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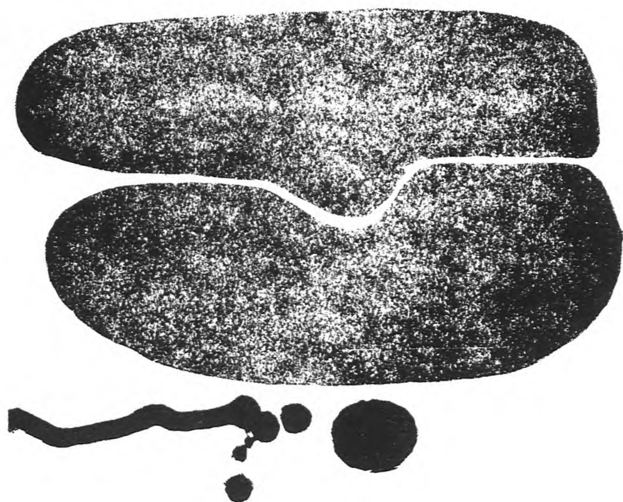

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Editor: Philip Hopkins
Assisted by Susan M. Hopkins

Dr. John Salinsky on a guided tour of Oxford.

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 and residential Balint Weekends at Ripon in May, and Oxford in September 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 Congress.

There is an annual Prize Essay of £500.00p (page 69), and the Journal is circulated each year to all members.

Editorial

Is anyone listening ...?

The chief aims of our Balint Society are ... 'to promote learning, and to continue the research in the understanding of the doctor/patient relationship' that was started by Michael and Enid Balint 45 years ago, in 1953.

Re-tracing my way through my files relating to the origins of the Society reveals both the ambivalence and pleasure that Michael seemed to have felt about the formation of an 'institutional' representation of his work. Perhaps he was right in having mixed feelings – because there are advantages and disadvantages to the achievement of public recognition.

As he predicted, it has been 'uphill work', but many of his ideas have filtered down through medical education, so that many younger doctors, as well as most established doctors, must know the name of Michael Balint and his ideas well enough. It is arguable that they may be 'taken for granted', with the risk that the technique may survive, without the underlying philosophy.

Our prize essayist notes that despite various advances in medical practice and administration, the organisation of the provision of medical services still seems to be based on the belief that a doctor can do all that is necessary for a patient in six to eight minutes.

What indeed, has happened to the 'short consultation'? The answer must be as Balint predicted, 'if the doctor ... (and anyone else? Ed.) ... asks questions in the manner of medical history taking, he will always get answers – but hardly anything more.'

And indeed, is there any human problem that can reliably be addressed in a few minutes? Would any solicitor, accountant, surveyor, priest or any other service provider attempt such an impossible task in so little time?

Another question has been asked. But is anyone really listening? Michael and Enid did superlative and insightful work in helping us to learn how to make the most of short snatches of time in a therapeutic relationship of variable and uncertain length. Much good work on healthcare relationships has been generated. But has something been missed?

Michael always said that the group-work was research as well as training – and he was always the scientist, as well as the seminar leader. The Balints were both psychoanalysts. One of the main roots of their understanding of the doctor/ patient relationship, was their grasp of the importance of what happens when a patient encounters someone who is believed to be a source of help, and the vicissitudes of the relationship of attachment and dependence that may ensue. In coming to an understanding of this relationship and all its implications, both psychosocial and physiological, we are not only studying the doctor/patient relationship – fascinating and important in itself. In addressing interpersonal and intrapsychic phenomena which stir up fundamental emotions, we are dealing with the essentials of psychosomatic health or disease. If the healthcare clinician is 'created' in the patient's psyche as a significant 'object', the *conduct* of that healthcare carries tremendous responsibility. Now that we know more about how psychic contents can influence neuro-hormonal systems – and therefore many connections with 'organic medicine' – it matters more than ever whether someone is listening.

The area of knowledge we address is crucial – but insufficiently understood by the majority of doctors and educators, not to mention Health Ministers and Treasury officials. A misunderstood and psychologically isolated patient is not only miserable – but more sick, more expensive, and more likely to pass on their troubles to the next generation.

So is anyone *really* listening?

PHILIP HOPKINS
SUSAN HOPKINS

Balint-groups 45 years on: What have they taught us?

John Balint, M.D., F.R.C.P., Professor of Medicine,
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Balint-groups arose from the interaction of three converging influences – Michael Balint's interest in the doctor/patient relationship, Enid Balint's work with family counsellors and the new National Health Service which excluded general practitioners from direct participation in the care of their patients when they were in hospital. General practitioners were therefore looking for a new role, and found the work of the groups to be one answer to their needs. The subsequent work of these groups brought to light several important features of the patient/doctor interaction which until that time, that is the early 1950s, had not been clearly recognised or defined.

The work done by the original groups with Michael Balint as summarized in *The Doctor, his Patient and the Illness,* identified six major influences that shape the patient/doctor relationship:

1. 'the basic fault' in patients and physicians.
2. the physician's 'apostolic function'.
3. the role of the physician as a therapeutic agent (the 'drug', doctor).
4. the 'mutual investment company'.
5. the 'overall diagnosis'.
6. the conspiracy of 'anonymity'.

I believe these six dynamic features of the relationship remain fundamental to an understanding of the therapeutic relationship between physicians and patients, not just in primary care settings, but in all the varied interactions in which this relationship is present.

The significance of these six features of the relationship is that they emphasise the bi-directional influence of physician and patient on each other. It is the evolving mutuality which gradually defines the relationship, and sets the parameters within which the therapeutic interaction has to proceed. We must recognise that these mutually, but not always consciously agreed boundaries, exist. In many ways they allow a harmonious relationship that is of great benefit to the welfare of the patient, and comfort of the physician. But in other ways it may preclude exploration and resolution of some other issues outside the agreed boundaries and these can be a source of much difficulty down the road.

The readers of this essay hardly need a definition of the six features. I would just like to briefly comment on each of these in the context of the late 1990s. The basic fault will always be there and must be recognized by us as physicians in our patients and ourselves. Indeed, we must still heed those who went before us and advised 'physician know thyself'. We must be always aware of the constraints the basic fault places on a particular relationship.

The apostolic function of the physician is a paternalistic and generally beneficent behaviour intended to educate the patient, and persuade her or him to behave in a way that will lead to an informed and cooperative relationship. Enabling the patient to be an informed participant in the partnership with the physician is a new facet of the apostolic function as a result of the new emphasis on patient autonomy.

Closely related to the apostolic function is the role of the physician as a therapeutic agent. We must continually remind ourselves that all our interactions with patients influence the patient's response to disease or illness for good or ill. We remain ignorant of the pharmacokinetics and proper dosage of this drug. But as the relationship evolves under the influence of the apostolic function, the patient's feedback and of the 'drug' doctor the patient and physician establish the mutual investment company which defines their mutual adaptation and agreed *modus vivendi*. The overall diagnosis is now harder to arrive at, at least in the United States, where patients and physicians are more geographically and, therefore, socially separated than in the Britain of the 1950s. Therefore, getting a good sense of the patient's family, social and work setting has to be based on history and not on personal observation.

The conspiracy of anonymity also has become more of an issue than it was 45 years ago. The increasing complexity of medical specialties and technology leads to patients seeing more specialists, who focus on isolated organ systems and sometimes even on parts of organ systems, e.g. a retina specialist. The primary care physician must firmly grasp the helm as captain of the ship, and assure good communication with the patient to guide him/her through the maze – an important part of the apostolic function.

What we have learned from Balint-groups, is the paramount importance of a good patient/doctor relationship based on the six features that define it. These six aspects of the relationship are the foundation for a good, trusting relationship, that permits effective care of our patients.

Reference:

Balint, M (1957) *The Doctor, his Patient and the Illness.* (First Edition). London, Pitman Medical.

'This won't take a minute, doctor ...' *

Marie Campkin
General Practitioner, London.

Whatever happened to the short consultation? A generation or so ago, there seemed to be several 'brief encounters' in the course of a routine surgery – for repeat drugs, blood pressure checks and certificates (including the old private certificate at a shilling at a time, if you go back far enough). With appointment systems in their infancy, or yet awaiting conception, this could enable the doctor to create a little more time for patients who needed longer – or to finish sooner and get on with something more interesting, depending on inclination.

Such brief consultations have largely disappeared. Computer and staff do the repeat prescriptions, and the practice nurse does the blood pressures and pill checks and smears, whilst the simplification of long and short-term certification has also contributed to minimising the doctor's involvement in short contacts. So is there now more time to spend with other patients?

It appears not. Despite delegation, self-certification and a general though not universal lengthening of appointment times from five or six minutes to eight or ten, there has been a concomitant increase in the amount to be squeezed into each consultation. The agenda grows remorselessly, along with the doctor's sense of pressure. There are reasons; adoption – or dumping – of work from secondary care, patients' increased expectations, the latest government-inspired 'pro-active health initiative', the newest media-generated scare story. Add to this, an ageing population – of both patients and general practitioners – and a general practice recruiting crisis, and there is a problem. Against such a background, should we not then give a wholehearted welcome to the patient who states that he or she hardly needs a minute of our time?

If only it were so simple. Experience suggests that such offers are more likely to herald complications than brevity. Whereas 'while I'm here, doctor' honestly betokens a request for more time, the phrase 'this won't take a minute' tends to belie its true nature. In effect the two phrases are virtually synonymous, except that the former is commonly a 'parting shot', the latter is more likely to be an 'opening gambit'.

Both are usually followed by that deceptive little word 'just', 'I just want a prescription' – for sleeping pills, antibiotics, or some drug cryptically mis-spelled on a scrap of paper, which has worked wonders for a neighbour. 'I just want a certificate' – for the employer or to be excused jury service; 'I just want a letter for the hospital' – department and reason unspecified.

What does the word 'just' actually mean? Is this really about saving the doctor's valuable time? Sometimes, perhaps it is. The patient may, in effect, be saying 'you're more important than I am, I'm not worthy of your time, look at all these other really ill people.' Yet these patients may also be the ones most likely to have some serious condition that they are minimising – through ignorance, fear or embarrassment. It may be easier to request sleeping pills, or the repeat or an old prescription to avoid discussion of a painful or difficult matter. It may be easier to self-diagnose and ask for what might be the appropriate treatment to avoid a physical examination, 'It's my thrush again'. For the doctor, it may seem easier to comply, or collude, than to challenge or confront.

A young Arab immigrant requests 'just a few sleeping tables'. He has had them previously, only a small number, and quite a while ago. Clearly he has not abused them, but it seems right to find out why they are needed. It turns out that he is setting up his own electrical maintenance business; working an eleven hour day, six days a week, and offering a twenty-four hour emergency service. (Something about this regime sounds distantly familiar). Needing money to buy a house and business; he cannot afford to employ many staff. When he gets to bed he is sometimes too tired to sleep.

If I simply agree to his request, am I encouraging him to start what sounds like an unhealthy, albeit in some respects laudable, lifestyle? He is married with no children yet, and I wonder what his wife makes of the situation. He assures me that she has her mother and friends to spend the day with, though he is himself tired and irritable when he gets home. He then mentions that she does seem to have a problem, in that she has to keep getting up at night to go to the toilet, and this disturbs his sleep all the more.

At this point, do I just give him the prescription, or do I start to speculate on his wife's difficulties, medical, social or psychosexual? Should I suggest that he might bring her along to see if she needs help, and how many more minutes will this take to explain? In the long run one hopes the extra time is well spent if it enables the patient to admit or recognise an underlying problem which, consciously or unconsciously, is being evaded, and which eventually will cause more trouble.

On another occasion it may be a potentially serious mistake on the doctor's part, that is avoided in the extra minutes.

A woman of 43 and her 12-year-old daughter were extras in an evening surgery. The daughter was presented first with general viral

* The Balint Society Prize Essay, 1998.

symptoms, raised temperature, nausea and diarrhoea, diagnosed as 'gastric flu', and given routine advice on appropriate treatment and diet. The mother then admitted to similar symptoms of sickness and mild diarrhoea, and also had slight pyrexia. As her vomiting was particularly troublesome, the doctor offered her metaclopramide. She then complained of rectal pain and was found on examination to have a small peri-anal haematoma, which was fully explained. As she was about to leave, she asked 'Can I just ask you about my periods – it won't take a minute?' The doctor, exasperated, started to suggest she should make a further appointment, but hesitated. The patient then said her periods had been heavy for two years, apart from the last one. She was about due now, and had had a slight show. Was this the menopause? Suddenly, remembering her sickness, the doctor asked if she could be pregnant, but she said she had an IUCD. However the doctor suggested she had better do a pregnancy test before starting the metaclopramide.

To the surprise of both patient and doctor this proved positive and she was urgently referred for a scan to exclude an ectopic pregnancy. It was in fact, intra-uterine, but was subsequently terminated. The doctor was left relieved, contemplating what else might have transpired.

Sometimes the implications of the 'won't take a minute' routine are not just about the patient's diffidence or the doctor's convenience, but have a more hostile connotation, in that the patient knows exactly what he or she wants and does not expect any argument or awkward questions asked. This may be about medication – 'I know it's only a cold, but it always goes on my chest if I don't get antibiotics; certification – 'my employer insists on a certificate from the first day, and I want a 'panel' one'; litigation – 'my solicitor told me to get a letter about my injuries; social services – 'the Housing said you have to give me another letter.'

Here the threat is not so much to the patient's well-being as to the doctor's. Apart from the expenditure of time involved in challenging the demand, the possibility of eventually having to give in threatens one's morale and self-esteem, while standing up for one's principles may incur verbal or even physical violence. If what is being demanded is potentially illegal, unethical or fraudulent some form of confrontation is unavoidable, but its tone will depend on the doctor's relationship with the patient. If this has been good in the past, negotiation may be possible to resolve the difficulty.

If it has always been somewhat fraught, unfinished business from previous skirmishes may make conflict inevitable. If this is their first encounter, the patient's experience with previous doctors may well influence the outcome, but so will the present doctor's skill at approaching the difficulty and dealing with it.

More often, the demand appears inconsiderate because the patient does not really understand the system – for example, the fact that a legal report should be requested in writing by the solicitor rather than verbally by the patient. One can explain this in terms of needing to know precisely what details are required, without necessarily mentioning the other issue, that an undertaking about payment should also be included. In the case of a hospital referral, the patient can usually be persuaded that the doctor does need to know what is wrong before deciding where (and even whether) to refer, let alone what to put in the letter.

Even when the doctor's agreement to the actual request seems reasonable and desirable, there may still be a need to pause, take stock and clarify the implications before acting. Sometimes one can look back on a consultation and see how a whole story has evolved in a series of stages, whereas it might have come to a full stop at the end of the first sentence.

A woman in her mid-thirties comes in requesting a 'morning after' pill, after an accident with a condom. The 'just a minute' consultation might consist of confirming the circumstances and dates, checking blood pressure, excluding contra-indications, briefly explaining the treatment and issuing the prescription. Given a little longer, the subject of alternative methods of contraception is raised, including a tentative enquiry by the patient about possible sterilisation. In a further few minutes, it emerges that this patient has in fact had post-coital contraception on a number of previous occasions, as well as several terminations of pregnancy.

Clearly there is much more to this than a simple failure of contraceptive technique. As might be guessed from the history, this woman has suffered sexual abuse, and most of these events have occurred since a court case that re-opened old wounds. Her current relationship is with a man who works abroad, and it seems that every time he returns there is some sort of crisis about contraception.

She begins to recognise that there may be some connection between her history of abuse, the repeated interrupted pregnancies, the recurrent panics about contraception, her ambivalence about childbearing, and the fact that she has chosen to have a relationship with some-one who is away most of the time.

In the end she leaves with what she came in for – a prescription for the 'morning after' pill. It has taken a good deal more than *just* a few min-utes – probably at least half an hour, but she has undertaken to return to look again at some of the matters which have come to light. It seems likely that without this extended consultation, her next attendance would have been about yet another condom failure. Or maybe it will be, just the same.

So what has happened to the short consultation? Can it be that as Balint-doctors we have rendered ourselves virtually incapable of sticking with the patient's initial offer, and may

be looking for hidden agendas even when they are not there? A while ago I was bemoaning my inability to keep even within hailing distance of a ten-minutes appointment system, when a younger colleague said he could not imagine spending ten minutes with any patient. 'What on earth do you find to talk about once you've sorted out their problem?'

I suspect he may get on better than I would have done in the brave new world of National Health Service general practice for the new millenium.

Empathy: The Key to the Doctor/patient Relationship

David F. Law*
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The doctor/patient relationship is the cornerstone of good medical practice. Judged carefully, it not only allows appropriate management decisions to be taken, but may also provide therapeutic caring. However, the traditional paternalistic model for the relationship has come under heavy criticism from modern generations who have, on the whole, rejected such a behaviour pattern. Hence informed reflection is now required to establish new guidelines for doctors and medical students to be able to recapture the essence of this special relationship. It is the author's opinion that the genuine aim of the physician/patient interaction has always been the same: to empathise. In other words, if I was this patient with all the appropriate medical knowledge about this condition, how would I want to be related to, and what management decisions would be important to me. Rather more simply, if that is the aim, we have to step into their shoes if we are to succeed with ultimate care.

Exposition, Reflection and Action

I met Mr AB when in my first year as a clinical medical student in my first attachment, 'General Surgery', at a large teaching hospital in Great Britain. Our relationship began prior to any formalised 'Communication Skills' teaching. What unfolded and developed was both surprising and enlightening.

Getting Involved

This first encounter with Mr AB was a positive one. It occurred in a group setting on a consultant ward-round the morning after Mr AB's night-time arrival at the General Practitioner Referral Unit (GPRU). Those students present were still being taught the basics of abdominal examination – inspection, palpation, percussion, auscultation – and Mr AB was please to participate. The symptoms and signs elicited were those of acute cholecystitis; indeed they appeared so classical that the senior clinicians joked about discovering a new pathognomonic patient description, and strongly encouraged us to return to the patient later, to discover more about the features of this common condition. Appropriate management plans were instituted and we proceeded to finish the round. Hence an encouraging start for the patient, a rapid diagnosis and suitable treatment with a probable swift resolution and return home – a positive experience reflecting favourably on the relationships being established.

Knowing something of the prevalence of gall bladder problems in our society, I was keen to return to speak further with Mr AB and took my opportunity later that day. Once I had tracked him down in the ward though, I found that his wife was with him. Now a dilemma, one commonly faced by medical students; I need to learn, but is it great enough to intrude on a patient's time spent with his wife or other visitors, or dozing, or watching a favourite television programme. The pressure of my lack of time allowed me an easy option, to introduce myself in order to arrange a more convenient time to visit him later, I thought. Still feeling contented and relaxed however, Mr AB was keen to introduce me to his wife, who was seven months pregnant. By chatting for a short while, I discovered that he was a chef at a local RAF base. This provided 'cooking' as a point of common interest, and I was able to establish a good rapport with them both, and we began to build a good student-doctor/patient and family relationship.

One of the big advantages of being a medical student, is that the relatively few responsibilities compared with those of the qualified staff, allows me to spend a larger amount of time to relate to patients. This became apparent with Mr AB over the following week, as his clinical course was not straight-forward, and I was able to discuss his symptoms and management with him. By the time two ultrasound scans, a diagnostic laparoscopy and a CT scan had been performed, no evidence had been found to support the clinically suspected gall bladder disease.

Mr AB needed considerable encouragement not to lose heart either in the reality of his condition or our motivation to help him get better. This was a difficult situation, as I had invested considerable amount of time in understanding him, and did not believe he could have any reason for fabricating his condition. But the surgical team was beginning to have second thoughts. A 'gold service' of investigations, they were saying had shown nothing – the objective was more persuasive to them then the subjective.

An attachment to another hospital nearby, ended my relationship with Mr AB and his wife, but I remained fascinated by his outcome, and the uncertainty about the possible truth behind his true medical condition. On my return, I discovered that he had been discharged home with resolving pain, soon after my departure. He was followed in an outpatient lipids clinic, where the only abnormal finding was a slight rise of his triglyceride. An unsatisfactory outcome, with too many loose ends, I thought, both diagnostically and emotionally.

Being the Expert

As a medical student, it is rare to have sufficient knowledge of any clinical situation to be completely confident, and rarer still to be the expert.

* One of the two students from Oxford University School of Medicine who shared the second prize in the 1998 essay competition awarded by the Swiss Foundation for Psychosomatic and Social Medicine, and the Swiss Red Cross.

Much of the time in the clinical setting we are asked to do things, such as a new procedure previously only observed, for which we might feel prepared, but inadequate. This was not the case when Mr AB was returned to hospital by ambulance fifteen days after his discharge. By chance, I was working with the new surgical team 'on-take' at the time, and I was surprised and pleased to meet him as he was brought through the front door. I had been reviewing his case history over the past two weeks, and researching into the possible causes of his symptoms; I had thought about the questions which should have been asked previously, and so was better placed than any of the doctors, to discover what was going on. The surprise gave way to excitement when I realised the possibility of finally solving Mr AB's diagnosis. This also suddenly made me feel responsible for his care. Unusually, I was the expert.

Having a reliable 'doctor'/patient relationship as well as a detailed medical understanding was something of a double-edged sword. The trust and intimacy previously gained, allowed for further thorough history-taking, including difficult questions about potential sexual relationships whilst serving away from home for six months in Bosnia. This was important due to the aetiology of some mimicking diseases of cholecystitis, such as Curtis Fitz-Hugh syndrome, a sexually-transmitted infection associated with Chlamydia. The established relationship also provided some frustrations though. Despite abdominal pain, these had never been requested by the doctors. Clearly as a student, I was unable to order them. Knowing the background and the need for thoroughness in difficult diagnostic cases, it was hard to feel both very involved, but also very impotent. Another example of this was Mr AB's request to return to the ward on which he had previously been – as he got on well with the nurses there. I knew that in the normal course of events this would be unlikely since he had only been previously admitted there before, due to a lack of space on the usual ward. As a doctor, I may well have been able to admit him back to the ward he wanted, not least because such contentment may positively affect his outcome, the length of his stay in the hospital and hence the ultimate cost. However as a student, my best opinion was to persuade him that his new ward would be as good, or perhaps even better than the last one.

