not listening". On the positive side I was greatly impressed by the willingness of these doctors to show that they are not perfect, and that they do not know the answer to everything. Coming from a teaching hospital environment in which everyone tries to show they know it all, (at least, it seems that way!), this was tremendously refreshing, and human. It was obvious that the demonstration group cared deeply for both the patient and the presenting doctor, and that they wanted to help him in his relationship with the patient.

By Saturday morning, though still not really knowing what to expect, I was keen to get started in the group. Having been informed of the one rule the night before — that the leader was there to protect each individual — I felt ready to have a go. After introducing ourselves we went straight into our first case. It was interesting to watch how various people in the group picked up on different aspects of the case, and how their comments opened up new ideas for going forward.

As the weekend progressed, the group got to know each other better, and we seemed to be coming together as a team. Both the experienced people and the newcomers to Balint-groups could say things without any fear or embarrassment. The group-leaders led discreetly, and extremely well. I am still puzzled about what the leader is really meant to do. Both in the demonstration group and in our own group, the leader gave me the impression that he was a Grandmaster playing a game of chess, and the rules had been changed such that only he knew them!! Not that this was bad — it just kept me in suspense!

During our final group session I presented Stan, a patient who I had met during my psychiatric attachment. This thirty-seven year old huge tree trunk of a man had a slowly growing brain tumour, which had made him go blind at the age of two, left him 'educationally sub-normal', and more recently had resulted in a psychotic episode. His parents could no longer cope with him at home on account of his feather suffering a myocardial infarction, and also since Stan had occasional violent episodes (e.g. breaking down a door, and ripping up mattresses when angry). I was allocated him as one of 'my' patients on that ward, and struggled to try to get to know him. Every day I would go and touch his hand and say 'Hello Stan. It's Su the medical student. How are you today?" His reply every time was 'I want to go home.'

After several weeks on the ward it was decided that more suitable future accommodation should be found for him, and that I could help in this by making a video of what Stan could do in hospital, and what he could do at home. The family lived in a small house which seemed all the smaller because of the size of the people inside it! His mum, dad, and even their pet labrador were as large as one another!! I was amazed at how dextrously Stan could manoeuvre himself around the living room which was full of china ornaments and a collection of brass instruments. In addition, at home he would talk a little more, go out to buy milk, and even play dominoes very successfully.

Producing the video was an interesting experience, but at the end of eight weeks I was tremendously frustrated, feeling I had not got

to know Stan as a person at all. Perhaps I was naive to expect a response form him to me as Su rather than as an agent of the hospital, but nevertheless I was disappointed, feeling I had not really established any form of relationship with him at all.

The group's insight and years of clinical experience were very valuable in helping me understand this case, and myself, better. For example, I had not really considered that the fact that Stan was dying (albeit slowly) had affected me. To me, Stan existed, he was my patient, and therefore I had to try to get to know him. I thought my frustration was because I felt I could not communicate with him, but the group showed me that there was more to it than that. Part of it was my powerlessness as a student to do anything for him, and also my anger that no progress was seen during my eight-week psychiatric attachment (which, after all, was on an *acute* psychiatric ward.) The more I think about it, those comments are probably true. Also there was the hurt pride, that Stan had not recognised me — Su — despite my efforts of time and emotion spent on him. The group helped me to see the 'bigger picture' and to put the case behind me as a learning experience. They also encouraged me to go on from there in my care of future patients.

The weekend was over all too quickly. I enjoyed feeling 'the brotherhood of doctors', as one of our group put it, and the supportive spirit of the group. Doctors of different ages, at various levels of training and experience, could each contribute and receive from others in the group. I certainly enjoyed that. I would love to come next year and follow up at least some of the cases we discussed this year.

SUSANNA MOREY
4th year Medical Student
University of Oxford Medical School.

Letter from America

An extract from the American Balint Society Newsletter on 13 May, 1992, reprinted with kind permission of the author, Dr. Frank Dornfest, President, American Balint Society.

The American Balint Society National Workshop, St. Louis, Missouri, April 1992.