As a re-admission, Mr AB was returned to the care of his original surgical team, but I continued to be informally involved. By day-one there were problems. One of the junior doctors took it upon himself to explore a few psychological questions with Mr AB. 'Were things alright at home? Was he worrying about the expected arrival of their first child? Were there problems at work?' The timing was not good. Having just been returned to hospital, feeling even worse than before, being asked a list of such questions can only mean one thing – the pain is being doubted. Even to suggest that someone has Munchausen's syndrome who does not, is clearly disastrous for the whole team's realtionship with the patient. It is acceptable and even necessary to entertain the diagnosis as one of exclusion, and admittedly Mr AB had worrying risk factors having had extensive contact with other medical and ambulance services, but confrontation is rarely helpful. Gentle probing in the context of a trusting relationship, something this junior doctor lacked, would have been more effective. So a salvage operation on the team dynamics was required. At the time I felt trapped – caught without formal input in a damaging situation and identifying on one hand with the medical staff and their frustration with the lack of a diagnosis and on the other, with a befriended patient who was hurting.

Fortunately the strength of relationship I already had with Mr AB and my aloofness from the surgical team now treating him, enabled me to steer clear of his anger and frustrations. I was able to reassure him that as a profession we still wanted to take him seriously and, through some feedback to the other house officer on the team, the bridge-rebuilding began. Spiking a temperature later that day lent some validity to Mr AB's sickness and the onset of a second periodic, burning, retro-sternal pain was not necessarily unrelated to the stress he had been caused.

Feeling Vulnerable

Anyone who has stopped to think about their own friendships, could tell you that as you grow closer over a period of time, you also become more vulnerable. You open up and relate more as you learn to trust each other, but if feelings are misjudged, you can also feel more pain. Such a risk is also present in the doctor/patient relationship. It was good to share the patient's relief, 'a weight off my shoulders', on the day that one of the test results was positive, and indicated that there probably was some gall bladder pathology after all. Having shared so much thought, I perceived it as derogatory when, after he was involved in student assessments, Mr AB remarked that another student who he had spoken to, and who had examined him was 'so thorough, really very good'. In relationships of all kinds it is easy to over-interpret what is said; however to me, I was likely to be Mr AB's benchmark student and here he was indicating how much better somebody else was than me. Unintentional it may have been, but it hurt.

Occasionally, patients seem to be unaware that we also have feelings, just like them. The white coat we often wear is no emotional protection, though there are temptations to use it as such. During Mr AB's inpatient stay his wife was visiting regularly and often tied this in with having the necessary antenatal examinations. At about 34 weeks gestation she was found to have a relatively high blood pressure and concerns about pre-eclampsia led to her admission to the on-site Women's Hospital. Over the weeks that I had become involved with Mr AB, I had also come to know his wife, and she could now not only not give him the support that she had

done by her visits, she was also, very legitimately, a concern for him.

Suddenly a void of care had developed and I was standing next to it. How involved should I become, professionaly speaking? Could I avoid this extension of the duty of care I had already undertaken? It is all very well to develop friendships, but at the end of the day it is my workplace. Should I feel guilty that as I hang up my white coat, I am abdicating the care I could be giving? There is no need to feel guilt. We are not an inexhaustible resource; to care for others we must care for ourselves. As in any other line of work, it is appropriate that we should demarcate time free from our working environment and responsibilities, so as to be able to relax. Such an attitude should not however encourage us to become different people with our white coats on. If we choose them to be a barrier to our real selves then we have already weaked our ability to form ideal patient relationships.

A further issue of vulnerability and professional practice, arises from meeting patients outside the clinical setting. Due to our mutual interest in food, and the fact that Mr AB was a chef, he was keen to be able to cook for me when he was well again. A perfectly natural method of sharing for friends, but something that felt outside my professional 'comfort zone'.

To refuse such a generous offer would appear rude and ungrateful, perhaps even proud, yet to accept would lead to an engagement I would find it very hard to keep. Realising this and not wanting to end the otherwise successful relationship on a discord, I used time to my advantage. We made no firm plans and I felt sure that the pressures of the Christmas period and the impending arrival of a first child would cleanly sweep away the difficulties. I was never contacted; an honourable conclusion.

A Final Insight

Before leaving the hospital, Mr AB promised that he would be writing to the management to thank them for the care that the team had provided for him and his wife. I did not doubt his intentions, but it seemed it might be an easy task to forget, in the midst of returning home and getting back to work. I was wrong. A few weeks later, a note from the Chief Executive with an attached copy of Mr AB's letter was forwarded to me. The team and personal commendations were heart-warming. For this patient at least, the outcome was a good one.

Aside from the positive feedback though, the letter also revealed something else to me. The personality behind the few spelling mistakes, the rough grammar and the unformatted text was a character I would probably not naturally interact with in a different context. This should come as no surprise. As doctors and students alike, we can never choose who will fall ill and come under our care, but we hold the same duties towards each one of them. We must serve them all as best we can.

Progression – the Road to Improvement

Empathy is the key to the doctor/patient relationship, and it is the difference between a reasonable doctor and a great doctor. Intuitively it is a skill that can only be mastered in practice and over a considerable period of time; however there are in fact large steps that may be taken towards enhancing this quality through various simple activities. These processes encompass general lifestyle, as well as specific learning objectives and contribute to both personal and professional development.

Our lifestyle outside medicine provides many ways in which we can promote our ability to empathise. It is very important to be interesting and interested people in wider society. The more we are involved in sports, religion, current affairs and leisure, the more experiences we have to share; the more common ground we are able to find with others and the easier it is to relate to those of all walks of life. Not only this, but we should also ensure that we are making time to experience personal relationships. Building trust, fostering openness, and sharing difficulty and joy whilst discovering true friendships strengthens our humanity. We must become well-rounded people.

We must also take time to reflect. The benefit to personal life of keeping a diary or journal has often been recognised, and it is a good example of how self-directed analysis allows expression of emotion with an ability to trigger behavioural change. Reviewing the pressures we have felt and the successes or failures we have perceived allows us to plan our own road to improvement as well as charting where we feel vulnerable. These principles are as relevant to our workplace, interactive as it is, as they are to our own friendships. The local conclusion is to introduce the task of keeping a work-related 'emotions' diary as an assignment for medical students to incresae their awareness of their psychological situation. Whilst this may be too radical for some students (and some medical schools), the curriculum should include the need to write a commentary of personal experiences with a given patient or patients. This practical exercise would force students to think as much about their emotional interaction with patients as the 'medical' input, which is often recorded in such a manner.

Indeed since most medical education is hospital-based, and most hospital medicine is diven by technological intervention, the power of human interactions has increasingly tended to be neglected within medical training. Although this crucial deficit has now been realised, much is required to redress the balance between the science and the art of medicine. Moreover the 'window of opportunity' to empower students with this expanded vision is small. The crucial period is very early in the clinical phase before the inevitable desensitisation to what it is like to be a patient, as opposed to being part of the he (Balint, 1957 althcare professions). It is ony then that we can still perceive our pre-medical lives and appre-

ciate the fears, beliefs, concerns and expectations of our patients. That is the time to begin the reflection process.

Once reflection individually has taken place, and only then, is it possible to engender discussion of cases within a group-setting. These gatherings can be augmented by reading relevant literature; in particular the product of Balint teamwork, to gain other genuine case examples and assess the analytical approaches used as an opportunity to learn from others, to share good practice and to lend support where difficulties have been encountered.

It must be acknowledged that this may not be an easy process for those with certain types of personality to be involved in. The perception of outside scrutiny of behavioural practice, like an audit, can be threatening, and bringing such scrutiny to an even deeper level of the emotion behind the interaction is challenging. Hence, these groups must be stable and small enough to become safe and accountable with experienced leadership to provide a guiding hand.

Balint's contribution in this field has been well documented in a huge bibliography, starting with his original book, in which he described in detail the results of his work with general practitioners in what he called his training-*cum*-research groups, and now simply called Balint-groups all over the world (Balint, 1957).

'Communications Skills' has been designated a key area by the General Medical Council (GMC) and small group teaching has consequently begun. At present however, most interaction focuses on the behavioural level since this is more superficial than an emotional or awareness approach, and because personal reflection is required before a group discussion. Until the mechanisms are put in place, as outlined above, to bring about this prerequisite stage, then the goal of enhanced awareness and the impact on empathetic caring will not be achieved. Boldness is required personally and from the professional body to make the necessary difference.

The aim of these strategies is to produce empathetic doctors and hence to reshape the doctor/patient relationship for the benefit not only of patients, but also for doctors. There is a by-product, however, which is a very positive bonus for those students, and subsequently doctors, involved in these learning tasks.

This is the coping ability which is put in place. The personal reflection followed by a group discussion provides an emotional outlet, as well as support derived from those who can most easily understand the difficulties being faced. Encouragement and advice can be offered and caring follow-up commenced where problems develop. This is vitally necessary in today's medical community. The statistics for doctors with respect to reactive depressive illness, alcoholism, divorce and suicide all too adequately do justice to the need for better strategies to deal with stress; teaching medical students how to care for each other may be the best way to secure the profession.

For those who are already qualified and finding difficulties in dealing with their relationships with their patients, especially in general practice, discussions with colleagues in small groups has been found to be of enormous value for those who are able to commit themselves to long term attendance in such groups.

Conclusion – Towards a Better Outcome

Medical students are ideally placed to be able to learn empathetic caring. We have the luxury of time to devote to learning from patients, getting to know them and understanding how they feel.

Following this with analysis and sharing of our emotional experiences enables skill development and support from colleagues. Our professional grade also enables us to be humble. Not a fashionable concept, but this is the way to build trust and respect as we become purveyors of medical information and intervention into people's lives. As we provide them with an intelligible perspective on their pathological conditions, we will understand them further, and be able to jointly make appropriate management decisions.

Developing our relationship we will then be alongside or patients in such a way that we can care for them, our presence and our words alone being therapeutic. For instance, in the case of Mr AB, negotiation with his re-admission to return him to his preferred ward, and more empathetic treatment with regard to assessing his psychological background may well have resolved his presenting complaint more rapidly. In expending our energies to sort out the small concerns for those like him, and for others, we will deal more swiftly and cost effectively with the more major issues. Ultimately the empathetic partnership between physician and patient can achieve optimal individualised care.

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A Psychosomatic Dilemma*

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Relationships with patients are one of the most rewarding aspects of the clinical course, and have taught me more about the art of medicine than any textbook ever could. I always regard it as a great privilege when complete strangers put their trust in me, and share with me their stories, their feelings and even sometimes, a closely-guarded secret. I have sometimes found it distressing too, when people tell me what they have been through. It can be difficult to know how to express my empathy and sympathy in an appropriate way – especially with psychiatric patients.

Of course, most illnesses are influenced by both physical and psychological factors, but it is more comfortable if one can dissect these apart with the scalpel of the intellect. The following case I found very challenging, because mind and body seemed inseparably intertwined. I was uncomfortable with both the doctor's and the patient's attitudes towards body-mind interactions.

Exposition

It was during my neurology attachment that I was sent to see Wendy Fineman (not her real name), a patient known to have multiple sclerosis, and who had had a relapse. When I arrived, Wendy was sitting up in bed – a rather unattractive, overweight young woman of twenty-five, with short, curly hair and round glasses.

I introduced myself, and asked whether she would mind me talking to her about her illness. She replied, 'All right then ...' in the resigned tone of a person who has already seen more than enough people in white coats.

First, I enquired about her present relapse. It had started a week ago when she was having a physiotherapy session at the rehabilitation centre. She felt short of breath, but this improved with the help of a nebuliser. On the following day however, she realised she was having an attack when she felt 'tingling' in the left side of her face, and felt 'drunk' and light-headed. In addition, her left arm and both her legs felt weak, and there was some difficulty in breathing and swallowing. On the following day, she felt she was having more difficulty in breathing and swallowing, and her left arm and both legs were now completely paralysed. Her general practitioner was called out. When he tried to give her a tablet of diazepam, she could not swallow it, not even when it was mixed in some jam. Her admission to the neurology ward was arranged.

When I questioned Wendy about her breathing problems, it became clear to me that she was describing episodes of hyperventilation. They would start off with a symptom like the desire to cough or yawn – and Wendy would think, 'Why can't I breathe?' She would then feel anxious, start to pant, and then would start having chest pain, which felt as though someone was strangling her. These episodes would last about half an hour, and made her anxious that she was having a heart attack. This made her even more anxious, and made her pant even more. She was sure that she had neve such attacks before the previous week. She communicated her obvious distress to me by the way she spoke.

I then asked about the history of her multiple sclerosis. She told me that she had had multiple sclerosis for two-and-a-half years, and that during her first attack, her doctor told her that it was 'all in the mind'. Her presentation was certainly not typical; she had been driving the car when her speech suddenly became blurred, and her left side became paralysed. She said it took her six months to get back to her work as a care assistant in a nursing home. She seemed to have lost count of her relapses since then; she told me this was the eighth or ninth, but on closer questioning, she described four previous relapses, two with similar symptoms to the first, and two when only her legs were affected. She felt she had not been told enough about her illness and its prognosis.

All this had profoundly affected her life. She had stopped working two years previously, and she was receiving help from an occupational therapist, a social worker, and a home help who came to put her to bed, because her parents were unwell and could not cope. She really wanted an electric wheelchair and a stair-lift to give her some independence.

When I examined her, Wendy started saying, 'No one knows what's wrong', and 'Put me down!' I could not decide whether she was genuinely worried, or whether she was being flippant – as she spoke, she would smile and giggle, in a disconcerting way. Her visual field was diminished on the right, as was her corneal reflex; she could not feel me touching either side of her face, or the back of her throat. Her right arm was weak, she could not more her left arm or legs, and there was clonus at her left ankle.

After thanking Wendy for letting me see her, I went to read her notes in order to set things straight in my mind before I presented her case-history to the registrar. The picture they painted was rather different from Wendy's account. Her first attack had apparently been only one and a half years ago, and it had been diagnosed as a 'possible right internal capsule stroke'. It was only six months later, when she had her first relapse, that an MRI-scan showed two lesions which were considered to be multiple sclerosis,

* One of the two students from Oxford University School of Medicine who shared the second prize in the 1998 essay competition awarded by the Swiss Foundation for Psychosomatic and Social Medicine, and the Swiss Red Cross.

and the notes stated, 'the diagnosis was discussed carefully with the patient', and, 'A frank discussion was undertaken with her with respect to the outlook, emphasising that disability is not invariably severe in this disease.'

She was rehabilitated over the next seven months, to the point where she spent five days in an independent-living unit, a fully contained flat at the end of the ward. Although the nurses had been available by pressing an alarm, Wendy had not needed to call them at all. Social services had found a suitable flat for her in the community, but this had provoked a sharp response from Wendy and her family. A letter from them was in the notes:

'IN KNOW WAY DO I INTEND TO MOVE AWAY FROM MY FAMILY, AS WE ARE A FAMILY UNIT ALL DECISIONS ARE MADE BETWEEN OURSELVES, WITHOUT REPEAT WITHOUT SUGGESTION FROM ANY OUTSIDE ADVISE FROM ANYONE. THIS IS OUR FINAL DECISION AND WE DO NOT WANT ANY MORE PRESSURE PUT ONTO US ON THIS SUBJECT FROM ANYONE, ANYMORE SO CALLED PRESSURE WILL BE REGARDED HAS HARASSMENT AND WILL BE TREATED AS SUCH, WITH THE POSSIBLE INTERVENTION OF LEGAL ADVICE/ACTION." *(sic.)*

It was signed 'Miss Wendy Fineman and family', with an added note:

'MY DAD DONE THIS LETTER NOT ME, SO WE WILL STAY WITH WHAT IT SAYS. WENDY.'

This confirmed my impression that Wendy was not very satisfied with her treatment in the hands of doctors, but left me a little bemused as to the relationship with her parents. Did she really want to stay with them? Or was she being pressured by them to sign a letter, when she would rather have moved out?

The registrar arrived, a brisk and efficient Australian neurologist: I presented the case-history to him. He was not very impressed with my examination findings; 'The sensory loss is impossible to prove, and she could be faking some of the paralysis.' He even asked me to try to mimic clonus as he examined my leg, in an attempt to show that Wendy might have been inventing it. His attitude to Wendy was aggressive; in her absence, he referred ot her as 'the mad woman', and in her presence, he would threaten her with injections of heparin unless she started trying to walk. I suppose that heparin would be a sensible precautionary measure to prevent deep vein thrombosis, but I felt uncomfortable with the way in which it was used to blackmail her.

Subsequent visits to Wendy on the ward-round had the atmosphere of a military intelligence mission more than of a medical consultation. The aim seemed to be to catch her out, rather than to reassure and sympathise. Wendy said she was having trouble in drinking, but the nurses reported that she had been drinking well. Wendy said she dould hardly move, but the nurses had seen her transferring from her bed to her chair without assistance. Wendy could not flex her wrist, but when her arm was supinated, the wrist did not passively extend with gravity. However, it was acknowledged that she did have a few 'real' signs – such as her left corneal reflex being under-reactive.

Over the next few days, Wendy started to try walking, at first needing support from two people, and gradually walking a little further, with a little less support. I would always try to be positive and encourage her when I passed by on the ward. The registrar attributed her improvement to his threats of heparin injections. 'After all, her legs had got better, but her arm had not.'

Wendy repeatedly said that she wanted to be 'put to sleep', so a psychiatrist was summoned. He identified her main problems as anger and frustration, not depression. Her threats of self-harm were intended to persuade people to give her better treatments for her illness. She had told me that she had heard of the new drug for multiple sclerosis (*beta*-interferon) and wanted to try it.

The psychiatrist felt that her present symptoms were probably due to hyperventilation and possibly *globus hystericus* – she had in the past suffered from anxiety in public places such as the supermarket and even in hospital. Unfortunately she resisted any psychological treatments, wanting only to be given medicines. She wanted to go back on to antidepressant medication, although it had not helped much in the past.

I met Wendy's familiy that Sunday when they came to visit her. The registrar had told me that they were all unwell, and that there must be something wrong with their psychological coping mechanisms. Her father was in a wheelchair, apparently because he had sustained an injury to his cervical spine at work. Her mother was very obese, and suffered from late-onset diabetes. It reassured her to have Wendy at home, because Wendy knew what to do in the event of a diabetic crisis. Also present was Wendy's little Goddaughter, who she said 'kept her going.' A sweet little girl of six or seven, she obviously enjoyed the attentino she got from Wendy. The family were polite, but seemed frustrated that more was not being done. Wendy seemed to echo their views when she told me, 'If I'm not ill, why am I in here? No one's doing anything for me.'

The next day, a review had been planned for Wendy at the rehabilitation centre, to which she was invited to attend, but she refused because she feared it would all end in an argument. Wendy told me how she wanted to return there and an inpatient to regain the skills she had lost, such as climbing stairs. She implied that if she was sent home, she might take an overdose.

The review ruled that she should not return as an inpatient, but that her care package should be reinstated. Over the next few days, Wendy underwent several tests: an *MRI-scan, and visual and sensory evoked potentials, all of*

which turned out to be normal. As she had started to walk around the ward with a stick, she became keen to go home – more because she felt that nothing much was being done, rather than through any feeling of having got better. She left about two weeks after she had been admitted.

Reflexion

As will have become clear from the above exposition, my relationship with Wendy was not an easy one. On the one hand, she was 'my' patient, and I felt that I should try to support her and act in her interest. On the other, I felt it difficult to betray my loyalty to the medical team to which I was attached, and to whom I felt a duty of respect.

I wanted to sympathise with Wendy, but not to appear critical of her doctors, or to give her false hope. I wanted to plead Wendy's case to the neurologists, that she should be helped with a wheel-chair or stair-lift, or with admission to the rehabilitation centre. But I did not want to appear to be challenging their more experienced opinion. I felt especially uneasy, and muted, when Wendy was referred to flippantly as 'the mad woman'. Perhaps Wendy was transferring some of her frustration to the doctors, and they in turn were transmitting their frustration to me.

I was not sure whether Wendy's emotional problems were a reaction to her disease, or whether they were caused by it. Multiple sclerosis is known to cause euphoria and pathological laughing and weeping, and the associated depression is expressed more through anger and irritability than through withdrawal and apathy (Minden, 1990). Either directly or indirectly, it seemed to me that Wendy's multiple sclerosis was responsible for a lot of her bad feelings.

Conversely, her beliefs and emotions must have contributed to her relapse, since there was no identifiable physical pathology shown by the latest set of investigations. There was a dilemma in my mind as to how best to proceed. Would it be wrong to concede to her demands for a wheelciar and stair-lift? Might it actually help to threaten her with heparin injections unless she tried to walk? Would it be counter-productive to give her *beta*-interferon?

Wendy was obviously very resistant to the notion that her mind could be contributing to her symptoms. The doctors attributed this lack of insight to a 'low level of intelligence'. It seemed to me that a low level of communication ability from medical team might have been just as important. Although the notes seemed to say that she had been fully informed, she clearly felt confused and neglected. It may have paid off to spend a little time exploring what she saw as her major problems, and to find out about the stresses in her life which may have precipitated the relapse. This approach would have been more in line with Balint's technique (Pavesi, 1972). Positive assurance and encouragement seem a more humane way to practice medicine, rather than blackmail and threats.

Action

I was uniquely lucky to have been granted a place at the Oxford Balint Weekend just a week after Wendy's admission. I had the great privilege of meeting and talking with many doctors experienced in dealing with the psychological aspects of medicine. I was accepted as an equal in a Balint discussion-group, and had the opportunity to present Wendy's case-history. It helped me to share my feelings about this difficult case, and simply to hear other people's reactions.

In the discussion there emerged many aspects of the case that I had not previously considered. Above all, the group was very supportive. I was assured that it was not abnormal to feel sympathy for Wendy. One group member told us about a friend of hers, also suffering from multiple sclerosis. Wendy was justified in feeling angry and frustrated to have such a nasty disease at such a young age.

The end result was a strategy for me to approach the doctors at the next ward round. I spoke up in Wendy's favour, asking why could she not be given some of the support that she was requesting. I think I was seen as niaive. I cannot have made any great impact on Wendy's management, but at least I had made a statement in her support. I would like to think that this resulted in a slightly less negative attitude towards her during her second week in hospital. Certainly the 'spying' seemed to cease.

A few weeks later, I had the opportunity to visit the rehabilitation centre, and to be taught by the doctors there, who knew Wendy very well. He told us that upto 10% of patients labelled with 'multiple sclorisis' are misdiagnosed, and are suffering from a psychological illness. In Wendy's case, her 'relapses' had mostly lasted less than a week, which is too short-lived to be attributable to physical pathology, as was their frequency, according to this doctor. They were more a response to external events, such as worry about her father's illness, or fear of discharge from the rehabilitation centre. The best approach was to increase the benefits of being well, and to decrease the benefits of illness. Wendy would have probably suffered more from the side-effects of *beta*-interferon (Consumers' Association, 1998), than she would have gained by taking it. Giving Wendy a wheelchair would have decreased her motivation to walk. The greatest difficulty was to get all the professionals treating her to adopt a consistent behavioural approach.

Epilogue

It is over a year ago since I saw Wendy, although I remember our encounter as if it had been yesterday. Out of curiosity, I looked up her medical notes to find out what had happened since. About a month after leaving the neurology ward, she was admitted to the Chest Unit, again with shortness of breath and difficulty in swallowing. She was treated with nebulisers, which helped her. The rehabilitation centre decided to decrease their involvement with her. This strategy was to avoid

hospital admission, and also to avoid psychological treatment because Wendy did not agree with this approach. To this end, Wendy was given a set of instructions to follow, in order to recover quickly from her 'relapses'. After this, she had no more admissions for her multiple sclerosis.

However, she had four admissions for 'asthma attacks', which improved quickly on nebulisers. Her attacks seemed more akin to hyperventilation than airway obstruction, although her peak-flow readings did decrease on one occasion. She had also made her way back to the neurology ward with convulsions, which after a week, were diagnosed as pseudo-seizures. It seems to me that Wendy feels a need for help and attention which her immediate family cannot give her. She also finds it difficult to accept that her illness cannot he cured completely. Perhaps as a result of this, she subconsciously finds ways of receiving medical attention.

In the same way that Wendy finds it difficult to accept that medicine cannot cure her multiple sclerosis, I found it difficult to acknowledge that there are certain patients whose psychosomatic symptoms do not respond to psychological and social approaches. Yet in patients with multiple sclerosis, it seems that those with no significant disease activity at the biological level are least likely to improve, whatever strategy is employed (Schiffer, 1987). About 50% of patients with hyperventilation do not return to see their doctor after he has tried a psychological approach, possibly because of their difficulty in experiencing feelings (Zalidis, 1994). Simply being able to air my thoughts in the Balint-group empowered me to speak to the doctors managing Wendy, and helped me to deal with my own frustration.

Although it may never be possible to cure everyone, there is always scope for improvement. I do not think that Wendy received optimal care in terms of communication and psychological support. The strategy she was given for coping with relapses was very successful, but not all doctors are as skilled as her rehabilitation consultant in providing such strategies. It seems that a similar approach might have helped her to cope with her hyperventilation.

My experience of the relationship with Wendy and her doctors convinces me of the need for Balint-groups within the hospital setting. These should encompass all members of the team – doctors, nurses, physiotherapists, occupational therapists, social workers and even medical students. All should have an equal footing, and be able to express their concerns freely. This would be a learning experience for all concerned, and would result in a more consistent approach to difficult patients. Although Balint-groups have been mainly used in general practice, they have also been tried successfully in the hospital setting (Pavesi, 1972).

For students especially, I think it would be valuable to have a separate group to discuss their patients with people who do not know them. This is important because students may feel uneasy expressing their opinions in from of more highly qualified and experienced colleagues. Such groups work especially well if attendance is voluntary, so that only interested students would participate. However, this could be seen as 'preaching to the converted'; only about 10% of students attend (Luban-Plozza, 1979). It may be that few students would understand what was involved if they had not previously seen an experienced Balint-group in action, as I had the privilege to do. I think all medical students should have the opportunity to observe at least one such case-discussion, either live or on video, in the course of their training. This might get more people interested, and give students an idea of what they are supposed to do when they have the chance to participate in a Balint-group.

Emotional and psychological problems occur in a large proportion of medical patients (Feldman and Morrison, 1979), and they contribute to disabilities, for example, like those resulting from neurological disease (Wade, 1996). Yet as their training progresses, medical students lose interest in treating emotional problems and become less empathetic (Brock, *et al,* 1992).

I certainly found that my experience of taking part in a Balint-group revealed to me a whole new facet of the art of medicine, quite different from our standard teaching, but deeply interesting and rewarding.

If all medical students were to benefit from a similar experience, the future might see a generation of doctors better at recognising and more interested in treating the underlying psychological factors in disease.

This could well be the best way of making the care of patients with emotional difficulties more humane and effective.

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Balint-work in Germany*

Heide Otten
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I was very happy to be invited to speak to the Balint Society in London, where Michael Balint started his influential work with Balint-groups. The London groups were the pioneers.

When his book, *The doctor, his patient and the illness* (*Balint 1957*), was translated into German, the interest in his work grew fast in the German speaking countries. First of all it was the Swiss doctors who came to London to hear more about this method and to meet Michael Balint himself. They then invited him to come to Sils-Maria, a picturesque little town in the Swiss mountains, where Friedrich Nietzsche started to develop his philosophy.

Balint demonstrated his work and many doctors came to watch and listen to him. Following the development of his seminars, or Balint-groups, he created what has become known as the 'fish-bowl group', with up to twelve doctors sitting in the inner circle, the others sitting around, listening to their discussion.

The development of Balint-groups in German was remarkable, and widespread, and the method was soon used an an instrument for the education of all doctors, especially general practitioners who have to be members of a Balint-group for a certain time before they start in their own practices.

The German Balint Society was founded in 1974, and the first workshop took place in a little village in the Harz mountains called Hahnenklee. The Swiss doctors who had worked with Michael Balint came to help with leading Balint-groups as he had led them in Sils-Maria. One hundred German doctors came to this first workshop, and the interest has grown quickly since then.

Our Balint Society became a member of the International Balint Federation in 1976. At the same time the German Democratic Republic introduced the Balint method to family doctors. They established a good relationship between the Societies of General Practitioners and the Psychotherapists. Contact between the DDR doctors and those who had worked with Michael Balint increased when they met at the International Congresses in Dresden (1984), Budapest (1986) and Erfurt (1987). The two German Balint Societies became one in 1990, which was a very important step in the development of productive teamwork. Nowadays there are about one thousand members in the German Balint Society, four hundred of them are Balint-group-leaders, and the groups are widely scattered throughout the whole of Germany. About 700 doctors and students participate in some nineteen weekend-workshops, which we organize every year.

When I was a young general practitioner in a little village close to Köln, I went to a psychotherapeutic congress in Lübeck, because I felt that I had learned a lot about diagnosis and therapy in the university, but not how to handle the patient. If the patient had been a bicycle to be repaired, I would have been a good bicycle-doctor, but there were difficulties which I had not expected. When patients told me their life-story, I felt that it might have something to do with their illness. But I could not figure out how to handle it. I felt overloaded and I grew eager to find out what was going on in the relationship between my patients and myself. At this congress, I met Professor Werner Stucke, who invited me to go to his Balint-group. Not knowing what to expect, I went and was overwhelmed, but it was fun and very interesting at the same time. I love to use my fantasy and my empathy, both asked for in this method. I joined an ongoing group in 1979, and am still a member of this Balint-group which goes on, although our group-leader, Professer Stucke died two years ago. I would not want to miss this exchange with my colleagues, who by now are also friends.

In Germany the medical student's first 'patient' is the dead body in Anatomy. There he learns how to handle the 'material human being'. At first, the student is interested in the life story of his 'patient'; after a while he takes the body as a scientific specimen, where he has to learn the facts about its structure.

During their studies, the future doctors change their attitudes: At first they are motivated in an idealistic way, they want to help people who suffer. But preclinical teachers often emphasise a scientific perspective, and the students are left alone with emotionally demanding situations. So at the end of the medical school one finds an increase in cynicism and a reduction of idealistic, humanitarian attitudes. Students seem to be pressured into adopting a more rational position without their emotional involvement.

But we cannot kill our emotions, we can only ignore or repress them as a defence. As we all know, this can lead to illness and further suffering. Instead of ignoring the emotions we need to find out and talk about them. We learn how to use them as an instrument. That is what we do in Balint-groups.

Professor Boris Luban-Plozza (Switzerland) popularised student Balint-groups, which he called junior-groups. Students learn from the beginning to deal with their own feelings and to become aware of the personality of the patient, not only of his body and his illness. Luban-Plozza suggested an annual Balint prize, for the student who wrote the best essay describing the patient/student inter-action. Last year, the second prize was shared by two British medical students (Clark, 1997; Kay, 1997). A collection of the best student reports of the last 20 years was published

* Address given to the British Balint Society, in April 1998.

in German last year. We hope that it will be translated into English soon.

Today, there are many student-groups at medical schools all over Germany, and we try to include students and young doctors in our ongoing groups or weekend-workshops. This is an enriching experience for everybody. We learn from each other. And those young colleagues remember Balint-work later on when they work all alone in their own office, and whenever they feel that they need help or want to know more about the psychosomatic background of their patients' diseases.

Balint groups in Germany usually consist of 8 to 12 members, who are medical doctors from a variety of specialist trainings. There are general practitioners, gynaecologists, paediatricians, psychiatrists, ophthalmologists, and so on, in the groups. They may work in their own office or in a hospital or elsewhere. So we get an interesting mixture. Being a general practitioner and psychotherapist myself I always learn a lot about modern diagnosis and therapy from the specialists, besides the psychosomatic point of view. Michael Balint himself did not want the psychiatrists to take part in his groups, because he did not think that students would get anything out of it. We have the experience that they do not disturb, but enrich our work, and that they receive great benefit themselves.

Of course Balint's ideas have to be further developed in line with new demands. He began the groups with his aim of 'training-cum-research'. In the recent years in Germany we pointed out that Balint-groups are wonderful for training doctors in the first place, and provide help for them for their own 'psychohygiene' – as we call it – in the second place. We seem to have forgotten about research.

But lately, there has been renewed interest in research on Balint work. One of the reasons is that we have to present evidence of quality and effect to political committees, who decide about the content and funding of education.

In research we posed the question whether and how there is a change in doctor/patient relationship which makes treatment more effective, and a change in the personality of the doctor, for his own benefit. We think that a doctor has an effect on the patient almost like a drug. He can see and use this effect in therapy. The treatment will be more personality orientated and not only illness orientated, which means that the doctor does not only see the defective body but the ill person as a whole. Members of Balint groups verify that they have a more holistic view of the patient after having attended several group sessions than before. And they feel more competent in psychosomatic medicine. Self assessment shows that doctors think that they are more aware of the true needs of the patients, that they listen more carefully and understand better. This gives both the doctor and the patient a satisfying experience. Therapy is more effective and less expensive. K. Kohle and R. Obliers from the University of Köln began some research in 1993 about the *Development of the doctor's form of dialogue with the patient after one year of Balint-group-participation.*

They explored video-taped first interviews in general practice consultations before, and one year after, Balint-work. The hypothesis was that the doctor gains the ability during Balint-work to notice and analyse his personal feelings and his reactions to the patients' behaviour and to reflect on his relationship to the patient. When he is more orientated to the person than to the illness, they anticipated a discourse, which demonstrates this. They explored the dialogue to discover the linguistic and communicative differences.

I want to give one example of the very interesting studies: they counted the number of words between doctor and patient. Before having attended a Balint group, doctors speak 43%, patients 57% of the words in a consultation. After one year of Balint work, doctors use 27% of the words and the patient 73%. That means that the doctor gives more room to the patient's explanations; he is able to listen, he gets to know more about the sick person, instead of 'talking him down'. He is able to follow the patient's thoughts and gets an idea of the patient's fears, hopes and imaginations. There is less misunderstanding. The doctor does not need more time, but gets more information. He shows as much interest in the somatic disorders as before. Balint postulated that through this special group-work there will be 'a limited but important change in the personality of the doctor'. Maybe research can prove that he is right.

We, as Balint doctors, notice this change. And I think this is one of the most important reasons why this kind of postgraduate medical education has spread over the whole world. In the International Federation there are almost 40 countries as members. There might be slight differences in the way of leading and structuring the groups, but we arrive at similar results.

In Germany we have different kinds of groups, varying in the times to meet and the composition of members. There are groups which meet every week or fortnight for one case, which takes 11/2 hour. Other get together once a month for two or four sessions, or even four times a year for a whole weekend, which means that you spend a lot of time together, working, eating, going for a walk or having discussions in the evening. Of course that creates a special atmosphere and people get to know each other very well.

I am leading five different types of groups at the moment:

1. A student-group at the Medical School in Hanover – meet 6 times each semester.
2. A group of psychiatrists in a psychiatric clinic nearby – they meet every fortnight.
3. A mixed group – getting together on Saturdays for four sessions from 10 a.m. to 6 p.m. once a month.
4. A group of young doctors who are training in

order to specialise as general practitioners – they have to attend 15 group-sessions.
5. Various mixed groups on our weekend-workshops.

I would like to give you an idea of what is going on in the different groups:

1. A male student gives a description of a meeting with a young female patient, whom he met in the clinic in internal medicine, where he worked during his practical studies. He had to take the history and to take blood from her for analysis. He liked talking to her and started to flirt. She responded. When they said 'Goodbye', he gave her his phone number. He felt uneasy afterwards. But he admitted that he had no girl friend at that time and was open to a new experience. In the afternoon he had some free time and went into the room to exercise. He was surprised and shocked when he found the young lady lying on the bed, dressed in nothing but a pair of panties. He had not expected her to be still in the clinic. For a second he thought he would run away, but instead he tried to play the role of a scientific doctor, who started a check-up and was interested in her kidneys, her liver and so on. His hands were shaking, his heart was beating loudly, his face was red all over. He felt very uncomfortable.

   He was ashamed to talk about this situation and he expected the group to condemn him. His question was: 'Can I ever meet her again as a treating doctor? How can I save the student-patient relationship?' The group were very emphatic. Some of them admitted that they sometimes felt an erotic response to patients and that they also did not know how to deal with it. Several ideas were brought up. They were thankful to be able to talk openly about those 'forbidden' feelings. Some admired the presenter for his courage in bringing this problem. They felt relieved.
2. A member of the Balint-group in the psychiatric clinic presents a case: a colleague refers him a man in his fifties who seemed to be restless and suicidal. The man comes to the clinic and talks breathlessly about his fears and sorrows. He has a young wife, who quarrels a lot with him. She wants more activities like going out, meeting friends and so on. He prefers to stay home. But he is afraid that she will leave him and points out that he cannot live without her. The doctor suggests continuing the consultation with him and his wife. He phones her. She agrees and comes to the clinic. The man feels a lot better when she is there. And she is happy to be able to talk about what is embarrassing her. So far nobody has been really interested in her complaints and problems. The doctor is listening, full of empathy. The husband is relaxed and no longer under stress. He wants to go home, and suggests to his wife that she should come back and talk to the psychiatrist. She agrees and makes the next appointment. The doctor feels 'run over'. On one hand he is angry about the situation, on the other hand he feels he should help. The question to the group is: 'How will I face her at the next meeting?'

   Fantasies arise about what has happened. Anger comes up against the husband, who presents his wife like a broken car, which needs repair. It becomes clear that the presenter is angry on one hand, but proud on the other, that he was the 'better man' for this young lady. He had just listened, and she told him more than she had ever told her husband. After a while he recognised that he was in a similar situation to that when he was with his own parents: his mother used to tell him all her thoughts, her problems and sorrows, especially when his father had gone. Suddenly he understood what made him angry. He was sure that he did not want to start psychotherapy with this woman but would refer her to a colleague.
3. A dermatologist in the mixed group reports on an old lady who came to the clinic because of an itching eczema. Nobody could find a cause, although many investigations had been made. So they thought it might be psychosomatic. The colleague started to ask for her life story. She told him that she was half Jewish and talked about her difficulties during the Third Reich and the sufferings of her family. The young doctor was very impressed, because it was the first time in his life that he met a Jewish person who had been involved in this part of German history. He was not very much interested in her present life and hardly asked her what had happened before she developed the eczema. They had several sessions, where the doctor listened fascinated to the patient's account. He felt guilty as a 'grandson' of the Nazis; he was ashamed, and felt responsible for reparation. He was stuck with some unpleasant feelings. His question to the group was: 'What can I do for her?'

   The group was not as much impressed by her early history. They wanted to know more about her life after the war and especially in recent years. We learned that the old lady lived together with her daughter, who was a lawyer and had a little son. The patient had lots of quarrels with her, nothing was right, she felt she was 'the victim' everywhere, nobody seemed to be able to please her. In her eyes the whole world had done her wrong, her husband had tortured her, the children were egoistic, the grandson was a burden etc.

   The group members felt and pointed out, that all these complaints, and the itching eczema were an expression of her aggression. She made the others feel guilty. She was full of rage and hatred, which she was not able to express other than by scratching her skin and complaining. And the young doctor, who saw her only as a victim had been 'blocked'. In the next Balint session he reported that he had a much better feeling when he talked to the patient again. He was more relaxed and able to

bring up critical questions without fearing her anger or her condemnation.

So there are some examples.

Now, what is the group-leader good for? In our *International Guidelines for Accreditation of Balint Leaders* it says that he or she should be able:

- to focus the work on the doctor/patient relationship rather than seek solutions
- to create a safe and free environment within the group
- to create a learning environment rather than resort to didactic teaching.

Good leaders do not talk much themselves, they encourage the group-members to develop their thoughts and fantasies and feelings. Nothing is wrong, nothing is dumb, everything is enlightening. The more the leader is able to create an accepting and free atmosphere, the more aspects we get for the presenter of the case. The leader guides the group members by posing questions or giving a short summary or pointing out feelings or fantasies; always leading back to the doctor-patient-relationship. Special attention has to be with the presenter and their feelings, the leader has to protect the presenter from being hurt by attacks or the more knowledgeable colleagues who tend to give advice.

Balint-leaders in Germany have to go through a special training before they may form their own groups. In the first place they have to be psychotherapists or psychoanalysts, medical doctors, or psychologists, and they have to have group experience. They must have been members and co-leaders in a Balint group for a long time themselves. The German Balint society offers workshops to train the leaders. Usually there are 24 members in a training group, 12 are working as a normal Balint-group, the others are supervising together with the trainer. One of the trainees leads the group, another one is co-leader. They stop the group work after one hour and analyse and discuss what was going on in the group process and how the leader dealt with it. When the leader has finished this training he or she can go out in 'the country' and start their own Balint-group for his colleagues in the region.

The group consists of 8 to 12 medical doctors. One of them presents a case. He does not use any medical notes, he just tells the group what he remembers. Mostly this takes about 10 to 20 minutes. Afterwards the others may ask him questions. Then the leader tells him to lean back and relax and listen to what the group-members feel and think about the doctor/patient relationship.

Whatever one fantasises helps. Pictures are drawn, fairy tales come up, symbols are used. The patient may appear as a lion, the doctor as a mouse. Or the members of the patient's family are seen as trees. Nothing can really be wrong. As Balint said: 'Think freely' and 'Have the courage of your own stupidity'.

The case presenter can look at what is going on from a distance. He will find new aspects, he might see his blind spot, which made it difficult to get along with his patient. Sometimes he may think that some thoughts and fantasies are crazy and far away from truth. The group is like a mirror or magnifying glass, which shows a complex picture of the person and the relationship between them. Sometimes during the session the presenter has a sudden 'Aha!' experience, sometimes he reports to the next meeting that the patient was quite different when he saw him again. The communication becomes easier and the compliance better. The doctor and the patient feel relieved. The feedback is a valuable ingredient of the continuous groups.

Let me give you an example:

A young general practitioner, working in his own office for four years, presents a case in his Balint-group. They have known him for five years as a calm and humorous colleague. This time he seems to be under pressure. He talks about a patient, a young man around his own age, who works with computers. He comes to the doctor quite often, complaining about headaches and stomach-problems. He just wants medicine, nothing else. But none of the pills help him. He gets more and more angry, does not want to wait, quarrels with the nurses and is impatient. The doctor tries to satisfy him, gives him more of his time, talks to him, offers him the best medicine, but without success. His question to the group is: 'What else can I do?'

The group members react with anger and lack of comprehension; and then with astonishment: 'Why does the doctor feel under such pressure? Does the patient transfer his own stress to the doctor?' He makes the doctor suffer like he suffers in his life.

Suddenly the presenter of the case understands what is going on and feels empathy with the patient. He is then able to react in a different way. Now he has new ideas how to handle the situation and how to get along with this young ambitious man, who always had to be the best. Next session he told the group that the patient was able to transfer his goal: 'I always have to be the best' into another: 'I have to find out what is best for me'. The relationship became much more relaxed and the treatment successful.

Enlightenment and mind-expansion help us to find a way out of a dead-end-road and save our energy.

Besides the necessity of continuing education in our work as general practitioners, the Balint-group members notice the benefits obtained for ourselves. Other professional groups came to know Balint-work and started to use it, such as nurses, social workers, judges, teachers, priests and so on.

When you want to feel what Balint-work does for you, try it!

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The doctor's trauma – or how one doctor became de-skilled

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Recently with the help of a LIZEI award*, I was leading a new Balint-group of young local general practitioners who had been bothered by 'heartsink' cases and chose to look at them. These were defined arbitrarily as any patient whose very name strikes fear and trepidation into the general practitioner's heart from a distance. It soon became apparent that some doctors could be de-skilled or even overwhelmed by the intensity of their 'heartsink' patients' demands, although many doctors would deny this; and the various defence mechanisms that the doctors displayed were not always sufficient to protect themselves.

One of the first assumptions that was tested in the group was that doctors were tough and could always be relied upon to find some basic defences even in the most trying of relationships and never failed to survive. I would like to present this case as an unusual example of survival technique.

One of the most difficult situations that any doctor has to face is the patient in acute distress. Red-hot feelings and raw emotions erupt to provide a challenge to medical education, which cannot prepare students for every distressing encounter that they might meet in the future. Where the patient is confronted by a new unexpected stress it can rapidly lead to a profound emotional disturbance (especially when it collides with an unresolved problem in the doctor). The following unique presentation was made of an ordinary patient who was well-liked by her general practitioner, which was not typical of our 'heartsink' cases. She was faced with an overwhelming conflict, which she revealed in a most bizarre manner.

The Doctor

Margaret has been in practice for ten years and is one of the very good doctors in our Balint-group who was bursting with an overload of distress at our last meeting. She has a large inner-city practice, and many of her patients have been abused as children, and she is very caring and attentive towards them and will take them on for long interviews and counselling. She arrived at the Balint-group late and had to wait after another case presentation to tell us she was bursting with a 'quickie' about her struggles that morning.

The Patient

'During the morning surgery the police rang to say that one of my patients whom I know well had had her hands and feet chopped off by her spouse with a machete and could I come to the police station to make a statement later. While my head was still bursting with this news, an extra patient was fitted in who was a theatre nurse, aged 40, whom I had known for ten years and liked. She started to talk once again about her father who had abused her physically and sexually when she was young but who was no in hospital dying of cancer. The rest of her family were full of pity but were too busy, and expected her to nurse him through his impending death. She had had 18 months of psychotherapy but the therapist had now gone and left her confused. She was full of unresolved anger and grief at what her father had done to her in the past and for which he had never apologised; and about whether she could bring herself to approach him to care for him, having had nothing to do with him for many years.