Clive Brock, Laurel Milberg, Ron Stock, Alan Johnson, Paul Scott, John Salinsky and I met the night before the workshop in order to get things lined up and make each other suitably anxious. We had a big last minute adjustment to make. Sadly, Rex Pittinger had to make the decision the day before, not to attend as key-note speaker due to the very sudden, serious illness of his wife. Rex, we wish you the best of everything! So we had to make some last minute major adjustments that sent Laurel and I scurrying to prepare last minute presentations.

The day itself went very well. I think we ended up having 53 participants. We acquired 13 new members, making the total paid up membership of the Society up to 109. John Salinsky did a good job telling the new people what Balint-training is about and the extent of Balint activities internationally. Laurel Milberg brought everyone a step further in understanding the Pittsburgh part of Balint history. After a few words of definition from me about what a Balint-group is, we moved right in to a fishbowl demonstration. This process was artfully and gracefully managed by Laurel and we had ten enthusiastic volunteers led by Don Ramson and John Salinsky. The group then split into two: a beginners' group and an experienced group. The beginners group then divided up into three randomly assigned, facilitated groups and from all accounts they experienced a lively and helpful discussion including a question and answer session.

Paul Scott divided the experienced group into three focused groups. The word is that Clive Brock's idea of recording these sessions was wise. They will be transcribed by Alec Chessman and sent back to the participants for validation and clarification; themes will then be extracted and these will be the subject of a paper. I hope Clive and his group in Charleston will tell us more about this in the next newsletter.

What about the future? Here are some of the future arenas already discussed:

Basic Balint, 1993

At the National Society of Teachers of Family Medicine Conference, San Francisco, Spring 1993. A half-day Beginners Workshop run by a new cast.

Balint-Leaders' Intensive 1993

This will be 3-4 days of intensive work to allow established leaders to have the benefit of some of the more sophisticated aids suggested by the membership. An example is a ????? of an 'absolutely perfect Balint-group' with explanations of interventions, or the lack of them, and an up to date American book with actual cases and comments in the margin about what the leader should, or might be thinking. We will also have to address a theory that underpins all this.

International Balint Congress

The International Balint Federation Council have taken us up on my offer to host an international meeting in 1994. You'll be hearing much more about this later. The meeting will be in Charleston, South Carolina, during Charleston's 'high season'. The venue will be the Omni Hotel. The theme will be 'Where are we going?' We will focus on current understanding of the Balint training process and how to advance our understanding and our practices. It is anticipated that 200 people will be there.

FRANK DORNFEST

Report from the South African Balint Society

The SA Annual Balint Weekend Workshop: 25th-26th April 1992

Twenty people took part in a Weekend Workshop in Cape Town. We broke from 'tradition' and only started on Saturday night.

Participants included general practitioners in private practice, Vocational Scheme trainees, clinical psychologists who work with general practitioner groups, a final year medical student, an intern and a psychiatric social worker.

We started with a 'volunteer' group instead of an established group, which set the tone for the weekend. The group gelled well, and trust was quickly established.

The first case highlighted the problem of being an employer and doctor as well. The doctor had highly confidential information about his patient and put himself in conflict with his colleagues. The doctor was also feeling overprotective and the group felt he had gone far beyond the bounds of duty in caring for his patient. There was a disparity in the perception of the patient — some saw him as a 'conman' whilst others saw him as very vulnerable. Some members felt sympathy for the patient, whilst others felt anger. There were no clear boundaries in this case which made it difficult for the doctor to function adequately.

The second was presented on Sunday morning. It was about a female doctor who became friendly with a patient. They became quite enmeshed in their relationship, doing lift schemes and shopping for each other when each in turn had to be hospitalized. When the patient became pregnant she did not want her to be present at the Caesarian Section. The doctor felt hurt, angry and rejected. It made for a very lively and emotional discussion and once again involved 'boundaries.' Can we effectively treat our friends? The presenting doctor gained many insights into the dynamics and sexual overtones of their relationship. It highlighted that we are all human and clearly demonstrated how being in a Balint-group can help us get in touch with our feelings.

The third case was of a doctor who had to look after a severe head injury case. She had a problem being realistic and honest with the patient's mother. The patient had a poor prognosis and the doctor could not convey it to the patient or the family. The doctor acted as a go-between for the mother and the hospital specialists. The mother spent every day with the patient and started reading medical and pharmacological books and started to question the management. The doctor started to avoid the 'pleasant, smiling and chirpy' mother. The mother would become angry and panicky if her daughter was not given her medication.