She went to see him in hospital with some doubts and eventually asked him whether he felt sorry for what he had done to her all those years ago. But he said 'you enjoyed it and willingly took part', as if she had entrapped him, and she came away feeling awfully sick.

The doctor tried hard to listen, but could not devote her normal attention to the patient and her distress and asked the theatre nurse to come back when she had more time. The patient begged her to stay 'please hold me – no-one else will', and reluctantly she held her hand. But the patient refused to go and went on moaning about the abuse and crying how awful her father had been to her, and that her mother (and the rest of her family) had never listened or known about it, nor defended her. She could not be mollified and was angry and demanded the doctor 'do something'. Then she became dizzy and faint and lay down on the floor crying behind the door and would not get up. The doctor was puzzled and surprised by this unexpected drama, as they had discussed the abuse several times before in the past without any misgivings. Now she felt confused and unable to help her patient and kept looking at her watch and remembered she had to leave to go on her visits.

She felt somewhat embarrassed and went next door to the practice nurse and asked her to help lift the woman and eventually left the practice to do her visits feeling guilty while the nurse gave her coffee in her room'.

The Group

Margaret gave a dramatic description of the patient and her feelings but was unable to work the matter out clearly. There was an animated discussion of the case by the group and they

agreed that the doctor had brought a vivid impression of the horror of the patient's problem; and on reflection we all 'caught the panic' in the doctor and were sympathetic to her; but like her, they were stopped in their tracks by the patient's outburst and were not very much help, perhaps partly because they were all new to Balint-work. Interestingly, the group avoided discussing the first case of the woman who had her hands chopped off, as a form of denial or suppression of stress.

Analysis

Eventually the Leader interpreted that the patient was treating the doctor (mistakenly) as if she were her mother who had not listened; that she was re-living her childhood in the consulting room and that she was angry with her mother (the doctor) for not noticing what was going on in front of her eyes and could not forgive her for not listening to her cries for help, and defending her daughter against those terrible assaults from her father.

When Margaret would not or could not understand her feeling of pent-up frustration and what it meant to her, the patient blew up and acted out her rage and helplessness on the doctor. She acted as if she fully believed the doctor was her mother who had caused her 'illness' via what is known as a 'transference reaction'. It appears that she saw the doctor as a 'wolf in sheep's clothing'. Someone who acts nicely, but underneath the facade is just as bad as her parents.

Transference

The patient was driven to act out her feelings of rage and helplessness on her 'mother' (the doctor) unconsciously, by way of mounting frustration and revenge. This regressive response was not prompted by any deliberate action of the doctor, who was floating along on a tidal wave of the patient's feelings of helplessness and rage, which submerged and de-skilled the doctor professionally in a domino effect. Margaret was clearly unable to understand what was happening to herself and her patient, nor to respond appropriately – and beyond the doctor, this had an identical effect on the group who were also sterilised by this patient and who could not think of any new ideas. The doctor felt compelled to withdraw to survive and find breathing space in order to regain her normal composure; until she found a new improved defensive solution to supplant the old.

Margaret said that she was unable to be as attentive to the second patient as she normally was, because of her shock at the news from the police about the first patient, which had dented her usual capacity to empathise. It was this lack of emotional availability which would have precipitated the strong transference reaction because it was a repetition of the nurse's experience with her own family – thus the first patient was an important element in the full story.

Helplessness

The normal defences that maintain the internal milieu in status quo, have been penetrated by the patient's helplessness and rage in a 'transference projection' into the doctor (and via her, to the group) in an intolerable dose. The doctor's ultimate nameless fear is that the traumatic state of helplessness in which she is placed will be completely over-run, and the danger is that the anxiety and unpleasure will get spirally worse or never stop. A new balance needs to be found for herself of conscious, thoughts and ideas that are positively constructive and therapeutic against those that need to be denied.

Enactments – or acting-out like this, involve the doctor as participant, caught up in the relationship; rather than alongside it; vulnerable to her own feelings, and susceptible to blind spots. There is a hidden danger that she may act out her feelings of revenge on the patient, which would be totally unprofessional. Afterwards, when the penny dropped and Margaret realised she was not the target of the patient's private paranoia she became much more relaxed like her old self and rejoined the group.

Defences

After the twin assaults on her defences, first by the machete-attack and then by the emotionally-disturbed nurse it is not surprising that her defences were affected by this 'double whammy'. That of course does not alter the fact that it is part of our professional burden to bear the pain of our patients' suffering to a greater or lesser degree. The doctor's own defences against distress and helplessness are a key background influence on her care and treatment of her patients; more than she would care to admit or is aware of, which can modulate her sensitivity to listen to the patient's complaints and affect her report to the group.

Personal World

Here I think that we are entering a new world beyond the boundary of the doctor's knowledge and experience of physical medicine and into the doctor's personal life; which is a private area upon which we would not normally dare to intrude. Margaret is reticent and hardly even begins to disclose her own personal feelings. The doctor's private self is not usually exposed to the light of day in Balint-groups. Although she knows and trusts the Leaders and the members of the group to use their discretion to protect the presenter from over-exposure, she is still defensive about her own role and she can hardly bear to reach out to hold the patient's hand and empathise with her. The doctor wanted to help the theatre nurse with her overwhelming needs and feelings, as she was an extra patient fitted-in when the doctor was already running late, but at the same time the doctor needed to escape and protect herself. The time pressure, this mounting

sense of urgency, and the need to rescue the patient, while protecting people's vulnerabilities were all acted out in the group. While it is only with experience and careful understanding of the doctor/patient relationship and her personal defences, that the Leader can make a proper interpretation in this case. And yet without this deeper understanding of the doctor's own feelings the group would be unable to make any headway in this case.

Question

The crucial question is whether any general practitioner would recognise the unconscious mind at work here in the 'transference projection' that stopped Margaret in her tracks and in the process de-skilled her and the group? In fact, I do not think many general practitioners would have recognised this mental mechanism at work without considerable experience in Balint-groups etc, and would probably have referred this case to a counsellor. This case marked a turning point in the group's development and ability to listen and focus on the patient's complaint. Training in a Balint-group may be helpful in fine-tuning the threshold of the doctor's personal sense organs to recognise feelings as clinical signs.

De-Skilling

In medical education today, doctors are not encouraged to notice or recognise feelings, even though these are important clinical signs, of the illness. Yet as the relationship between a general practitioner and his/her patient grows stronger, there is more scope for feelings to develop within a consultation, but it is only within Balint-groups that their value is considered and commented upon. Unconscious feelings, such as the transference reactions that snookered Margaret, are almost imperceptible, rarely noticed or described in the literature. General practitioners cannot avoid dealing with unconscious feelings every day, and will recognise Margaret's case as a normal stressful, run-of-the-mill occurrence. Yet these reactions are rarely brought to their attention because they are 'soft', trivial and can easily be obscured, by the mixture of loud complaints of physical symptoms and greedy demands that patients make.

Enid Balint has said 'the doctor must endure the trauma of not being able to find an escape from the suffering he is encountering ... to endure not being helpful, without becoming rigid, closed or shut in'.[2]

Conclusion

Primarily this case shows that any doctor who is not aware of feelings will miss the clinical signals and will be unavailable and inaccessible to patients with sexual abuse, without proper training. Doctors need to be sensitive to their patients' feelings, in order that they can stand back and observe changes in the doctor/patient relationship as they develop in a transference situation.

Previously Margaret thought she understood the theatre nurse, whereas she had only brushed the surface of the case, but when she was driven by the patient towards a deeper level of feelings, she began to approach the heart of the matter. This shows that to help to make sense of the case, we need to develop a deeper understanding of the doctor's own personal thoughts and feelings, as well as the patient's.

Further, this case shows that there is an invisible domain of unconscious thoughts and feelings, that general practitioners cannot see or recognise, like a 'stealth bomber', called transference, to which we have never been formally introduced, nor taught to work with, and this is where we are de-skilled.

The message that comes across from the patient is powerful, confusing and contradictory. The one source of help that the general practitioner usually turns to for educational matters, the Royal College of General Practitioners, its library and its journal are silent. There is little advice on how to begin to recognise or explore by ourselves these hidden feelings or make some sense of them.

Unless we want to go naked into the consultation and be de-skilled by these powerful hidden emotions, and surrender to them, then we must study them in the cold light of day in all their variations and the best method is in a regular weekly Balint-group.

I would not have been able to write this paper without the total support and collaboration of my Co-Leader Adrienne Saunderson and I would like to express my sincere gratitude for her valued work with this group. Also I am grateful to the East London and City Health Authority for the grant of a LIZEI award in order to form a Balint-group.

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A History of the International Balint Federation and the International Balint Congresses: the Balint Movement in the World *

Roger van Laetham
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(with a postscript by John Salinsky)

To begin with, it is necessary to emphasise the double ambiguity, or apparent contradiction, which characterises the Balint-movement today.

On the one hand, it is a social phenomenon which is found in all parts of the world, but on other hand it remains marginal, as there is no more than a minority interest in the world of medicine. But, there is a growing contrast between its sometimes spectacular development in 'the new countries' of Eastern Europe, and the relative stagnation, and even decline in the countries where it began, in England and most of the West European countries, except Germany.

'Balint': a social phenomenon

The name, 'Balint' appeared for the first time in the Petit Larousse Dictionary in France in 1986, a sure sign of something or someone being universally recognised. Moreover, at the same time, on a political front, the International Balint Federation was officially recognised on 1st January, 1986, as a Non-Governmental Organisation by the Council of Europe, with its members from twenty-one countries.

Eventually the negotiations had advanced to the point at which recognition, and perhaps the organisation of a joint congress, was granted by the World Health Organisation. The Federation was also mentioned in the International Congress and Convention Association Bulletin, in the Yearbook of International Organisations, and in the Gale Encyclopaedia, an American reference work which is one of the most important in the world. We should also remember the translations of Balint's writings which continue to be made in many languages.

International Balint Congresses

At the time of Michael Balint's death on 31st December 1970, Dr. Philip Hopkins, president of the British Balint Society, and its Council, were in the process of organising an International Congress to celebrate his 75th birthday. This eventually took place in London, sadly without him, but as a celebration for his life and work, on 23rd to 25th March 1972.

The theme of the Congress was taken from the three topics with which his well-known book was concerned: *The Doctor, his Patient and the Illness,* each day of the meeting was devoted to one of these topics. On the day following the Congress, 26 March 1972, the first meeting of a 'Steering Committee' took place in London, to consider the international co-operation of Balint Societies.

Those present were: Mrs Enid Balint (England), Drs. J. Colet (Belgium), Kongs (Belgium) and A. Moreau (Belgium), Max Clyne (England), Philip Hopkins (England), Aaron Lask (England), M. Mayer (England) and Stephen Pasmore (England), and Drs. P. Bernachon (France), M. Dufour (France), G. Harle (France), C. Rosowsky (France), G. A. Ferrari (Italy), V. Pavesi (Italy), A. Romei-Longhena (Italy), R. Pittenger (USA), and D. Meier (Switzerland). It was decided at this meeting that an International Association of Balint Societies should be formed. This, shortly after, become the International Balint Federation whose aim was to promote and co-ordinate the growth of Balint-work all over the world.

The second Balint Congress took place in Brussels, in April 1974, and was organised by those who founded the Belgian Balint Society, shortly afterwards in May of the same year. The Congress was very successful, attracting around 700 delegates from 16 countries, meeting concurrently in more than ten rooms of the Palais du Congres, with simultaneous translation into five languages.

In June 1975, the French Balint Society, (founded in 1967) the British Society (1969), the Italian Society (1971) and the Belgian Society (1974), met together in Paris to decide on the establishment of an International Balint Federation, with Mrs Enid Balint as president, Dr. Pierre Bernachon as secretary and Dr. Roger van Laethem as treasurer.

The third International Congress was held in Paris in May 1978. The theme was: 'Specific features of Balint training'. On this occasion the (West) German Balint Society (formed in 1974) was warmly welcomed as a member society of the Federation; the Netherlands and Switzerland were admitted with observer status, the former represented by the Psychological Commission of the 'Nederlandse Huisartsen Genootschap' and the latter by the Swiss Psychosomatic Society.

The fourth Balint Congress took place in London in September 1978; this took as its theme 'Aims, Achievements and Assessment of the Balint System'. During this meeting, the Netherlands and Switzerland became full members of the Federation.

During the Federation Meeting in Ascona

* Translated by Mary Salinsky and John Salinsky.

in 1979, a new Committee was elected, consisting of Mrs Enid Balint (Britain), Honorary President: Dr. P. Bernachon (France), President; Dr. R. van Laethem (Belgium), Secretary; and Dr. V. Dubois (the Netherlands), Treasurer. For the first time the meeting welcomed observers from countries without existing Balint societies, among whom were delegates from Greece and Poland.

A further Federation meeting took place immediately following the workshop, organised to celebrate the fifth anniversary of the founding of the Belgian Balint Society. At this meeting, Balint Societies from Argentina and South Africa became members of the Federation. Preparations were also made at this meeting for the fifth Congress to be held at Cologne in Germany, at the end of October 1981. The theme was: 'The prevention of disease and unorganised illness'.

The Japanese Balint Society joined the Federation in September 1983.

The sixth Congress was held at Montreux, Switzerland in October 1984. The theme on that occasion was 'Training and changes in Balint-groups'. A new committee was chosen, consisting of president, Dr. Dufey (Switzerland); vice-president, Dr. Buttner (Germany); secretary, Dr. Roger van Laethem (Belgium), and treasurer, Dr. John Salinsky (Britain).

Two new societies, Denmark and Sweden, were granted membership of the Federation at the International Council meeting in Zurich in November 1985. Hungary became a full member in April 1986, elected as vice-Presidents. Dr. J. V. Salinsky continued as honorary treasurer, and Dr. R. van Laethem as general secretary.

At the council meeting in Hamburg in February 1990, the Finnish Balint Society became our 14th member, and organised in a small Balint congress at Helsinki, in August of that year.

At the council meeting of the Federation held during that Congress, the American Balint Society founded in Seattle in April 1990, became the 15th member, and the East German Balint Society became the 16th member of the International Federation. Negotiations continued for the formation of Balint Societies in Austria, Canada, Portugal and Spain.

The Federation also had, by this time, individual corresponding members in Spain, Portugal, Austria, Algeria, Australia, Brazil, Canada, Greece, Hong-Kong, Iceland, Israel, Luxembourg, New Zealand, Norway, Mali and Zaire in Africa, and also in Czechoslovakia, Eastern Europe and Romania.

A universal phenomenon: but a marginal and minority one

Here we put our finger on one of the primary contradictions of Balint: if the ideas inform the whole world, their fundamental application is not concretely experienced by technical or magical medicine (this is the same, but in a more evolved shape) other than by a minority of doctors and the small number of groups throughout the world can testify to that.

The development in the former Communist countries of Eastern Europe, and the stagnation in the foundation countries, is the second Balint contradiction. Two cases will serve to illustrate this proposition.

In Sweden, a small country with a little over 8 million people (fewer than in Belgium), there are today more than thirty Balint-groups and furthermore, fifteen years ago in a study which I carried out of French family doctors, the part of the budget dedicated to psychological medicine and mental health was minute.

In the Netherlands where, during the 1970s around fifteen thousand family doctors (amounting to almost a tenth of the total number of Dutch doctors) had taken part in Balint-groups, by 1986 there were only a few groups left. Dr. Dubois, who had been treasurer of the Federation, requested that the Dutch Society leave the Federation for this reason. But, and this is important, Balint's ideas are accepted everywhere and they are incorporated in other methods for teaching psychological awareness in medical education throughout the Netherlands.

The decline of Balint is much less noticeable in Belgium, Britain, France and Italy, since there are still a number of very active groups in these countries which organise well-attended study-days.

Nevertheless, there is a lack of growth there, which contrasts with the development in the former Communist states which I have called 'the New Countries'.

A noticeable exception to this, is seen in Germany. In former West Germany there were many Balint meetings, for example in Bad Nauheim, Berlin, Lubeck, Priem, Wurzburg, etc. Following unification, with the amalgamation of the thriving Balint Society in the former East, with the Western one, there are now over one thousand members in the German Balint Society. Balint-training is incorporated in all stages of basic and postgraduate medical education and there is a weekend course in a different centre every month of the year.

Is this success due to the fact that Balint-training is not only part of the medical curriculum (note the remarkable work of German medical students during Ascona meetings), or as much to the fact that their method of training psychotherapists, can be combined with education for family doctors, without having to develop a separate specialism? The issue is worth considering.

The Swiss also constitute a special case: there is no national Swiss Balint Society, but the work is carried on through the Swiss Psychosomatic Society which organises occasional Balint-training sessions; for example, the workshops at Sils, the study-days at Annecy and the meetings at Ascona. There are many Balint-groups which use other psychological education models in addition, such as the systemic method.

Dr. Salinsky has described a somewhat

similar situation in Britain. He comments that in Britain, Balint-work is regarded, with a few exceptions, with considerable respect, but other, more 'up-to-date' methods such as video-recording patient-consultations with their doctors, for later study and discussion, are often preferred. There is no financial incentive to form Balint-groups, nor to take part in Balint-training. In Britain (with the exception of those at the Tavistock Clinic, where Balint-work is still carried on), there seems to be a shortage of psychoanalysts who are interested in family medicine.

Conclusion

Finally, having looked at the development of scientific, medical education on the one hand, and the great spread of medicine in the West, it remains to be seen whether medicine in the future will become increasingly technical, or whether in contrast it will revert to the much needed emphasis on the importance of relationships.

Postscript

(In April 1993, Dr. Roger van Laethem stood down from his post as general secretary and was replaced by Dr. John Salinsky, who now continues the history of the Federation: Ed.)

In April 1993, the council of the Federation met in Aachen (Germany). Dr. Jack Norell concluded his term of office as president, and was appointed as Ambassador to the Balint Societies of Eastern Europe in recognition of the important work he was doing in his frequent supportive visits to these countries. Professor Frank Dornfest was elected as the new president of the Federation, Dr. Salinsky became general secretary and Dr. van Laethem replaced him as treasurer.

At the 7th International Congress in Stockholm in 1989, a delegation from Yugoslavia (as it then was) headed by Professor Muradif Kulenovic invited us to hold the next Congress in Zagreb in 1993 – and this was agreed. But four years later, Yugoslavia had disintegrated, Zagreb was now the capital of independent Croatia, and the war between Croatia and Serbia had only recently subsided. Nevertheless, the 8th International Congress took place in Zagreb in 1993. As a result of continuing apprehension about safety, very few people from Western Europe attended, but I am glad to say that I was one of them. The Congress was well attended by delegates from Croatia, Hungary, Romania and Slovenia, and there was some very interesting discussion about the ways in which Balint-groups could be helpful to doctors and other health professionals working with those who had suffered terrible losses in the war.

In the following year, the International Federation crossed the Atlantic Ocean for the first time. The 9th International Congress was held in Charleston, South Carolina, in November 1994. The expense of travelling prevented many people from attending and the numbers were less than 100, but those who were there rated it as one of the best Balint Conferences ever. The participation of three social scientists who were able to comment critically, but sympathetically on our work, was particularly helpful.

The 10th International Congress was mounted in Budapest by the Hungarian Michael Balint Society as a celebration of the 100th anniversary of Michael Balint's birth. It was a great success and a hugely enjoyable event.

Since then, the Federation council has continued to meet twice a year and has spent a lot of time discussing the question of training and accrediting group-leaders. This resulted in the drawing up of some International Guidelines for leader accreditation which have now been accepted by all member Societies (see page ??). Balint Societies in Croatia, Latvia, Poland, Romania, St. Petersburg (Russia), and Slovenia, have been added to the list of members.

The 11th International Balint Congress is of course, being held in Oxford, U.K., where the British Balint Society have held very popular and successful annual weekend meetings for 20 years.

The 12th Congress will be in 2001 (we are avoiding 2000 as there will be too many conferences being held already!) We do not yet know where it will be, but if you come to the General Assembly meeting of the Federation in Oxford on Sunday 13 September, we shall be discussing it. Krakow? Ljubijana? Paris? Zardar? or where? Please come and help us decide!

JOHN SALINKSY

The Story of the University of Oxford

Mary Salinsky, MA(Oxon)*

Oxford is the oldest, and in my view, the most beautiful of England's universities. It is also the third oldest in the world, after Bologna and Paris. But if the visitor asks 'Where is the university?' – there is no campus nor even a central group of buildings which can be indicated to him. Do the Colleges constitute the University? Or if they do not, what then does the University consist of? This inability to locate, or even easily to define it is illustrative of the way Oxford started and the way it has developed. For Oxford is a City as much as a University, and the two have grown up together over the past eight hundred years.

Oxford University began in the twelfth century when in 1167, the English scholars studying in Paris were required to leave. Henry II persuaded them to establish their studies in England and they chose Oxford as their site. The arrival, in a short space of time of some 1500 masters and students. None of them earned their living, and in a town of around 4000, this created tensions. Fierce conflicts broke out between the two groups, between 'town' and 'gown', leading to violence and on occasion, to deaths among both citizens and students. However after each serious riot the University appealed to the King for protection and the town was ordered to provide the University with everything they needed, at prices they could afford. One of these riots, in 1209, resulted in a group of masters and students leaving Oxford and setting up in another town, Cambridge, where they hoped, vainly, that life would be more peaceful.

The teachers at Oxford, the Masters of Arts, set up halls of residence for their students; and monasteries organised hostels for their own members (as they still do at Campion Hall and Blackfriars). All teaching was controlled and supervised by the Roman Catholic Church, and all teachers and students wore black gowns (the original of the academic gown common in all modern universities) to indicate they were clerks in holy orders.

The curriculum was similar to that at Paris, and the language of study was exclusively Latin. The basic course lasted seven years, covering first grammar, rhetoric and logic, after which the student became a Bachelor of Arts, followed by the study of arithmetic, geometry, astronomy and music, at the end of which he became a Master of Arts, with a licence to teach. Today the Oxford BA graduate needs to wait only seven years from matriculation to be awarded an MA on payment of a modest fee.

In the mid-thirteenth century, the Dominican and Franciscan friars arrived in Oxford. Their intellectually adventurous approach contributed much to Oxford's pre-eminent place among the medieval universities of Europe. Colleges began to be founded at this time, the three earliest being Balliol, Merton and University Colleges. These were secular, well-endowed establishments, and new Colleges have continued to be founded ever since. The medieval halls of residence, with one exception, St. Edmund Hall, are not the precursors of the Colleges which were all separate foundations.