There appeared to be a lot of 'buck passing' and denial. Doctors tend to deny and somehow find it difficult to say 'we don't know.'

The final case involved a 60-year old socially disadvantaged patient who wanted a disability grant form signed by the presenting doctor who works at a Day Hospital. The patient was hypertensive and epileptic and when she couldn't get her own way was known to throw 'fits.' She would even have 'heart attacks and strokes' and be brought to Casualty. The doctor felt guilty she didn't qualify for a disability and felt he could not allow the 'abuse' of state funds. He also admired her for abusing the system and getting away with it. However, he felt manipulated and did not feel comfortable with the authority to decide by the stroke of the pen whether she should get the grant. The doctor felt helpless within the system. One of the members pointed out that when a doctor feels helpless we call it 'manipulation.'

A feedback session was held, followed by the Annual General Meeting of the S. A. Balint Society. A newcomer to Balint expressed how impressed he was with the level of interaction over the weekend. He found the quick gelling, openness, honesty and trust was very useful.

One member found the group leader 'daunting and criticizing' and felt she wouldn't dare go against him. Another member found it hard to 'disagree' with him and made the point: It must be 'right' if he says so!!

It was felt that the volunteer group was a good way to start the weekend off. It was hoped next year to have the Workshop at a more convenient time to enable vocational trainees from other centres to attend.

Fisons were once again thanked for their continuing sponsorship of the annual Workshops.

SAVILLE FURMAN

Balint Weekend at Ripon

8th-10th May 1992

The Fourth Ripon Balint Weekend took place at Highfield House on the campus of the College of Ripon & York St. John, Ripon, North Yorkshire. As all our weekend courses, it was accredited for one day Health Promotion and one day Disease Managment.

The attendance was low, only 13 delegates, but this may be explained by the very recent foundation of a new Balint-group in Liverpool by ex-participants of Ripon weekends. It was decided to form two small groups to give people more opportunities for case-presentation, and to prevent known personality clashes. The leaders were John Salinsky and Paul Sackin in one group and Erica Jones and David Watt in the other.

The groups met for five one-and-a-half-hour sessions, giving everyone a chance to present more than once and indeed, no one had experienced quite such an easy flow of relevant case material before. Some group-members said that they found it less stressful to present to a smaller group. Towards the end of the weekend one did however begin to wish for larger groups, to appreciate more minds focusing on the individual cases.

Nevertheless we hope for a higher attendance next year, and in the plenary session it was suggested that we would easily achieve this if everyone brought a colleague next year! Ripon 1993 will take place from May 21st to 23rd next year at the same venue, which is proving more and more congenial each year.

DAVID WATT

Obituary

John L. Skinner, O.B.E., F.R.C.G.P., D.R.C.O.G., D.M.J.

John Skinner took over a single-handed practice in Ilkeston following his father's death in 1954, and by the time he retired in 1990, he had developed it into a group of nine doctors.

John was one of the first general practitioners to get a Balint-group going outside London. He advertised through all the Family Practitioner Committees in the Trent Region (in 1973), and received responses from 0.5% of the general practitioners, a figure which is now established as the 'normal' response rate. Perhaps we should call it the Skinner rate!

He managed to get eight of the general practitioners who had expressed interest, to form a group which was led by Dr. Desmond Dunleavy, who was working in the Nottingham Medical School at that time, as a psychiatrist, and who was experienced in psychodynamics.

After they had been meeting for a year or so, John invited me to sit in on a group meeting to see if it was a 'true Balint-group'. Dr. Dunleavy met me at the station, and after we had established an immediate rapport, he told me that a wasp had flown into his car when he was on the way to the station, and he had wondered whether that was an omen of my visit to the group!

There was, of course, no doubt that the group was truly Balintian. After the meeting, Jane entertained us all to an amazing cold buffet before I was tucked up in the spare-room for the night. The group joined the Balint Society and later presented a paper on *Establishing an ongoing seminar for the investigation of doctor/patient relationships,* to a meeting.[1]

John's untimely death is a great loss but although only 62, he had packed at least another fifteen years' more activity into that time than most people manage to do.