The University had no buildings of its own until 1320; it used Oxford's principal parish church, St. Mary the Virgin, for its formal discussion, and for the disputations which tested students' knowledge and skill. In the fifteenth century the University acquired its first library when the collection of books belonging to Humphrey, duke of Gloucester, brother of King Henry V, was donated and a special library built to house them above the Divinity Schools building. This original home now forms the nucleus of the world renowned Bodleian Library.

Several first rank scholars worked in Oxford at this time, including Roger Bacon, the thirteenth century scientist, John Wyclif, first translator of the Bible into English, and in the fifteenth century, Erasmus, the Renaissance scholar who contributed significantly to opening Oxford to the new learning based on the re-discovery of the classics and including the study of Greek as well as Latin.

Although during the sixteenth century Reformation, two great Oxford abbeys were closed and the monks and friars forced to leave, Oxford gained as an indirect result, its largest and possibly finest college, Christ Church. The University gradually adapted to the new Protestant religion although not without martyrs on each side, with the Catholic Edmund Campion, and the Protestant Archbishop Cranmer, author of the Book of Common Prayer, both being put to death for their faith. The University ceased to be the exclusive preserve of the church and minor nobility and landed gentry began to send their sons there. In 1598, Sir Thomas Bodley, retiring from royal service, began to build additions to Duke Humphrey's original library, which had suffered depredations by extreme Protestants. The great library we see today was gradually taking shape.

In 1642, when England's Civil War divided the country between Crown and Parliament, King Charles I moved his court to Oxford and made it his military and political headquarters. War disrupted study then, as it did later in the twentieth century. However, Oliver Cromwell, ruler of England in the 1650s between the two kings Charles I and II, was also Chancellor of the University, so intellectual life recovered somewhat.

* Born, brought up and educated in Oxford.

Shortly after the return of Charles II, the first scientific institution, the Royal Society, was founded in London in 1662, from a nucleus of Oxford scientists including the chemist Robert Boyle, William Harvey, discoverer of the system of circulation of the blood, and Edmund Halley who accurately predicted the return of the comet now called after him. Charles II, like his father, brought his court to Oxford, but this time to escape the Plague. He also met Parliament here in 1681, although only peremptorily to dissolve it.

The eighteenth century was an inglorious period in the intellectual life of the University. Undergraduate numbers fell and there was little scholarship. One person who at this time did not find his stay in Oxford rewarding was the historian of the Roman Empire, Edward Gibbon, who commented that 'I spent fourteen months at Magdalen College; they proved the fourteen months the most idle and unprofitable of my whole life'.

Musically however, Oxford enjoyed visits from Handel in 1733 and from Haydn, one of whose symphonies became known as the 'Oxford' after being played here. In reaction against the general indolent atmosphere, two undergraduate brothers, John and Charles Wesley, founded the 'Holy Club' and became known as Methodists for their strict religious observance which they later preached throughout England. At this time, Oxford was refused the greatest benefaction it might ever have received; the collection of Sir Hans Sloane, which went instead to London and formed the core of the British Museum. Only two Colleges were founded in the eighteenth century, Hertford and Worcester, bringing the total to twenty-one.

The nineteenth century was, for the University as for so much of British life, a period of reform. Part of the prompting was the foundation in 1826 of London University, the first permanent university foundation in England since that at Cambridge, six hundred years earlier. Oxford was resistant to alteration and needed prodding to change. The religious requirements were abolished so that non-Anglicans could study and teach at the University. Proper written examinations were introduced, and new subjects like law, history and physical science were introduced while the older ones, Latin, Greek, Philosophy and Mathematics were reorganised.

In 1878, the first woman became a recognised undergraduate and from 1920, women received degrees. Five new colleges for women were founded in the nineteenth century.

The University was greatly affected by both world wars, losing a high proportion of undergraduates and dons. The undergraduate population fell from 1400 in 1914 to 369 in 1918. In all, 2700 members of the University died in that war. Every college chapel has its Roll of Honour, with additional names added in 1945. Six of the eight men who rowed in the Trinity College boat, that won the University boating competition in the summer of 1939, were killed.

Two notable post-war changes in Oxford have been that of the position of women, and of the standing of science in the University. The award of the Nobel Prize to Howard Florey and Ernest Chain for their development of the therapeutic use of penicillin, helped Oxford belatedly to realise that science could be socially useful and bring it world fame. In the 1970s men's Colleges began to admit women as students and teachers (the limitations on the number of women were lifted in 1956) and women's Colleges soon after, became mixed until now only one exclusively women's College, St. Hilda's, remains.

There are now 39 Colleges, of which seven admit graduate students only. Of around 16,500 students in total, some 11,500 are undergraduates. Every one of these Colleges selects its own students, houses them for much of their course, provides meals and social facilities, but above all, organises and supervises their academic work. It is to Colleges that would-be students apply; no one can become a member of the University until they have first been accepted by a College.

Most Colleges teach most courses and they all use the tutorial system as the core of their teaching method. A tutorial is a weekly meeting of one or two students with the tutor to whom they are assigned for that subject. The student presents the results of the week's work, based on the reading of the sources suggested by the tutor the week before. This might be in the form of a solution to a problem or as a formal essay. The aim of the tutorial system is to teach students to think for themselves and to develop their ideas as creatively and critically as possible, under guidance. Teaching is also carried out by the standard university methods of lectures, classes and laboratory work. Lectures are generally optional although they can be immensely stimulating.

In common with other British Universities, Oxford admits students to study a particular subject. While courses allow for specialisation within them, changing courses is not particularly easy. Oxford's courses are still essentially unitary, allowing progressive understanding of the subject which students are expected to display in their final exams at the end of three years. Recent recommendations however include less emphasis on finals with examinations each year, easier transfer between courses, and an extension of non-examination forms of assessment hitherto limited to dissertations instead of – or as well as – some written papers. Oxford University is part of Britain's publicly funded system of education, although it also attracts substantial private funding. Even its high academic standards, like those of all UK universities, are independently monitored by the Higher Education Quality Council.

The University is a loose federation of its colleges which are all independent bodies and can make their own rules. It has no permanent Chief Executive, this role being filled by the Vice-Chancellor, appointed every four years from among the heads of the Colleges, an arrangement

which started in the seventeenth century. The office of Chancellor is now purely honorary, although the honour it conveys is considerable. It has been held in this century by notable statesmen such as Lord Curzon, former Viceroy of India, Harold Macmillan, former Prime Minister, and now Roy Jenkins, former president of the European Union. The University awards degrees, accepts government funding, and decides what is to be taught. Its existence consists solely in what it does, not the buildings it inhabits. It is the Colleges which dominate the city and give it its character.

Oxford University has had an influence in the political, religious, cultural and intellectual life of England enormously out of proportion to its numbers. It has produced first class figures in every generation: William of Ockham, John Locke, Samuel Johnson, John Ruskin, Lewis Carroll, Isaiah Berlin. The chief prelates, statesmen, administrators and scholars in every generation have predominantly been educated at Oxford, from medieval bishops and Archbishops, to most of Britain's Prime Ministers since World War One. The red carpet has always led from the College gates to the seats of power.

A walk around Exeter College

John Salinsky

Exeter College will be our home for the duration of the 11th International Balint Congress and I hope everyone will be comfortably accommodated and generously fed within its historic walls. Once you have registered, found your room and located the all important nearest bathroom, you will be eager to explore your surroundings and learn something about the College and its history. Exeter was founded by a bishop of Exeter, Walter de Stapledon, for the education of scholars in his diocese. The original community was set up elsewhere in Oxford in 1312 and moved to the present site two years later. Sadly none of the original buildings have survived and most of the ranges surrounding the quadrangle are of the 17th Century. But you can still see Palmer's Tower which dates from 1432 and is the oldest part of the College. It is in the North east corner of the Quadrangle, in the far left hand corner as you look across the lawn from the main entrance (the lodge) in Turl Street.

On your right hand side from this same vantage point is the Dining Hall where we shall be having our meals and coffee breaks. This is a large and magnificent room, built in 1618. It has a fine wooden collar beam roof and a Jacobean screen of the same period. On the left (West) side of the quadrangle is the College chapel, which you will notice at once, is much smaller than the surrounding ranges and in a different style. The chapel is one of Oxford's most distinguished Victorian Gothic buildings. It was designed by Sir George Gilbert Scott (who was also responsible for the Foreign Office and St. Pancras Station Hotel in London). The new chapel was built in 1854-56, replacing the old one from the 17th Century. It cost £17,000 which was a lot of money in those days. I am told that the Fellows each donated a year's salary in order to pay for it. The design is modelled on the church of St. Chapelle in Paris and it is very French Gothic in feeling with a rounded apse and a thin elegant spire which is visible all over Oxford. Feel free to step inside and admire the interior which is tall and impressive. The original stained glass enhances the atmosphere and there is some fine stone and wood carving. Look for the tapestry of *The Adoration of the Magi* which was designed by Edward Burne-Jones and William Morris of the Arts and Crafts movement: both were members of the College.

The rounded East end of the chapel leaves a gap through which you can reach the adjoining Margery Quad. To your right as you pass through the gap is Palmer's Tower (now the Rector's Lodging) and then some more room blocks also designed by Scott in the 19th Century but in the same collegiate style as those in the main quadrangle. Margery Quad is completed by the Thomas Wood Building of 1964, a modern block, which blends in quite nicely. In the far right hand corner as you enter Margery Quad is a large gate which will often be open during the day. It leads out to Broad Street from where you can easily find your way to the Sheldonian Theatre by turning to your right and looking out for the row of Roman Emperor's heads which decorate the surrounding wall. A little to the right of the Broad Street area some steps lead down to the Saskatchewan Room, a modern lecture theatre where we shall be having most of our plenary sessions.

Back in the main Quadrangle a passage facing the lodge leads to one of Oxford's most delightful secret places: the Exeter Fellows' Garden. The garden is a green and pleasant place in which fellows (and nowadays students also) can take tea and play croquet in the summer. The building on your left as you go in is the college library and beyond this, surprisingly, is the Divinity School and Bodleian Library around which the Fellows' Garden seems to have lovingly wrapped itself in unexpected intimacy. But the biggest revelation comes at the far end where steps lead up to a sort of gallery looking over the far wall of the garden. When you climb up and gaze over the wall you find yourself looking into Radcliffe Square as if from an expensive box at the theatre. The dome of the Radcliffe Camera looms up ahead of you with the Old Schools building on your left and the crocketed spire of St Mary's on your right. People in the square below go about their business apparently unaware that they are so closely observed from the invisible secret garden. At sunset the view is, of course, magical.

Architecture in Oxford: a beginner's guide to the historic buildings

John Salinsky?

The buildings of Oxford University are spread all over the city centre. The historic ones you will particularly wish to see, consist of the individual Colleges, the University libraries and ceremonial buildings and the churches associated with the University. The 39 Colleges are small, independent institutions where students live, study and are taught. If you climb to the top of the tower of St. Mary's Church in the High Street, you can see the Colleges spread out beneath you; you will notice that each has two or three squares of immaculate green lawn enclosed by buildings of a honey coloured stone. You will notice a gate house, probably slightly taller and if you know what to look for, the more substantial bulk of the chapel and the dining hall and perhaps the College library. A few colleges (Christchurch, Merton, Magdalen) have graceful and distinctive towers. The remaining blocks contain the living accommodation for students and tutors, traditionally arranged on winding wooden stair cases, each with an entrance onto the path surrounding the quadrangle below. The large domed building (suggesting the great Brain of the University) is the Radcliffe Camera, a University library which we shall be visiting in due course.

How old are these buildings and in what sort of style are they constructed? The first question is more difficult because most of them have been altered over the years; in some cases, to bring them up to date and in others to preserve the original appearance. To some extent the age of a building can be deduced from its style; so it is a great help when looking at them to know something about the two styles of architecture which dominated European building from the 14th century (when most of the early college buildings were started), until the end of the 19th century and the age of Modernism.

The first of these styles is Gothic, which itself has several phases. Gothic is the typical style of the medieval church. Everything in a Gothic building has a tendency to soar up to heaven. The archways and vaults are all pointed and the windows whether single or in clusters also narrow to a point at the top. On the outside, the roof is supported by graceful flying buttresses in several stages, often decorated with carvings and topped with spires and pinnacles. Inside a Gothic church, the ceiling is carried by stone pillars which narrow as they get higher and turn into a network of rib vaults which both decorate and support the ceiling. Of course, this kind of grand and glorious architecture is not really suitable for ordinary living accommodation, and in Colleges and private houses it is considerably modified. The windows are smaller but they are still pointed as are the arches and entrance doorways. There is more than a suggestion of fortification as the first Gothic houses were also castles.

The oldest Oxford College buildings were started in the 14th century, in the Gothic manner, but there are very few of them left today. If you go into Mob Quadrangle at Merton College, you will get an idea of how the first Colleges must have looked. Throughout the 15th and 16th centuries the Gothic style continued to be popular in England, although it was continuously being modified. Everything became less fortified as life became more civilised. Walls became thinner and windows were allowed a more generous surface area. In domestic and collegiate buildings there was a tendency for the windows to become square rather than narrow and pointed. Or at least, a group of narrow pointed windows was enclosed in a square frame and topped with a horizontal stone lintel. Most of the Colleges you see in Oxford today have a similar ground plan. A typical college (Exeter is fairly typical) will have two or three quadrangles in a modified Gothic style originally built between te late 1400s and the early 1700s. (The basic style did not change much, thanks to the architectural conservatism of Oxford academics). The building surrounding the quadrangles seem to be all joined up apart from the archways which lead from one quad to another. Here and there a difference in shape and size will indicate one of the three essential communal buildings: the chapel, the dining hall and the library. Some of the chapels are magnificent and one of them (at Christ Church) is also Oxford Cathedral, pre-dating the college by centuries. The halls are also very splendid, with hammer beam roofs and oak panelled walls lined with portraits of ancient clerical gentlemen, looking sternly down at the young people eating their dinners.

Some Colleges have special features which must be seen and savoured. The particular delights of Exeter College, the home of our Congress, are described in a separate article. The largest College is Christ Church whose gate house tower with its cupola is another Oxford symbol and landmark. It owes its distinctive shape to Sir Christopher Wren who added the finishing touches. The other (pointed) tower looming up from the back of Christ Church is much older and belongs to the Cathedral. Christ Church was built for King Henry the Eighth's chancellor, Cardinal Wolsey, and was to have been called Cardinal College. Unhappily, Wolsey fell into disfavour with the King and was dismissed from his powerful position. His original buildings remain unfinished and you can see the beginnings of arcades which were to have enclosed the paths surrounding Tom quad, still the largest quadrangle in Oxford. At Magdalen College (pronounced

'Maudlin') you can see a completely roofed arcade making the quadrangle resemble the cloisters of a monastery. Magdalen also has a beautiful tower which stands beside Magdalen Bridge at the Eastern gateway to Oxford, proudly announcing that you are about to enter a University City. Medieval Gothic dining halls are seen at their best at Christchurch and Exeter; the most impressive chapels are probably those at Merton and New College, and of course the Cathedral at Christ Church which is on a much grander scale. It was begun in the 12th Century and as you wander through it you can trace the evolution of the Gothic style right up to the 17th century. Outside the colleges, the University Church of St. Mary's, in the High Street, provides a magnificent example of late Gothic ecclesiastical architecture. It has a huge spire encrusted with decorations which soars up into the sky forming a wonderful contrast with the dome of Camera. This is the spire you can ascend for one of the best views of the city.

On St. Mary's North side, away from the High Street, is Radcliffe Square with the circular Radcliffe Camera in the centre (more about that later). Beyond the Camera is the Old Schools Quadrangle, a university building originally used for examining students. The side facing the Square consists of a rather formidable stone panelled wall with an embattled top (very Gothic). If you go in through the arched doorway, you find yourself in a large paved square, something like a College quadrangle without the grass. To your left is the statue of the Earl of Pembroke on horseback, and behind him the entrance to the Divinity School, one of Oxford's most treasured buildings in the Gothic style. It has an elaborate and beautiful vaulted ceiling. And above that ceiling is another remarkable room, the original library (known as Duke Humfrey after its 15th century founder, the King's younger brother). Duke Humfrey can be visited on special guided tours and is a must if you enjoy the sensation of gazing at stacks of ancient leather bound books forming a cosy nest for the readers at the tables.

On the continent of Europe, however, architecture was undergoing a much more radical change. The Renaissance or rediscovery of Classical Art and Learning started in Florence in the early 1400s and with it came a new architecture, modelled on the buildings of Greece and Rome. Renaissance architects in Italy regarded the narrow pointed arches, towers and battlements of their predecessors' architecture as barbaric (hence the name 'Gothic') and wanted to pull it all down. Their buildings had a more human scale in which proportions were carefully calculated in order to produce harmony and elegance. Arches, windows and doorways in the classical style are always semicircular (as in ancient Rome) and they are supported by cylindrical columns (plain or fluted) whose tops (capitals) are decorated with the same formal designs used in Greek temples (Doric, Ionic and Corinthian). The Greek temple front is also echoed in the form of the triangular pediment which is often used to top off a colonnade or the central part of a facade. This new style spread rapidly over Europe but in England, as usual, there was resistance to Continental ideas and the universities continued to build their colleges in Gothic until well into the 17th century. Of course, there were a few *avant garde* architects who were more in sympathy with the 'modern' style and were eager for a chance to try their hand at designing renaissance buildings. One of these was Christopher Wren, a young mathematician and Professor of Astronomy in the University of Oxford. He created Oxford's first renaissance building – the Sheldonian Theatre, which we have been able to use on the first day of our Congress. Although it is made of the same honey coloured stone from the local quarry at Headington, the Sheldonian is strikingly different from the Gothic structure of the Bodleian Library and the Divinity School which stand behind it. It is based on drawings of the Roman Theatre of Marcellus and one could easily imagine it standing in the Roman forum (an impression enhanced by the stone heads said to be of Roman Emperors which adorn the railings of its Broad Street front).

In the early 18th century a number of colleges replaced some of their buildings with new ones in the now fashionable classical style. The Queens College, in the High Street was made over entirely in the classical manner. At All Souls' College, next door, however, the Fellows instructed their architect (the distinguished Nicholas Hawksmoor, a pupil of Wren) to continue building in Gothic which they thought more appropriate. The result (though pleasing enough) suggests a classicist playfully using Gothic themes.

Meanwhile, in Radcliffe Square, just opposite All Souls', the University was building the Radcliffe Camera, a thoroughly Classical building, circular in shape and surmounted by a huge and harmonious dome. If you let your eyes travel up it from ground level to the lantern on the top, your gaze will pass through a number of contrasting stages from rusticated stone (ground floor) to double columns surrounding windows, to a circular entablature (cornice) followed by a noble balustrade above which one more preparatory stage leads to the final triumphant curvature of the dome. The architect was James Gibbs, an Edinburgh man, and his building (one of the university libraries) has become one of the symbolic shapes of Oxford. Radcliffe Square is a good place to stand and contemplate the contrasting styles of Oxford's architecture. Facing the dome of the Camera to the North is the looming medieval style wall of the Old Schools Quadrangle; to the West the traditional collegiate Gothic of Brasenose College; on the East side is Nicholas Hawksmoor's 18th Century Gothic fantasy; and to the South the soaring pinnacled tower of St. Mary's Church. The 20th century is usually represented only by a stall in the North East corner selling 'Oxford University' tee-shirts.

After 1714 when Queen Anne died and all those Georges came to the throne, the fashion in English architecture changed again. The mood was still classical, but less exuberant. Instead of the flamboyant Baroque of the continent, the English taste was for something still elegant and classical but more restrained. The word 'Georgian' sums it up. Conservative as ever, Oxford continued to build in their earlier, more extrovert style as exemplified by Worcester College. But some Colleges did put up new ranges of quadrangles which look a little like the graceful terraces you can find in Bath or in some of the 18th century country houses. A good example is Peckwater Quadrangle in Christ Church.

In the Victorian age, Gothic became the fashionable style once again. At first the ideal was felt to be the early Gothic of the 13th century which was often copied rather slavishly in church architecture. Later on the Gothic vocabulary of pointed arch and soaring pinnacle was deployed more imaginatively and with greater originality. The use of new and colourful bricks, tiles and glazes also helped to create buildings with a different look from anything that had existed before. Exeter College's chapel (1857-9, by Sir George Gilbert Scott) is one of the best Victorian Gothic buildings in Oxford. But perhaps the most spectacular is William Butterfield's Keble College (1862-82). Here we have an entire College, including a chapel on a grand scale, built mainly in red brick but enlivened with patterns of blue and white and chequered stripes. It was much derided fifty years ago, but is now recognised as a great and original work of art.

In our own century the Colleges have continued to add to their buildings in a variety of styles. Some of these 'new' buildings blend in tactfully while others are more assertive and modernistic. I will leave you to come across them and judge them for yourselves as you wander round the City. I hope this brief guide will help to enhance your understanding and enjoyment of Oxford's architectural splendour.

JOHN SALINSKY

Eleventh International Balint Congress

9-13 SEPTEMBER, 1998

AT EXETER COLLEGE and THE SHELDONIAN THEATRE, UNIVERSITY OF OXFORD

Doctors and Patients in the 21st Century

Hosts: The Balint Society of the United Kingdom
President: Dr. Paul Sackin, and
The International Balint Federation
President: Professor Frank Dornfest

Accommodation: All delegates will be accommodated in Exeter College, whose buildings date back to the 17th Century. The rooms are arranged around traditional quadrangles. Some are single bedsitting rooms, while others consist of a shared sitting room with two bedrooms leading off them. Some rooms have full facilities, while the rest have washbasins with bath, shower and toilet facilities adjacent. All meals will be provided in the College Dining Hall, including the Congress Banquet on Saturday evening.

On Thursday, we shall have exclusive use of the elegant Sheldonian Theatre, the University's Ceremonial Building where degrees are awarded. It was designed by Sir Christopher Wren (architect of St. Paul's Cathedral in London) and built in 1669.

Plenary sessions on the remaining days will be held in the Exeter College lecture room. All the small group meetings will be held in seminar rooms in the College.

Personal Papers: There will be a session of ninety minutes for presentation of short personal papers of 10 minutes each, and also a display of posters.

Balint-groups: All delegates will be able to participate in an ongoing Balint-group which will meet for ninety minutes each day. Groups will be available in English and other languages according to demand.

Weather: September temperatures in Oxford may range from 12° to 20° Celsius. There is a good chance of fine weather, but a light raincoat would be useful in case of showers. The Sheldonian Theatre is very close to the College and the historic centre of Oxford is very compact.