First, as part-time lecturer at the Nottingham Medical School, police surgeon, part-time medical officer to Nottingham prison, chairman of Alfreton Disablement Advisory Committee (his OBE was for this work), and leading the campaign for the establishment of Ilkeston Community Hospital. He also found time to restore furniture, as well as for bell-ringing, swimming and taking flying-lessons. He was truly dynamic. He is survived by his wife, Jane, and two sons, John, who is a surgeon, and Tom.

MIKE COURTENAY

John Llewellyn Skinner, a general practitioner in Ilkeston 1954-90, died 15 March 1992, aged 62 years. Born Essex; Educated Ilkeston Grammar School, Birmingham University. (M.B., Ch.B., 1952). Awarded O.B.E. 1983.

1. Skinner, J. L., Dunleavy, D. L. F., and Foster, J. *Journ. of Balint.* 1976, **5**:11-20.

From the 23rd Annual General Meeting held on 18th June, 1992

Presidential Address given by Dr. John Salinsky

In the Museum of Fine Arts in the city of Boston, I came across a large and rather mysterious picture by Gauguin. It consists of three panels, each depicting residents of Tahiti engaged in some sort of activity which I do not clearly remember. What I do remember is the title of the picture. The three parts of the tryptich are labelled 'Where did we come from?' 'Who are we' and 'Where are we going?' These are questions I think we could usefully ask about our Society.

First of all, were did we come from? That is an easy one. We came from Michael and Enid Balint, the Tavistock Clinic and the old General Practice, where there was no fund-holding and doctors had more time for hand-holding. It was a Balint world where groups met once a week, they were led by analysts and they did research, producing books with names like *'Night Calls'* and *'Repeat Prescriptions'.*

We knew we were a small minority among general practitioners, at the same time we wanted to spread the word and have some influence. We were waiting for something to happen: not a second coming, exactly, but some sort of new dawn in which doctors everywhere would recognise the importance of Balint's ideas and there would be a proliferation of Balint-groups all over the country.

While we were waiting for this to happen, we got involved in Vocational Training. A number of us became Course Organisers and were able to start Balint-groups for trainees. Soon small group-work became an essential part of the trainees' half-day release course. Not all the groups were Balint-groups by any means, but at least we were well represented. That is where we came from and, as you can see, the Society still exists. But where are we today? And what are we doing?

Earlier this year, I sent out a questionnaire to all our members. There were 93 replies out of 120 (see Table), a response rate of 77.5% which I understand is very respectable. You will also see that we have only 12 members who are still leading groups. Of these groups, 5 consist of principals, 6 of trainees and one is a mixed group. Only 6 people had taken part in a regular group as ordinary members in the last year, and 19 in the past 5 years. So it does seem that very few of us are regularly taking part in the activity which our Society is dedicated to promoting. This is disappointing, but not surprising.

The good news is that 48 people (40% of the total membership) have been to a weekend group at Oxford or Ripon in the last 5 years. Most of our newer members have joined at weekend meetings. Most of our leaders now do their group-leading at Oxford or Ripon. So the answer to the question, 'Who are we?' seems to be that those of us who are active at all are Balint Weekenders.

Where are we going? Well, clearly, we are going to Oxford and Ripon. I hope we will go to some other places as well. You will see from the survey that some of us go to weekends and conferences abroad and have discovered that Balint is alive and well in Europe, and other continents too. It seems to be a bit like cricket: we invented it here, but they seem to be better at it just about everywhere else. Never mind. Let's join in and show them a bit of leg spin. In October 1994 there will be an International Conference in America, in the beautiful old city of Charleston, South Carolina. I hope that lots of us will be there.

Here at home, I think we should have another go at teaching our fellow Course Organisers how to run Balint-groups. Especially as many Balint Society Course Organisers are now retiring. Secondly, I think we should do more research. At this year's Oxford weekend I would like to have a group of experienced members functioning as a research group, investigating a particular clinical topic, and then continuing to meet regularly to go on with the work after the weekend is over.