Travel to Oxford: There is a good bus service running every half our for most of the day from London's Heathrow Airport to Oxford (Gloucester Green Bus Station). The journey takes about 45 minutes. Trains from London (Paddington Station) arrive at Oxford Rail station. The train journey is also about 45 minutes. Taxis are available.

Fees: The overall charge for the Congress is £550.00. Which covers registration fees, single bedsitting room accommodation in Exeter College for four nights, all meals including the Welcome Reception, Conference Banquet, the concert and the organ recital. Accompanying persons staying in College will be charged the full rate and will be entitled to attend the opening plenary sessions and all social events. Some 'sets' with two small bedrooms leading off a single sitting room will be available. A programme of guided tours will be available for non-delegates.

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CONGRESS PROGRAMME

Wednesday, September 9th

02.00 p.m. Registration at **Exeter College.**
06.00 p.m. Welcome Reception Party in the Fellows' Garden.
07.30 p.m. **Dinner in Exeter College Hall.**

Thursday, September 10th

Opening session in the Sheldonian Theatre (Broad Street)

09.00 a.m. Chair: Professor Frank Dornfest, President, International Balint Federation.
09.10 a.m. Dr. Paul Sackin, President, British Balint Society.
09.20 a.m. Dr. Philip Hopkins, Founder and first President of the British Balint Society, Editor of the Journal of the Balint Society. 'Who was Michael Balint?'
09.40 a.m. Dr. Anthony Hope, Reader in Medicine, University of Oxford.
'Teaching ethics and communications in the clinical school.'
10.10 a.m. Discussion.
10.30 a.m. **Coffee in Exeter College Hall.**

Second session in the Saskatchewan Room, Exeter College

Chair: Dr Paul Sackin
11.15 a.m. Ian McWhinney, Emeritus Professor of Family Medicine, University of Western Ontario, Canada.
'The physician as healer.'
11.45 a.m. Roger Higgs, Professor of General Practice, Guys's and St. Thomas' Hospital Medical School, London, UK.
'Finding the doctor in the patient, and the patient in the doctor.'
12.15 p.m. Discussion.
01.00 p.m. **Lunch in Exeter College Hall.**

Afternoon session in the Sheldonian Theatre (Broad Street)

Chair: Dr. John Salinsky.
02.30 p.m. Demonstration Balint-group and discussion.
Group-leaders: Dr. Michael Courtenay and Dr. Sally Hull.
04.00 p.m. **Tea in Exeter College Hall.**
04.30 p.m.-06.00 p.m. **Small groups – Session 1 in Exeter College.**
06.30 p.m. **Dinner in Exeter College Hall.**
08.00 p.m. **CONCERT by *I FAGIOLINI* in the SHELDONIAN THEATRE.**

Friday, September 11th

09.00 a.m. **Morning Session in the Saskatchewan Room, Exeter College.**
Chair: Dr Michéle Lachowsky and Dr Philip Hopkins.
Dr. Carl Edvard Rudebeck, General Practitioner, Stockholm, Sweden.
'The doctor, the patient and the body experience.'
09.30 a.m. Discussion.
09.40 a.m. Michelle Moreau Ricard, Psychoanalyst, Paris, France.
'The history of the Balint movement in France.'
10.00 a.m. Discussion.
10.10 a.m. **Coffee in Exeter College Hall.**
10.30 a.m.-12.00 noon Small groups – Session 2 in Exeter College.
01.00 p.m. **Lunch in Exeter College Hall.**

Afternoon Session in Saskatchewan Room, Exeter College.

02.00 p.m. Chair: Dr. Heide Otten and Dr. Heather Suckling.
Short papers.
07.00 p.m. **Dinner in Exeter College Hall.**

08.30 p.m.	**ORGAN RECITAL in EXETER COLLEGE CHAPEL by DR. JOHN HORDER, Past President of the Royal College of General Practitioners.**

Saturday, September 12th

09.00 a.m.	**Plenary Session in the Saskatchewan Room, Exeter College.** **Symposium: 'Balint in the 21st Century.'** Chair: Dr. John Salinsky. Speakers from the Tavistock Clinic, the German Balint Society, the American Balint Society, and Balint Societies of Eastern Europe.
10.30 a.m.	**Coffee in Exeter College Hall.**
11.00 a.m.	**Balint Research.** Chairman: Professor Frank Dornfest. Presentations of work in progress.
01.00 p.m.	**Lunch in Exeter College Hall.**
02.00 p.m.- 05.00 p.m.	Optional free tour to Blenheim Palace, including tea.
05.00 p.m.- 06.30 p.m.	**Small Groups – Session 3 in Exeter College.**
08.00 p.m.	**CONGRESS BANQUET AND DANCE, with Ceilidh (Traditional Scottish Dancing).**

Sunday, September 13th

09.00 a.m.- 10.30 a.m.	**Small groups – Session 4 in Exeter College.**
10.30 a.m.	**Coffee in Exeter College Hall.**
11.00 a.m.	**Final session in Saskatchewan Room in Exeter College.** **Meeting of the General Assembly of the International Balint Federation.**
01.00 p.m.	**Lunch in Exeter College Hall.**
02.00 p.m.	**Annual General Meeting.**

Closure and Farewell.

The Balint Family: John, Michael and Alice.

Short Paper Session

Friday, 13th September 2.00 p.m. to 5.00 p.m.

Chaired by Dr. Heide Otten (Germany) and Dr. Heather Suckling (UK)

2.00 p.m. *The effect of Balint and non-Balint training on residents' skills and group comfort.*
Andrew L. Turner PhD (University of Wyoming Family Practice Center, Cheyenne, Wyoming, USA) and Geoffrey M. Margo MD PhD (Harrisburg Family Practice Residency Program, Harrisburg, Pennsylvania, USA)

2.15 p.m. *Structural interventions in the Balint-process*
Karen M. Glaser PhD and Karen D. Novielli MD (Department of Family Medicine, Jefferson Medical College, Philadelphia, Pennsylvania, USA)

2.30 p.m. *Using the Balint-group method in a psychiatry training program*
Geoffrey M. Margo MD, PhD and Katherine Margo MD (Harrisburg Family Practice Residency Program, Harrisburg, Pennsylvania, USA)

2.45 p.m. *How do people change in a Balint-group?*
Albert Lichtenstein PhD and Franklin Dornfest MD. (Guthrie Family Practice Residency, Guthrie Clinic, Sayre, Pennsylvania, USA)

3.00 p.m. *Has Balint-activity by general practitioners any effect?*
Dorte Kjeldmand MD (General Practitioner, Eksjö, Sweden)

3.30 p.m. TEA BREAK

4.00 p.m. *Balint-group leader education has started in Sweden*
Anita Häggmark, Ekerö, Sweden.

4.15 p.m. *Implementing Balint's method within a clinical department of a medical college*
F. Ludwig-Becker, A. Schwarte, V. Perlitz and E. R. Petzold Medical faculty, RWTH University of Aachen, Germany.

4.30 p.m. *Preventing the burn-out syndrome by means of the Balint-group*
Kornelia Bobay PhD, Budapest, Hungary.

4.45 p.m. *A Balint-group for internal medicine residents of the Emergency Hospital 'Dr Clemente Alvarez'*
Lazaro Gideckel MD and Liliana Topolevsky Ps, Rosario, Argentina.

Balint Research

Saturday, 12th September 11.00 a.m. to 12.30 p.m.

Chairman: Professor Frank Dornfest (USA)

11.00 a.m. *Doctors' Defences: work in progress*
Two papers reporting on the work of a Balint-research group which has been meeting in London since 1993
Michael Courtenay MB BS and Paul Sackin FRCGP (General Practitioners)

11.30 a.m. DISCUSSION

11.45 a.m. Just an accident
Marie Campkin MRCGP (General Practitioner)

12 noon *Captured by a Script*
Clive D. Brock MD and Alan H. Johnson PhD (Department of Family Medicine, Medical University of South Carolina, Charleston, South Carolina, USA)

12.15 p.m. *Empathy and the Balint-group*
Ellen More PhD (Department of Medical Humanities, University of Texas Medical Branch, Galveston, Texas, USA)

12.30 p.m. *An antidote to physician-burnout; the Balint-group as a hermeneutic clearing for the possibility of finding meaning in medicine*
Richard B. Addison PhD, Department of Family and Community Medicine, University of California, Santa Rosa, California, USA

11th International Balint Congress

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Abstracts of Papers Presented (in Programme order)

Who was Michael Balint?

Philip Hopkins*

Michael Balint addressed the study of the doctor/patient relationship in a manner that was both scientific and analytic, as well as being humane and practical. When he began his seminars, they were a fresh and original project; and are constantly being re-discovered as such by 'new recruits'. What kind of person had such clarity of perception, and conceptual skill in distilling the complex of life of the groups into ideas which have not only endured, but gained popularity?

Despite the passage of time, the discoveries in his own, Enid's, and subsequent research-*cum*-training groups remain vital and relevant. We are still 're-inventing the wheel' when we investigate the highly-charged interpersonal relationships which arise in medical settings.

*Philip Hopkins FRCGP Independent Family Physician, London. Founder and First President, Balint Society, UK.

Teaching ethics and communication in the clinical school

Anthony Hope*

Scarcely a week goes by without an issue in medical ethics hitting the headlines. But complex issues in medical ethics are not limited to these headline-grabbing settings. Ethical issues arise in the everyday practice of medicine.

We have been developing a course in Oxford, for clinical medical students, which combines ethics, communication skills and the law. It aims to help students to practice everyday medicine to a high standard. We see ethics, communications skills and law as closely related. Consider, for example, the question of valid consent. There is an ethical and conceptual aspect to this, namely clarifying the components of valid consent and their application. In addition, practitioners need to know the legal aspects. Indeed, analysis of some of the legal cases provides useful material for ethical analysis. If these principles are to be put into practice, then communication skills are also important. For example, one component of valid consent is for patients to be informed. But how do you inform patients most effectively about different risks and benefits of treatment?

The approach that is taken in the course in Oxford will be described together with examples of what this means in practice.

*Anthony Hope, Lecturer in Practice Skills, Division of Public Health and Primary Care, University of Oxford.

The Physician as healer: the legacy of Michael Balint

I R McWhinney*

I will review Balint's leading ideas, especially the importance of listening, and the need for a change in the doctor's personality. We need to reconsider Balint's teaching in the light of more recent trends in Western thought, notably the dawning recognition of our neglect of the emotions in cognitive science, neuroscience, education and medicine; and the awareness of our erroneous assumptions about the disembodiment of the emotions. The influence of Oriental psychology promises to have a profound influence on our approach to these issues, especially in medical education, and our approach to the doctor/patient relationship. Listening in Balint's sense of the term should be at the centre of our teaching.

*Professor I. R. McWhinney, Professor Emeritus, Department of Family Medicine, University of Western Ontario.

Finding the doctor in the patient and the patient in the doctor

Roger Higgs*

This presentation looks at the moral consequences of a psychodynamic approach to healthcare, set against current challenges (or obsessions) such as evidence-based medicine and resourcing issues. It finds a number of difficulties unsolved and sometimes even unstated, and attempts to chart a possible way forward for those interested in bringing the spirit of Balint into modern practice and beyond.

*Professor Roger Higgs MBE FRCP FRCGP is founder and Head of the Department of General Practice and Primary Care at King's College School of Medicine, and a general partner in Walworth, South London.

The doctor, the patient and the body experience: the role of bodily empathy

Carl Edward Rudebeck*

The frame of reference for the presentation of a body symptom is the body, as lived and experienced: the existential anatomy. The doctor shares with patients the basic bodily conditions through the senses, movements and the inner organs. Professional experiences may, in various ways, add to the doctor's familiarity with the existential anatomy. The ability of the doctor to approach symptom presentations inter-subjectively we call bodily empathy.

Balint-seminars yield an understanding of patients by way of the exploration of the doctor/patient relationship, and the feelings raised in the doctor. A 'difficult' patient may raise emotional discomfort in the doctor, a discomfort then brought to the Balint-group. Sometimes, the difficulty might simply lie in the difficulty of understanding the patient's experience – i.e. in a lack of bodily empathetic communication. As a result of medical training, a set of automatic cognitions, the biomedical reflex, are evoked in the doctor when confronted with symptom presentations. In situations of discordance between the knowledge of diseases and the symptom presentation, the biomedical reflex may lead to confusion through the identification of a 'difficult patient'.

On the other hand, when recognised and properly addressed, non-understanding may be the fruitful begin-

ning of a mutual effort to achieve understanding. Understanding, in the direct, non-interpretative sense, may be a theme worth exploring in Balint-seminars. In addition, the facts of bodily being, of being mortal and vulnerable, bring an important emotional load into the clinical interaction.

*Carl Edward Rudebeck, MD PhD is a general practitioner in Stockholm.

The Balint movement in France and its institutionalisation: the creation of the first Balint Medical Society

Michelle Moreau Ricard*

In France, the history of the Balint movement is linked with that of the French psychoanalytic movement and its institutional crisis.
After examining the situation of psychoanalysis in this country and the troubles in what was then the only Psychoanalytic Society in France, the Parisian Psychoanalytic Society (S.P.P.) which provoked the first analytical schism, we shall show Balint's influence on the members and pupils of the S.P.P. during the pupil revolt against the opening of the Psychoanalytic Institute in 1953. Later, in 1960, came the translation by J. P. Valabrega of his cult book *The Doctor, his Patient and the Illness* (Balint, 1957). 1960 *(REFS)* Paris, PUF. and lastly, his influence on the newly born analytical association, SFP (1964).
My hypothesis is that in France, Balint found enthusiastic champions of his cause, both among young doctors and young analysts, some still in training.
Some even crossed the Channel, to the country of their traditional enemy, to be trained by Balint himself at the famous Tavistock Clinic. In turn, they trained medical doctors in Paris and in the provinces and later, clinical psychologists, and nurses in hospitals. They 'offered' the method to those who experienced difficulties in their everyday professional lives, mainly because they were not trained in the understanding of the doctor/patient relationship. But after a 'honeymoon period', conflicts arose between some leaders and their groups, conflicts which 'resolved' themselves through an 'acting out' by the trainees; the creation of a Medical Society for Balint Groups (SMGB), soon to become the SMB.
English leaders and trainees who, before then, had not felt the *need* to found such a Society, decided to follow this example, as did many other countries, linked now by the International Federation.
It may be the transmission of Balint- method could have been accomplished without any institution other than the work of Balint's'old guard'. We could debate this at our congress, but I have doubts about this hypothesis, knowing the working of the 'death instinct' in any living creature, and the power of internal destructive forces.

Method:
Scrutiny of the archives of the analytic societies, and of the SMB.
Compiling 'oral history' interviews, one with the founder of the SMB and others with senior participants in the training, also with some analysts of that time, those who are still active, and also those who have left the movement.

*Psychoanalyst, Paris Membre du Quaatrieme Groupe OPLF Mâitre de Conferences a l'Université de Tours.

The Effect of Balint and non-Balint training on residents' skills and group comfort

Andrew L. Turner and Geoffrey M. Margo*

In this pilot research, the authors seek to study the effect of Balint and non-Balint-training on residents' comfort and self-assessed skills with psychological issues in patient-care, as well as residents' willingness to explore such issues within a group-training format.
Using repeated measurements taken with both the Psychological Medicine Inventory (PMI) and the Professional Development Inventory (PDI), preliminary data will be analysed to assess differences between second year residents from a non-Balint-training program and those participating in either one or two year Balint-training experiences. Within-group and between-group differences will be examined to assess resident progress within the different program models.
This study will also examine the relationship between residents' ease with psychological issues and their openness to processing such patient/physician issues within a group format. The authors invite discussion about the application of this small group research to larger programs or research models.

*Andrew L. Turner PhD (University of Wyoming Family Practice center, Cheyenne, Wyoming, USA) and Geoffrey M. Margo MD PhD (Harrisburg Family Practice Residency Program, Harrisburg, Pennsylvania, USA).

Structural interventions in the Balint Process

Karen M. Glaser and Karen D. Novielli*

We report on three interventions which illustrate the importance of attention to structure in facilitating the Balint-group process.

1. In a Balint-group composed of 2nd and 3rd year residents, members of the two classes developed mutual mistrust and animosity. Each member was asked to write down anonymously a 'myth' about the other class that they thought would hinder trust and a good working relationship. The ensuing discussion revealed the 'mythical' nature of all the assumptions of both classes. The quality of work then improved.

2. Too much time was taken up with issues of closure and re-forming in a combined 2nd/3rd year group which had to re-form each year. When the leaders decided to run separate groups the difference in group process was dramatic.

3. A new resident who had entered the program in the 2nd year challenged the purpose of the group. The leaders acknowledged the difficulty of Balint-work and the perceived lack of safety in the group. A return to first principles with regard to the examining process and understanding of roles and responsibilities produced some case presentations by leading residents. These afforded other members the opportunity to participate and to renew their understanding of the value of the Balint process.

*Karen M. Glaser PhD and Karen D. Novielli MD. Department of Family Medicine. Jefferson Medical College. Flint. Michegan. USA.

Using the Balint-group method in a psychiatry training program

Geoffrey Margo and Katherine Margo*

Balint-groups are used in many family medicine training programs in order to provide experiential learning about the doctor/patient relationship. Although psychiatry training places much emphasis on the establishment of a 'therapeutic alliance' between doctor and patient, there are no publications reporting the use of the Balint method in psychiatry, understanding the doctor/patient relationship is important in caring for all patients, and consequently a Balint-group was thought to be poten tially useful to psychiatry residents. A Balint-group was offered in one psychiatry residency over a two-year period. Evaluation of the group after its completion showed that psychiatry residents appreciated the group. It gave them the opportunity to explore their relationships with their patients in a safe, non-judgmental, but formal setting with their peers. This experience was different from, and supplementary to their individual supervision. Balint-groups should be used routinely in psychiatry residency programs.

*Geoffrey Margo, M..D, Ph.D. and Katherine Margo, M.D., Harrisburg Family Practice Residency Program, Harrisburg, Pennsylvania, USA.

How do people change in a Balint group?

Albert Lichtenstein and Frank Dornfest*

What is the process that is reponsible for change in the members of a Balint-group? How does a particular group member go from a situation where there is a lack of empathy, understanding or direction to one where the doctor/patient relationship can be used in a more productive way? Beyond Balint's (1964) comments about what might lead to a 'limited though considerable change in personality', there has been little written about the actual mechanisms of change. This presentation will propose a framework for looking at the change process using a model of ego-development generated by Greenspan (1997) from his research and clinical work with children.

*Albert Lichenstein PhD and Frank Dornfest MD, Guthrie Family Practice Residency, Guthrie Clinic, Sayre, Pennsylvania, USA.

Has Balint-activity by general practitioners any effect?

Dorte Kjeldmand*

Together with a colleague, I have recently received funds to carry out a project, which we are going to start next month.

We want to study how general practitioners attending Balint-groups for at lesat one year comprehend their role when meeting difficult patients and how they cope with the situation. Has any change happened during their Balint-time? How is their quality of life and how does their work affect it? A group of non-Balint-participating general practitioners will be studied in the same way.

In our region of Sweden (south-east) four groups are established in Balint-work. Twenty-three doctors have participated for more than one year. The same number of doctors from other general practitioner practices are included as control groups.

The first part is a standardised questionnaire about quality of work and life, adding specified questions about Balint-activity. The second part is a long interview with ten doctors who in the questionnaire have expressed positive experiences of their Balint-group, carried out by a professional interviewer, in order to understand the doctors' view of their own role meeting the difficult patient and how they act. We want to catch the strategies and the feelings of the doctor.

Both questionnaires and interviews will be analysed in computerised programs. Can we, scientifically, prove the effect of Balint-work and thereby show our colleagues how to become betterdoctors and a way out of our profession's collective depression?

*Dorte Kjeldmand, general practitioner, Eksjo, Sweden.

Balint-group-leader education has started in Sweden

Anita Häggmark*

After several years of discussion and at least two years of preparation this education started in April this year. Three organisations co-operated: the Society for Medical Psychology (the Balint Section). Family Medicine in Stockholm and the Psychotherapy Training Unit of the Western part of Stockholm.

One important idea is to mix general practitioners with the experience of being in a Balint-group with psychoanalysts/psychotherapists and try to give them a common education.

There are nine students in the group, five general practitioners and four psychotherapists, who started on April 24th. They will meet for one day (8 hours) a month for two years.

The structure of such a day is:

1) **Lecture/Seminar,** 2 hours.
   The content consists of four main parts:
   a) Balint-work and the doctor/patient relationship
   b) Basic psychoanalytic concepts, important for Balint-group-leaders. Psychosomatics.
   c) Knowledge about groups and organisations.
   d) Various topics like ethics, immigrant problems, non-verbal language, etc.
2) **'Self-experience group'**
   The purpose is to give the students an idea of being in a group with the opportunity to talk about it. The group leader has experience from Group-relation Conferences of the Tavistock model.
3) **Supervision of the students' Balint-work** (the most important part) Groups of three meet with a supervisor for 3 x 45 minutes. By now the students are forming their groups with the aim to start them during next autumn. Urban Rosenqvist, who is a professor of Social Medicine will help us to evaluate the education.

*Anita Häggmark, Ekerö, Sweden.

Implementing Balint's method within a clinical department of a medical college

F Ludwig-Becker, A Schwartze, V Perlitz and E R Petzold*

With the installation of the clinic for psychosomatic and psychotherapeutic medicine at the medical facilities of the Aachen Polytechnical University, we sought to implement Balint's method in the medical education of junior, as well as of senior students. But also, we considered it necessary to apply Balint's method within the continuing education of our nursing staff.

With the presentation, we wish to document the progress made. So far, we successfully started a co-operation which includes six clinical departments, and we are in the process of training the nursing staff or two other clinical departments.
In Germany, the medical education consists of various terms. As a consequence, we regularly encounter junior students who do not possess any previous clinical experience, to be followed by senior students with only minor clinical practise. The official training is finalized by one year of rotation consisting of two mandatory terms and one elective. After passing their final national boards, students work as interns for another 18 months, to become finally medical residents.
We have therefore successfully offered training, using Balint's method, for the education of medical students. As we successfully introduced Balint's method in the education program of senior medical students, we are now poised to start a research project in evaluating Balint-groups
The Balint-group examined consists of students of all levels of medical training. Also, there are medical residents participating. A questionnaire was employed for the screening of this group, the results of which are to be discussed in our presentation.

*Drs F Ludwig-Becker, A Schwartze, V Perlitz and E R Petzold, are on the teaching staff of the Medical Facilities of the RWT University of Aachen, Germany.

Balint-group operation in internal medicine residents of Emergency Hospital 'Dr Clemente Alvaret', Rosano, Argentina

Lazaro Gidekel MD, Liliana Topolevsky Ps, Gabriela Abecasis Ps and Adria Giovannoni MD*

This work contains a brief account of the process of training residents achieved in this Balint-group since it started in 1991. The function and operative features are intended to reflect on two areas of interest:
1. Doctor/patient relationship: this is based on the patient's history and the discussion and recognition of transference and countertransference.
2. Group dynamics: Analysis of conflicting relationships among group-members.
In the co-ordination of the task led by a psychologist, the technique of 'Operative Groups' designed by Dr. Pichon Riviere is used.
The work also shows the way we are incorporating a psychological and social history in the classical organic orientated interview. This approach allows residents to explore the psychosocial dimension of patients' lives and it provides the framework to study the dynamics of the doctor/patient relationship. The inclusion of the psychosocial history has given us the opportunity of establishing a stronger therapeutic relationship, and a better understanding of the patient. It has also helped residents to develop their creative skills during the interview.
Two complex clinical situations are discussed where it is shown how residents were able to deal with them, using their creative resources.

Abstract of two associated papers on current Balint research entitled 'Doctors' defences'

Michael Courtenay and Paul Sackin*

The first paper describes the genesis of the Research Group which went on to study doctors' defences. It describes how, at a meeting of the Balint Society at which a previous group reported on its work and findings, there was a determination to continue research in the context of Balint-work. Initially a different research question was decided upon, but because of technical difficulties encountered in dealing with events which had occurred prior to the presenting consultation, together with the great stimulus of exposure to the hermeneutical viewpoint at the 10th international Balint Congress in Charleston, the present question was tendered by the leader and accepted by the group. The work as a whole is an attempt to take up Tom Main's challenge in his Balint Memorial Lecture of 1978 (Main, 1978).
The second paper is an account of the subsequent research done by the group. This comprises the formal questions which emerged during the work, followed by some illustrative cases and a brief look at the effect of the group on the doctors' defences. Some conclusions are then drawn in relation to Tom Main's original paper. The effect of the group on the work of the doctors was a central theme and involved advancing the boundaries of Balint-work into the private world of the members without allowing it to become a therapeutic group.

*Dr Michael Courteny is a retired general practitioner, and Dr Paul Sackin is a general practitioner in Cambridgeshire.

'Just an accident'

Marie Campkin*

We should take notice when we hear about accidents and mishaps that befall our patients.
I have been involved in the presentation and discussion of accident cases in Balint-group, first in the 1970s and again more recently. My continuing personal interest in the topic has led me to take particular note when patients I see in the course of a routine surgery mention accidental events.
The events are often minor in themselves and may be quite incidental to the presenting problem in the consultation. However I find it worth enquiring about the antecedents of the accident or mishap, in terms of what else was happening for the patient and their state of mind at the time.
Sometimes of course the incident was completely fortuitous, or due to another person's carelessness, but it is notable how frequently patients are aware that they were agitated, preoccupied, upset or depressed at the time, and that this contributed to what happened.
The event in question could be a driving accident, fall, burn or self-injury with a tool, or a mishap like getting locked out, losing possessions or forgetting appointments. It is as important to examine the circumstances of more obviously traumatic incidents as well; probably not at the time, but on a convenient later occasion.
Talking to the patient about what was behind the accident may reveal bereavement, family or work problems, or undiagnosed depressive illness that might not otherwise have come to the doctor's attention. Occasionally it could alert the doctor to a potentially suicidal situation.
In terms of preventive medicine and in particular, the prevention of accidents and suicide, I believe that further research is needed to explore the inter-relationship between accidents, depression and suicide.
I have found it surprisingly difficult to trace relevant research in the literature, and would welcome any information and references anyone may have.
Various possible lines of enquiry are suggested, including scrutinising the medical records of victims of fatal accidents and of successful suicides for evidence of previous lesser accidental or parasuicidal events.

However, a start could be made if individual general practitioners simply became more interested and curious about the background and meaning of their patients' mishaps.

*Marie Campkin, General practitioner, London.

Captured by a Script

Clive D Brock and Alan H Johnson*

The doctor/patient relationship is the foundation of health promotion, disease prevention, and patient satisfaction. When the doctor and patient are both satisfied with the visit, the relationship has increased therapeutic potential. When there is dissatisfaction with the visit, health outcomes are compromised. In Charleston, we have observed that when a case comes up for discussion in a Balint-group, the physician is playing a role in the relationship that is not satisfying (non-therapeutic) and most likely not therapeutic for the patient. Identifying those non-therapeutic roles in which residents get stuck will be the focus of our presentation.

We have observed that the physician making the presentation is most often stuck in one of five different roles:

1) Knight on a white horse
   The physician is fixated in a professionally idealized role.
2) Over-identification with the patient
   The physician is connecting with a characteristic in the patient which is unresolved in the doctor.
3) Induced complementarity
   The physician assumes a role that is not characteristic (not habitual). It is as if he/she were acting on cue to perform a nurturing, rescuing, or abusive function.
4) Over-identification with the family
   The physician is cued to fill an empty chair at the family table, playing the role of an absent parent, child, or sibling.
5) Habitual Roles
   The physician mode of functioning is derived from his own family of origin.

Each and every role has a place in the doctor/patient relationship, but only when used deliberately for strategic purposes.

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Triangulation: Then and Now

Alan H Johnson and Clive D Brock*

In 1970, Michael Balint used for the first time a global statistical approach in making inference about the doctor patient/relationship: in the paper 'Repeat Prescription Patients: Are They an Indentifiable Group?' (*Psychiatry in Medicine.* January, 1970). Michael concluded:

"It appeared that repeat patients needed human contact but somehow could not tolerate the tensions caused by its intimacy ... The patient gets something from his doctor which is most important for him, but at the same time he manages to keep a safe distance. (p.11)

This is an objectively clear example of triangulation: i.e. the way in which a relationship between two people, doctor and patient, is adjusted by their relation to a common third element (or person), the prescription.

Triangulation is a helpful and practical way to analyse how doctors and patients will negotiate a satisfying or frustrating relationship around an illness and its diagnosis, treatment and management. This is particularly relevant in dealing with chronic conditions so common in a specialty that promotes continuity of care; one sees again and again young family practice residents frustrated in how they would like to treat a disease and concomitantly maintain a workable relationship with the patient.

Today's short presentation will illustrate triangulation through Balint case material and comment on the part both doctor and patient play in arriving at a level of intimacy which is mutually acceptable. Triangulation is viewed not as a pathological process but rather as a natural social dynamic process which involves both doctor and patient in the control of intimacy in the medical consultation.

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Empathy as an interpretative practice; a historian's perspective

Ellen S. More*

Last spring, following the American Balint Society Intensive in Galveston, I began reflecting on the seeming incongruity of my roles as a medical historian and as a co-leader in a Balint-group. I would wager that I am one of the few historians (whose professional work usually deals with subjects who do not talk back) to venture into the slippery and fast moving waters of a Balint-group. I wondered what convergence of thought styles enabled me to move back and forth between those two quite different practices.

After giving a colloquium on historical methodology later that sping however, I thought I had begun to discover the answer. To a surprising extent, my interpretative work both as a historian and as a Balint-group facilitator are furthered by using the practice of reflexive interpretation, or hermeneutics. As a historian, I interpret written narratives, as a Balint-leader, I interpret oral narratives. In Balint-work, the technical language for such interpretation is 'empathy'. While a few historians speak of empathy as central to the process of historical interpretation, I believe the two practices share many characteristics. This paper will discuss empathy as an interpretative, or hermeneutic, form of knowledge, using case examples, and comparing the Balint-process with my interpretative practice as a historian.

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An antidote to physician burn-out: the Balint-group as a hermeneutic clearing for the possibility of finding meaning in medicine

Richard B Addison*

American medical practice is changing rapidly. What was once a noble profession is becoming a corporate endeavour with shrinking profit margins. Physicians are spending less time with each patient, seeing more patients, working longer hours yet making less money, and having far less autonomy and control of their existence. Although individuals were drawn to medicine for a variety of reasons, many find the dissatisfactions of medical practice outweigh the satisfactions. Emotional suppression, isolation, family problems, depression, burnout, impairment, attrition and suicide are definite risks.

Finding meaning in the practice of medicine, as well as developing a personally and professionally satisfying and balanced life, has become increasinglly difficult. Yet uncovering such meaning may be what is needed in the current medical climate.
Hermeneutic or interpretative thinking addresses the importance of creating a clearing for the possibility of meaning to appear. It is my thesis that a Balint Group can provide such a clearing in the dense, overgrown and weed infested forest that American medicine is becoming.

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Balint-group work in the prevention of 'burn-out' syndrome

Kornelia Bobay*

The Hungarian Michael Balint Psychosomatic Society, together with the Psychiatric Department of the Imre Haynal Postgraduate University Medical School organise a postgraduate course in psychosomatic medicine, which includes a Balint group.
The author compared findings from three courses with regard the Balint-group work. Doctors and psychologists who have never previously taken part in a Balint group were asked, by questionnaire, at the beginning of their courses, about what they expected from Balint group work; and at the end of their courses, and at the end of their courses, what they felt they learned from the Balint group, and had been their main experience in that group.
The majority opinion was that the Balint group had been valuable and encouraging in supporting the strengths of its members, and had assisted in preventing 'burn-out' which can experienced by professionals when working over a long period of time with difficult patients.

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The Emotional Context Preceding the Eruption of Herpes Zoster: Research in Progress

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Introduction

Michael and Enid Balint's pioneering work in general practice always included a strong element of research in progress, and their example gives me the courage to present this preliminary report on my ongoing research on the question whether life events, alexithymia, and depression are risk factors for the development of shingles (Balint, 1957; Balint and Balint, 1961). I volunteered to present this paper in order to formulate my thoughts and clarify my ideas, but mainly in order to communicate the striking pattern of stress, which I found to precede the eruption of herpes zoster.

What is herpes zoster?

Zoster is a Greek word meaning a belt. This is a graphic description of the painful, vesicular rash of herpes zoster (shingles) which occurs on one side of the body only, most commonly in the waist area like a blister-studded belt.

As every doctor knows, it is caused by the reactivation of the Varicella Zoster Virus (VZV) which also causes chickenpox when the person is initially exposed to it. As the immune system mounts its immune response and brings the chickenpox under control, the virus migrates up the sensory nerves and reaches the dorsal root ganglia which are situated along the spine or, less frequently, the ganglia of the cranial nerves inside the skull, where it remains dormant for the rest of the person's life. We do not know the exact biological mechanisms that keep the virus in latent form, but we do know that cellular immunity, which involves the T-lymphocytes, macrophages and Natural Killer Cells is very important.

When the control exercised by the cellular immunity falters, the virus becomes reactivated and starts replicating and progresses peripherally down the sensory nerve to produce the typical blistery rash which is restricted to the area of the skin supplied by that nerve, known as a dermatome. When the blistery rash occupies the whole dermatome there is no doubt about the diagnosis of herpes zoster or shingles. When however, the rash involves a small cluster of blisters it is impossible to know without serological tests, whether we are dealing with partially expressed VZV or herpes simplex virus infection.

The last two patients in my current series of eleven did not have a dermatomal rash, but their stress profile was similar to those who had herpes zoster. Although rarely a life threatening disease, herpes zoster is of concern because of the severe pain it can cause, and the risk of developing post-herpetic neuralgia that may follow the acute lesion. Post-herpetic neuralgia is defined as the persistence of pain beyond healing of the acute lesion. Because the natural history of herpetic neuralgia is gradual resolution of pain after the vesicles have healed, the point at which the acute condition is termed post-herpetic is a matter of definition. A reasonable definition considers post-herpetic neuralgia to be pain persisting for longer than two months after the vesicles have healed. Overall, 12-20% of patients with the acute condition complain of pain after the vesicles heal. This figure drops to 9% at four weeks, and to 1-2% at one year. These rates are greatly affected by age however, and in one large survey pain persisted for more than one year in 50% of seventy year-old patients! Post-herpetic neuralgia typically has several components including constant burning, lancinating pain, deep aching and allodynia which means pain induced by non-painful stimuli such as stroking. Commonly associated with pain are depressed mood, sleep disturbance, anorexia and weight loss (Galer and Portenoy, 1991).

The development of my interest

It is well known among hospital doctors that shingles occurs more frequently in the immunosuppressed, such as those who have a malignancy, those who receive chemotherapy, AIDS sufferers and the elderly. The majority of patients with shingles who present to me at my surgery in Hackney however, are healthy and middle-aged. Since I became a partner at the Well Street Surgery in December 1986, I recorded every consultation I had with patients with shingles. In my first nine years in general practice I saw 38 patients with it. Their mean age was 45 years, and none of them had any underlying medical explanation for immunosuppression.

So what was going on? What could be causing immunosuppression of equivalent severity as cancer or AIDS, which was sufficient to allow the development of this disease?

At the beginning of my career in general practice, a good friend of mine developed shingles a few weeks before his wedding and I realised then, that the eruption of herpes zoster might not be a random event. At about the same time, Dr John Paulley, one of the pioneers in psychosomatic medicine in England, (Paulley and Pelser, 1989) introduced me to the work of Bartrop who, in 1977, found that the responsiveness of T-lymphocytes taken from bereaved people was significantly reduced when compared with the responsiveness of T-lymphocytes taken from people who had not been bereaved (Bartrop

et al, 1997). I wondered therefore whether loss or other stresses might be responsible for the immuno-suppression. Certainly listening to my patients' stories, I had formed the impression that all of them were very stressed before their shingles erupted and most of them were reticent to talk about their distress. I thought at the time that this was due to their lack of awareness of their emotional distress, and that this was a manifestation of alexithymia.

In 1995 Lesley Southgate who was then working at our surgery and was also professor of general practice at St Bartholomew's Hospital, invited local general practitioners to become research associates in her department and develop protocols for reserch projects to test their ideas. I decided then to test my hypothesis that stress and alexithymia are risk factors for the development of shingles.

Dr Chris Griffiths, a senior lecturer in the department of general practice who was experienced in research methodology, became my tutor and advised me to construct a case control study that would compare the intensity of stressful experiences and the degree of alexithymia in patients who developed shingles with those of a control group. I chose for my control group, patients who developed ringworm. This seemed a good idea at the time, but it turned out that it was much easier to recruit patients with shingles than patients with ringworm. I therefore had to rethink the control issue. We based the power calculation on a paper discussing the prevalence of alexithymia in the general population (about 7.5%), and the statisticians advised that I would need at least twenty patients with shingles and twenty controls for the results to have statistical significance.

How do we measure stress?

The best way to measure stress at present is with the Life Events and Difficulties Schedule (LEDS). This is a semi-structured interview that was developed and validated by Tirril Harris, George Brown and other researchers at the Bedford Square College, during their research on the social origins of depression (Brown and Harris, 1978). As the success of this instrument depends on the skill of the interviewer, I had to train to use it, and attended a course run by Tirril Harris at Bedford Square College before I started my research.

Because herpes zoster is an acute disease, I was advised to concentrate my investigation on the year preceding the eruption of shingles, and also to include a measure of depression using the Beck Depression Inventory (BDI) (Beck *et al,* 1961).

Life events can be stressors and contribute to an increased predisposition to disease through the activation of negative emotions and maladaptive behaviours. In the psychosomatic model that informs my research however, increased susceptibility to disease requires an interaction between emotionally stressful life events and a personality predisposition.

Examples of personality predispositions are such constructs as 'alexithymia', 'hostility', and Type C behaviour pattern.

The word '**alexithymia**' was coined by an American psychiatrist of Greek origin, Peter Sifneos, in 1972 to describe the communicative style of psychosomatically ill patients who had marked difficulty in verbally expressing, or describing their feelings, and an absence of fantasy. It is derived from the Greek, *a* = no, *lexis* = words, *thymia* = emotions. Since then the alexithymia construct has become the object of intense study. Graeme Taylor, a Canadian professor of psychiatry, developed and validated a questionnaire that can measure it, the Toronto Alexithymia Scale (TAS-20) (Taylor, 1994; Taylor *et al,* 1997). The most enduring features of alexithymia are:

1. Difficulty in naming and identifying emotions.
2. Difficulty distinguishing between feelings and bodily sensations of emotional arousal.
3, Difficulty in describing feelings to others.

Alexithymia reflects a deficit in the ability to process and regulate emotion cognitively, imaginatively and symbolically. The thinking of alexithymic patients has an utilitarian style concentrating on trivial environmental detail, and shows a striking absence of fantasies and imagination.

Poorly regulated emotional arousal can dysregulate other biological systems and thereby be a risk factor that can potentially influence the onset and course of disease.

Hostility is the component of Type A behaviour pattern that has recently been found to be the risk factor in ischaemic heart disease and other diseases, such as peptic ulceration, asthma, rheumatoid arthritis, and thyroid problems. There are three aspects of hostility that are especially harmful to health:

1. Cynicism: a mistrusting attitude regarding the motives of people in general, leading one to be constantly on guard against the misbehaviour of others.
2. Anger: the emotion so often engendered by the cynical person's expectation of unacceptable behaviour on the part of others.
3, Aggression: the behaviour to which many hostile people are driven by the unpleasant negative emotion of anger, irritation and the like. (William and Williams, 1994).

Type C behaviour pattern, is characterised by suppressing one's needs and feelings, and harbouring chronic feelings of hopelessness hidden behind a mask of normality, until this defensive style is overwhelmed by an accumulation of stressful life events.

Lydia Temoshok in a study in 1985, operationalised the construct of Type C behaviour pattern and found that it correlated significantly with the thickness of the initial skin lesions of malignant melanoma (Temoshok et al, 1985).

The pattern of stress in shingles

The process of collecting information, using the LEDS is fairly laborious. The interview may last from one hour to five hours, depending on how much the patient has to say, and it may spread over several days. With the patient's permission, I tape-recorded the interview and when I listened to it again, I arranged the information that is scattered throughout the tape in distinct life events and difficulties, and then presented them to a consensus meeting where each one of them was rated by the group, according to the degree of threat or unpleasantness for the patient. The ratings are expressed in numbers and can be manipulated mathematically, and compared with those of controls. Blindness was preserved by not telling the group during the presentation what type of rash each patient was suffering from. For the purpose of this presentation, I have rearranged the information to create a flowing narrative and have disguised the identity of all patients.

When I started using LEDS to interview patients, I soon realised that because it surveys every aspect of a patient's life in a systematic way, I was collecting information that was beyond the scope of ordinary general practice consultations. From the first few interviews, I recognised that those patients who developed shingles had in common a pattern of stress they did not share with the controls. The pattern had three components:

1. An event or incident that aroused strong feelings of anger or fear, or both, occurred up to seven days before the eruption of shingles.
2. Ongoing difficulties that aroused a blend of chronic negative emotions over several months before the eruption.
3. Most patients had an experience of early loss, or adversity that provided a reservoir of non-declarative, emotional fear memories which created bodily changes when they were retrieved.

Contrary to my expectations, only one of the eleven patients I am presenting in this paper was alexithymic, Scot; and only two of the others had BDI scores in the range of mild depression, Rita and Winnie. The rest had minimal scores. So it seems that alexithymia and depression will turn out not to be significant risk factors for the eruption of shingles. None of the patients I have seen so far has developed post-herpetic neuralgia.

Interestingly, I found only one paper in the literature investigating whether life events are risk factors for herpes zoster. Kenneth Schmader and his colleagues published their findings and concluded that whereas patients with herpes zoster experienced the same kinds of life events in the year preceding the disease as did control subjects, recent events perceived as stressful were significantly more common among patients with zoster, and therefore stressful life events may be a risk factor for the reactivation of the VZV. The age of their subjects however, was over 50 years, and they used the Geriatric Scale of Recent Life Events, which is a questionnaire constructed from a modification of the Social Readjustment Ratings Scale (Holmes, Rahe). The data were collected by an expert telephone interviewer who was aware of 'case' and 'control' status, but was blinded to the study hypothesis. One hundred and one patients with shingles consented to participate in the research and were included in the study. The same number of controls who consented to participate in their study, were located by random digit dialling (Schmader *et al, 1990*).

From feelings to shingles

Once we identify fear and anger as the important feelings immediately preceding the eruption of shingles, we are faced with the challenge of trying to explain how intangible feelings can give rise to tangible bodily changes such as the blistery rash of shingles. Paul Martin, in his book (*The Sickening Mind, 1997*) tells us that finding the answer to this problem, became possible only in 1970 (Martin, 1997), when Robert Ader, a psychologist and Nicholas Cohen, an immunologist, discovered that the immune system (IS) and the Central Nervous System (CNS) communicated with each other. Theirs was a serendipitous discovery. Ader and Cohen were studying a form of behavioural conditioning known as learned taste aversion. As part of their research they gave rats saccharine sweetened water which made them nauseous. Soon the rats learned, through Pavlovian conditioning, to avoid sweet water because it made them sick. But rats that had been conditioned in this way began dying of infectious diseases, and the more sweet water they drank, the more likely they were to die. This was puzzling. How was it possible for an immunologically neutral stimulus like sweetness, make a rat die?

Of course Ader and Cohen knew that cyclophosphamide is a cytotoxic drug that also suppresses the immune system. So they formed a hypothesis that some form of conditioning process might have occurred in which the previously neutral stimulus, the sweet taste, had come to elicit the same biological response as the drug, namely immune suppression. They put their hypothesis to the test by injecting the immune conditioned rats with red cells taken from sheep, which are a powerful antigen. They found that the rats that had been subjected to immune conditioning produced significantly less antibodies. The sweet taste itself was sufficient to reduce their antibody response by a quarter. This meant that the immune system, like the central nervous system, could learn! It is difficult for us today, to imagine the sense of shock that the scientific community experienced at the time. Until that day, every doctor, every biologist, every physiologist, every immunologist, considered the immune system to be an autonomous entity that operated to a large degree, with no regard to the integrated physiology of the organism. Until then nobody knew of any pathways connecting the brain's centres monitoring what the rat tasted with parts of the immune system responsible for

the immune response of rats. This discovery marked the beginning of a new field of research called psychoneuroimmunology and since then, a great number of pathways have been discovered through which the immune system signals the central nervous system, and *vice versa.* (Ader et al, 1995; Watkins, 1997).