Finally, I would urge all of you to go to a Balint Weekend and take with you at least one person who is new to Balint. Our experience is that the word is best spread by personal recommendation, and if each of us brings one colleague we will double the annual attendance and help a lot of doctors to get more fulfilment out of their work. We must never forget that we have something of great value to offer our colleagues. If we fail to pass it on to them, no one else will.

TOTAL REPLIES: 93 (77.5%) TOTAL MEMBERSHIP: 120

	Total	Principals	Trainees	Mixed
Currently leading a group:	12	5	6	1
Led a group in last 5 years:	10	2	4	3
Member of a group in last year:	6			
Member of a group in last 5 years:	19			
Been to Oxford or Ripon weekend in last 5 years:	48			
Been to Balint Weekend abroad in last 5 years:	13			
Would like to join a new group:	YES: 43	NO: 37	MAYBE: 13	

Secretary's Report

We began the year with the Oxford Weekend, September 20th-22nd. There were 56 participants, the numbers a little increased with overseas guests attending for a meeting of the committee of the International Balint Federation which took place on the Sunday afternoon. The presence of six medical students was also much enjoyed.

Attendances at the Lecture Series were improved this year. There were five presentations, including a joint meeting with the Institute of Psychosexual Medicine at the Medical Society of London on the 4th of February 1992. This was attended by 44 people from the two societies, while the other lectures at the Royal College of General Practitioners, were attended by an average of 20 persons.

The Ripon Weekend, May 8th to 10th 1992, was a very small meeting, with only 13 participants in two small groups. Though this arrangement was interesting in itself, we hope to boost the numbers to around 20 again next year by careful publicity.

Of note is that a new Balint-group based in Liverpool began in April this year. It was largely made up of doctors who had attended Ripon in the previous 3 years.

The Balint-group Leaders' Workshop continues to meet at the Royal College of General Practitioners, convened by Peter Graham.

The Oxford Weekend takes place from September 18th to 20th this year, again at Lincoln College, which seemed very congenial to most members last year.

DAVID WATT

The Balint Society
(Founded 1969)

Council 1992/93

President:	Dr John Salinsky	*Hon. Secretary:*	Dr David Watt Tollgate Health Centre 220 Tollgate Road London E6 4JS Tel: 071-474 5656
Vice Presdident:	Dr Paul Sackin		
Hon. Treasurer:	Dr Heather Suckling		
Hon. Editor:	Dr Philip Hopkins 249 Haverstock Hill London NW3 4PS Tel. 071-794 3759	*Members of Council:*	Dr Marie Campkin Dr David Davidson Dr Andrew Dicker Dr Sally Hull Dr Pat Tate

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The Balint Society Prize Essay, 1993

The Council of the Balint Society will award a prize of £250 for the best essay about 'The Doctor/Patient Relationship in General Practice.'

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 prizewinners will be announced at the 24th Annual General Meeting in 1993.

Entries must be received by **1st April, 1993**, and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS.

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

1992-1993

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

Dr. BRUCE CHARLTON, Lecturer in Anatomy,
University of Glasgow:
Rival Concepts of Health: 27 October 1992

Dr. Graham Curtis Jenkins, Director of Counselling in Primary Care Trust:
Ration or Manage: Implications for Mental Health Care in General Practice:
24 November 1992

Drs. Jean and Stephen Pasmore will give
The 10th Michael Balint Memorial Lecture: 16 March 1993

Dr. ANNE CLOVER, Consultant Homeopathist, Royal London Homeoepathic Hospital:
Malignant Disease and Homoeopathy: 20 April 1993

(Details of meeting in February 1993, will be announced later)

The Oxford Balint Weekend, 1992

will take place at Lincoln College, Oxford: from Friday at 6 p.m. 18 September 1992
to Sunday at 1 p.m. 21 September 1992

The Ripon Balint Weekend, 1993

will take place at the College of Ripon and York, Ripon, North Yorkshire: from Friday at 6 p.m. 21 May 1983
to Sunday at 1 p.m. 23 May 1993

The Annual General Meeting, 1993

will take place at the Royal Society of Medicine at 7.30 p.m. 10 June 1993

The Oxford Balint Weekend, 1993

will take place at Lincoln College, Oxford: from Friday at 6 p.m. 17 September 1993
to Sunday at 1 p.m. 19 September 1993

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

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

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

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

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

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