A certain amount of confusion is perpetuated in the psychoneuroimmunological literature because the same word, 'stress', is used to indicate any form of emotional un-ease, ranging from the effort that is needed to answer a mathematical problem to the ravages of bereavement, or a nuclear disaster. Stress is an ambiguous term that refers both to the stressor and the ensuing distress. The most widely accepted definitions of stress focus on the individual's inability to meet environmental demands, and the negative emotions of hopelessness and helplessness that occur when a situation threatens to exceed the person's capacity to deal with it. Life events are stressors and they contribute to an increased predisposition to disease through the activation of emotional distress and maladaptive behaviours.

The term 'distress' is another ambiguous word that refers both to the arousal of non-specific negative emotions and the particular strategies that people have to manage them. It must not be confused with the way Tomkins uses the word 'distress' to indicate the low end of the spectrum of sadness. William Miller, a professor of law at the University of Michigan Law School, who has written extensively on the emotions of humiliation and disgust, points out that the word distress, in the imprecise sense of negative emotions, is an homage we pay to the fact that we rarely experience one emotion unaccompanied by others. Emotions flood in upon us as we respond emotionally to our own emotional states. We are guilty about our anger, disgusted by our fear, embarrassed by our grief, furious about our humiliation (Miller, 1997).

Donald Nathanson, a Clinical Professor of Psychiatry and Human Behaviour, at Jefferson Medical College, and founding executive director of the Silvan Tomkins Institute, understands the term stress to refer to the upper range of affective experience which occurs when the experiencing of several negative emotions together, one amplifying the other, produces sequences of terrible vehemence, so that we lose the ability to name each affect separately. Unfortunately, the strategies that most people have, to deal with the toxic experience of negative affect do not always involve the induction of calm (Nathanson, 1995). The ability to modulate the affective response adaptively, is essential for the mastery of stress, and this is one of my primary considerations in my clinical work (Zalidis, 1991, 1992, 1994a, 1994b, 1996, 1997, 1998).

Basic emotions

Emotions result from the direct action of the central nervous system. The modern way of understanding emotions dates from Darwin's observation that the facial and bodily display of certain emotions is similar in human babies, adults, across cultures, and in some apes. He proposed that there are certain discrete emotions that manifest themselves through distinct patterns of facial expressions and body language, which occur in a reflex-like manner, and result from the direct action of the central nervous system. He regarded these expressions as the evolutionary outcome of a signalling system, whose communicative function was important for social adaptation and survival (Darwin, 1872).

Silvan Tomkins, the founder of affect theory, pursuing Darwin's theoretical framework, identified nine basic innate emotions on the basis of their characteristic facial expressions and bodily response. Because the idea that emotion is expressed in degrees of intensity is so important for the concept of innate affect, he gave them all paired names to indicate the range over which each emotion might be expressed. So in this framework, fear and terror are not two different emotions, but the same emotion expressed in different intensity (Tomkins, 1962, 1963, 1991, 1992). He describes:

- Six negative emotions: Fear-Terror, Anger-Rage; Distress-Anguish (the emotion of sadness); Disgust-Revulsion; and Dis-smell-Shunning (the emotion created in us by someone who stinks).
- Two positive emotions: Enjoyment-Joy; Interest-Excitement (or enthusiasm).
- One neutral emotion: Surprise-Startle.

Emotions can therefore make us feel bad or good, which gives them their motivational role, and are essentially biological phenomena, in animals that do not have the neo-cortical formation necessary for the development of cognition. In humans, each emotion consists of a number of responses which carry the totality of its informational, or signal contents.

1. A neuro-endocrine response which uses the chemical language of hormones and neurotransmitters, to communicate with other parts of the organism. Psychoneuroimmunology discovered recently that the stress response and the immune response share the same chemical language. The best studied emotional response is the fear response, and it has been found recently that Corticotrophin Releasing Factor, Cortisol and cytokines are essential hormones for the regulation of both the fear and the immune response.
2. A behavioural response that relates to the impulse to express an emotion in action is communicated through body language.

   Those two responses operate outside awareness and are part of our emotional unconscious. They do create signals in the body however, which return to the brain as a somatic feedback and contribute to the development of emotional awareness. When we become aware of the visceral sensations of emotional arousal, we use such

expressions as feeling 'butterflies in our stomach'; 'gutted'; having 'gut-wrenching feeling'; a 'sinking feeling'; 'feeling drained'; etc.

3, A cognitive response which is communicated through verbal language and refers to the meaning of an emotion and the story behind it.

Despite the usefulness of the concept of 'basic emotions', their identification is at present a controversial point. Professor Joseph Le Doux, who studies the neural foundation of memory and emotion at the centre for neural science at New York University, states in his latest book, that attempts to find a single unified system of emotions have not been successful (*The emotional brain,* 1998). Using the label 'emotional behaviour' should not necessarily lead us to assume that all of the labelled functions are mediated by one system in the brain. He believes that different emotions are mediated by different brain systems or networks, and changes in a particular network do not necessarily affect others directly. Rather than thinking about basic emotions, he prefers to talk about 'basic functions necessary for survival'. Emotions are functions involved in survival, but since different emotions are involved in different survival functions, each may well involve different brain systems, just as seeing and hearing are both sensory functions, but each has its own neural machinery. He believes that coming up with a list of special adaptive behaviours that are crucial for survival, would be a better way of producing a list of basic emotions, than the more standard ways such as facial expressions, emotion words or conscious introspection (Le Doux, 1998).

Because we can be in the throes of an emotion without realising that we are having an emotion, affect theory reserves the word feeling for the subjective experience of an emotion that is recognised as part of oneself. We can make the observation that we are having a feeling, only when all three responses occur simultaneously and are free of blocks that cause isolation or dissociation, and we are capable of adequate reflective self-awareness and sensitive self-observation.

In the dys-regulation model of psychosomatic medicine, the separation between mind and body falls away when the organism is seen as a dynamic communication system of information processing and exchange which regulates its own behaviour, and that of its components in response to an internal signalling system. Accoring to Herbert Weiner, professor of psychiatry and biobehavioural sciences at the School of Medicine and Brain Research Institute at the University of California, the advantage of viewing the organism in this way is that a common language may be spoken which describes the part and whole functions of the organism. In this framework, verbal language and body language are communication signals and they perform analogous functions to the chemical language of hormones and neurotransmitters (Weiner, 1989).

Memories of early loss and adversity

Cathy, described in the tenth shingles story, is a very good example of the biological effects that retrieval of an emotional memory can have on the body. In order to appreciate the biological significance of memories of early loss and adversity, it is important to discuss briefly the distinction between explicit, declarative or narrative memories which can be brought to mind and described verbally, and implicit non-declarative memories which are created through the mechanism of fear conditioning.

Modern studies of the brain mechanisms of memory have demonstrated that there are two different memory systems. One is involved in forming memories of experiences and making these memories available to conscious recollection, which are referred to as declarative or narrative memories. The hippocampal circuits with their massive neo-cortical interconnections are the main components of this system. Another is operating outside consciousness and controlling behaviour without explicit awareness of past learning. This system forms implicit or non-declarative memories about dangerous or otherwise threatening situations, and the amygdala is the key anatomical structure. Memories of this type are created through the mechanisms of fear conditioning. The learning that occurs does not depend on conscious awareness and once the learning has taken place, the stimulus does not have to be consciously perceived in order to elicit the conditioned emotional response. Joseph Le Doux in his book, *The emotional brain,* gives a simple example that makes it easy to understand how the two memory systems operate. Suppose that you are driving down the road and have a terrible accident. The horn gets stuck on, you are in pain and generally traumatised by the experience. Later when you hear the sound of a horn both the implicit and explicit memory systems are activated. The sound of the horn having become a conditioned fear stimulus, goes straight from the auditory system, through the thalamus to the amygdala, bypassing the auditory cortex and implicity elicits bodily responses that typically occur in situations of danger, muscle tension (a vestige of freezing), changes in blood pressure and heart rate, increased perspiration, immune changes and so on. The sound also travels through the cortex to the temporal lobe memory system, where explicit declarative memories are activated. You are reminded of the accident, you consciously remember how awful it was, but in the declarative memory system, there is nothing different about the fact that you were injured and the fact that the accident was awful. Both are just facts, propositions that can be declared about the experience. The particular fact that the accident was awful is not emotional memory. It is a declarative memory about an emotional experience. It is mediated by the temporal lobe memory system and has no biological consequences itself. In

order to have an aversive emotional memory complete with the bodily experiences that come with an emotion, you have to activate an emotional memory system. For example, the implicit fear memory system involving the amygdala.

Recently, Joseph Le Doux discovered that the amygdala are the essential brain structures that are involved in the appraisal of the emotional meaning of stimuli. There is an amygdala in each half of the brain. It is an almond shaped cluster of interconnected structures situated above the brain stem, and it is part of the old brain. It is possible that implicity processed stimuli activate the amygdala without activating explicit memories or otherwise being represented in consciousness. For example, suppose that the accident described above happened long ago and your explicit memory system has since then forgotten about many of the details such as the fact that the horn had been stuck on. The sound of the horn now, many years later is ignored by the explicit memory system. But the emotional memory system has not forgotten. The sound of the horn when it hits the amygdala will trigger an emotional reaction. In a situation like this, you find yourself in the throes of an emotional state that exists for reasons you do not understand. In order for emotion to be aroused in this way the implicit emotional memory system would have to be less forgetful than the explicit memory system. Indeed recent research has demonstrated that this is the case. Conditioned fear responses not only do not diminish with time, but often increase their potency as time wears on, a phenomenon known as the incubation of fear.

Henry Krystal, an American psychoanalyst who has worked extensively with survivors of Nazi concentration camps, and drug addicts, both of whom suffer from intractable psychosomatic illnesses, has pointed out that because the acquisition of language and symbolisation is a gradual one, subject to lapse and distortion, many infantile memories have to be viewed as non-symbolic, non-verbalisable affect memories. When these primitive, pre-verbal, non-declarative memories are retrieved, their somatic component is very strong and the person is not aware of their precise nature. They are felt at a sensory motor level of emotional awareness and experienced as physical symptoms contributing to emotional dys-regulation (Krystal, 1998).

The existence of separate systems for storing implicit emotional memories and explicit memories of emotions, helps us understand how the content of memory is influenced by emotional states. Learning that takes place in one emotional state is generally best remembered when you are in a similar state.

Stories of Shingles

1. Mary

Mary is a forty-eight year old secretary working in a large company, and she is married to Joseph. She is of average build and height, attractive, smartly dressed, she is wearing glasses and had a slightly lopsided face. She talks with a midlands accent in an animated and engaging, even if somewhat intense way.

Shingles

One day, Mary developed an ache in her right shoulder, and four days later when she came to see me, she had developed a blistery rash in the right side of the neck and upper back, the right shoulder and upper arm and in the front of the right chest, in other words the territory of dermatomes of C5 and C6. She was in pain, and felt too exhausted to go to work.

Background

Mary's parents arrived in England as refugees from Poland, after the second world war. She was born in a refugee camp in the Midlands. When she was four years old, her three weeks old sister died of gastro-enteritis. Her father compounded her mother's distress by his infidelity, and her parents separated when she was ten years old. She has two older brothers and a younger sister, she is still very close to her mother who lives with her younger sister in a house very near her own, and whom she sees almost daily.

Ongoing stress

Joseph's infidelity

Joseph is six years older than Mary and when she met him twenty-seven years ago, he was already separated from his first wife. She fell in love at first sight. Both their families came from Poland, and they share a background of exile and poverty. Joseph is a very clever and joyous man, a talented linguist who has always been translating and editing books, and who is lively and interesting. When Joseph's mother developed cancer he looked after her devotedly and nursed her, with Mary's help to the very end. When she died ten years ago they should have moved to a better area but by then, her own mother had come to live in the same road. She wanted to live close to her in case she was needed. In her culture, children are honour-bound to look after their parents in old age. After his mother's death, Joseph was offered a public relations post back in Poland, and he went abroad for a year and a half. This was a welcome reprieve for him after his bereavement, but despite the glamour of his post, the pay was poor and unpredictable. Mary had to stay behind and carry on working and being the breadwinner, paying for the bills and subsidising him. It was during this long absence that she realised that he was unfaithful to her. She felt desperately jealous during his long absence and a couple of times she thought of committing suicide. His post has changed since then but it still involves frequent trips abroad. She tries to keep track of his movements, but she always discovers things about Joseph that do not fit. She should trust him but she always looks for things that do not tie up with his story. She keeps ringing him in Poland and not finding him where he said he was going to be. She is very jealous of his affections going to somebody else and is fearful when he goes abroad, which he does very often. She gets sick feelings in her stomach when he goes away and sinks into the depths of despair. She thinks he runs away from sharing the responsibility of running their household with her, and resents his leaving her with a house packed with his

mother's belongings, and having to go to her own mother's home in order to relax. And he resents her for resenting him. In the past year, he has been going away every five weeks for one or two weeks at the time. He returned from Poland twenty two days before the eruption of her shingles, and they had a traumatic quarrel seventeen days before the eruption. It started one day after they had been out shopping; Mary noticed that there was something wrong with the bill at the check-out of the supermarket and she questioned it, but Joseph did not want her to go on about it. However, the cashier corrected the mistake and they started walking towards the bus stop to return home. They were both feeling hot and tired and Mary kept complaining. Suddenly Joseph, thinking that she was accusing him of something, lost his temper, became furious and grabbed her by the lapels of her coat, and hurting her as he pinched the upper part of her breast. He shouted very angrily, 'Can't you stop?'. They do quarrel a lot, but it is unusual for Joseph to hurt her physically, and his vehement display of anger triggered her anger and, feeling disgusted with his behaviour, she felt a wave of mad anger coming on. She felt that she did not deserve this behaviour, and walked off, leaving him standing there. Although they made up when they met at home later, she feels that they have been through so much trauma in the last few years that anything could become the cause for divorce.

Infertility

Mary had always wanted children but despite a great sexual relationship she did not become pregnant. They started to investigate the problem of their infertility soon after they married, and it was discovered that Joseph had a low sperm count. After she overcame Joseph's objections, she tried artificial insemination by donor, but without success. She began to suspect that something might be wrong with her. Three years before the eruption of shingles, she went to see a well known professor of fertility who ordered full investigations. On the day she was due to go to his clinic to hear the results of her tests, she developed acute low back pain and could not go. Joseph went by himself and the professor gave him a copy of the letter he sent to her general practitioner, informing him that Mary's periods were non-ovulatory. She was not producing any eggs!! Mary felt that her whole world collapsed and that the professor, like God, decreed that she could not have any children. At that point, she gave up trying to conceive, and forgot the professor's letter which she kept at the bottom of her handbag for three years.

Seven weeks before the eruption of shingles, she experienced hot flushes which she understood could mean the onset of her menopause. She felt that this was the beginning of the end – the end of the woman she could have been, and the end of her hopes of ever having children. She experienced the hot flushes as a great shock and a great loss. She decided that she could not live with herself unless she made a final attempt to get pregnant and, following discussion with friends, she chose a private clinic for some additional fertility treatment.

One week before the eruption of shingles, she came to ask her doctor for a referral letter. He was rather sceptical about the wisdom of her rushing to have yet more fertility treatment, and urged her to explore some National Health Service options as well, before deciding. She felt very disappointed and let down by what she perceived as his lack of support and that night she had a nightmare. She dreamed that she was lying in bed and a man was standing by her bed with his hands in his trouser pockets looking at her. He was not a mere burglar because he would not just stand there. He wanted to rape her or kill her, or both. She had no time to reach for her alarm spray and she ran downstairs. A hand pulled her back by the shoulder and she woke up screaming with terror and Joseph had to comfort her.

The acute stress of remembering it is impossible to have her own children

Four days before the eruption of shingles, she came to the surgery in order to have a cervical smear taken by the nurse. As the nurse was looking at her notes, Mary peered over her shoulder and saw the letter that the professor had written three years previously. She asked the nurse for permission to read it and as she read it tears came to her eyes. She said that these were tears of anger and sadness. She experienced the emotional pain as a physical blow to her tummy. She had forgotten what was in the letter until she re-read it. Without eggs, another fertilisation attempt would be doomed to failure. Was she foolish to seek more fertility treatment? And yet even if she did waste a few thousand pounds she could at least say that in her life-time, she left no stone unturned. Perhaps the professor was mistaken. Perhaps the failure to produce eggs was temporary and was brought on by the stress of Joseph's infidelity. She would like a second opinion. And if there was no hope of having her own child they could consider adopting a Polish orphan when their house is repaired.

The shingles erupted four days later, on the day that Joseph was leaving to go abroad again.

2. Rita

Rita is a seventy-three year old woman, tall, well built, with short grey hair who speaks with a heavy Italian accent and is always apologetic when she comes to tell me of her various complaints.

Shingles

One day she presented with a T5 dermatomal herpes zoster rash, extending from the sternum, over her mastectomy scar, to her axilla, and all the way around to her spine. Although the rash was extensive, the vesicles were not very dense and formed two large clusters one at the front and the other at the back, with a few scattered vesicles in between them.

Rita lives in a council maisonette with her husband, Carlo, who is the same age as she is. They have three grown up children.

Ongoing stress

Rita met Carlo in her twenties when she was working as a waitress and fell in love with his dapper looks. Her parents opposed her marriage to him and her father disinherited her, rather than let Carlo benefit from his money. They came to London where Carlo worked as a motor mechanic and she became employed as a domestic in a hospital. It had not been easy being married to Carlo. He is an aggressive man, unsociable and a loner. When he used to come home from work he demanded angrily to have his dinner immediately, and he did not like having the children around. He used to hit them and, on several occasions he gave Rita a black eye. She did not imagine he would be like this when she married him. He has never been interested in other women, and has never been unfaithful. But he has not been very interested in her either.

When she needed to have a hysterectomy because of abnormal bleeding, he would not give his consent as a next of kin, and when she developed cancer of the breast and needed to have a mastectomy, he did not want her to have it done. In fact, their sexual life ended after her mastectomy fifteen years ago. She has never slept with him since then. Carlo had always been a heavy smoker and he developed ischaemic heart

disease. Five months before the erutpion of her shingles, he had heart surgery following a myocardial infarction, and although his breathing improved after the operation, he has not stopped moaning and smoking. He sits upstairs watching television all day long while he chain smokes. When she reminds him that smoking will harm his heart, he replies that he has nothing else in life and does not care. Although Rita is suffering from chronic bronchitis and heart failure, and her doctors advised her not to inhale smoke, he does not care about her health either. He refuses to stop smoking.

Rita has come to the surgery many times complaining of a persistent, productive cough which does not respond to any medication. Carlo has been more aggressive since his operation than ever. He shouts and swears at her, keeps telling her that she is a lousy cook and that she is always ill and moaning. He has stopped hitting her, however. Rita says that if he tried to hit her now she would push him down the stairs. She has had enough. Her children wanted her to leave him long ago, but she is old fashioned and believes that you marry for better or worse. You have to grin and bear it. Rita had been concerned about their eldest daughter Donna who, after divorcing her husband, was in the process of selling her marital home. Eight months before the eruption of shingles, she had a hysterectomy for abnormal bleeding and like Rita, she had suffered bladder damage. She lives in another city and since her operation she had been telephoning her mother frequently and complaining of breast pain.

The acute stress of daughter's telephone call

Rita finally persuaded her to ask her doctor for a mammogram, and one day before the eruption, Donna rang her mother in tears. She was very frightened because she had received a letter asking her to go back to the hospital for some more tests. Rita remained calm during the telephone conversation and managed to reassure her daughter, but as soon as she put the receiver down, she burst into tears and cried inconsolably for a long time. She was very worried about Donna's health because their medical histories had been identical so far with the hysterectomy and bladder complications, and it was possible that Donna might develop breast cancer too. She cried because she felt that Donna's problems were all her fault. She was very unhappy when she was pregnant with Donna, because her husband would not find a job and was cruel to her. She believed that if the pregnant mother is unhappy, then the child she carries becomes depressed and somehow, this unhappiness has something to do with the breast cancer. Also she could understand how frightened Donna must have been because she remembered her own fear when she was told she had breast cancer. She said that the night after that telephone call, she felt unwell and could not sleep. When she woke up in the morning, she noticed the blistery rash of shingles.

3. Antonio

Antonio is a fifty years old librarian who came to London twenty years ago, as a refugee from Chile, with his wife Sarah, one year after they were released from prison. He is a stockily built man who has a gentle, thoughtful expression and speaks softly with a faint Spanish accent.

Shingles

One day he experienced pain in his right loin, followed on the next day by a group of vesicles in a small area the size of a fifty pence coin, when he went to see his doctor. Two days later the rash spread and became very dense. In another four days, the blisters had coalesced and extended around his waist, occupying the whole area of the T10 dermatome, and he came to see me. The area of the rash was covered by a yellow crust and he had developed a high temparature. Assuming that the rash was now complicated by an acute staphylococcal infection, I treated him with a course of appropriate antibiotic therapy. His pain was intense and he needed painkillers every two hours.

Ongoing stress

Although Antonio had a university degree, he did not speak a word of English when he came to this country, and he was obliged to do a variety of odd jobs while he was learning the language. For the past ten years he had been working as a librarian in a polytechnic, and over the last two years he had experienced a doubling of his work-load. The number of students had increased, the library had grown, there were more books to be put back on the shelves, and the quality of the interaction with the students had diminished. There was not enough time to teach them how to do literature searches any more. He was fed up with the job and he would prefer to be a representative for a wine company, and promote the beautiful wines of his country.

Antonio met Sarah at university. They love each other, they have the same interests and they enjoy their conversation. She is his confidante. Soon after they came to England they had a son, but around the same time she developed asthma which has gradually been getting worse. Because she gets breathless climbing the stairs, they had to move their bed to the ground floor. Her breathing difficulty is putting him off sex, but that does not mean that they love each other any the less. Sarah can become very breathless very fast and then she requires steroids and nebulised medication. When Antonio sees her having an asthmatic attack, he feels dreadful as he is powerless to make her better. He calls the doctor, tries to calm her down and reassures her that the doctor is on the way. Every refugee's dream is to be able to return to his own country one day, but with the recent deterioration of his wife's asthma he has begun to fear that this dream may never come true.

Medical care is very expensive in their country and not as readily available as in London, and he is afraid that Sarah will not be able to have the prompt response to her asthmatic attacks that she has here, so that her life might be at risk. Because Sarah feels guilty about taking time off work she delays seeking medical attention until her asthma is extreme, and she needs urgent hospital treatment. Four months before the eruption of shingles, she became so breathless that she became cyanotic. She was rushed to hospital where the doctor told her that she nearly died because she did not take her illness seriously.

Antonio feels that if Sarah dies, it will be the end of them as a family. She is the home-maker and without her, life in London would be intolerable. He will have to pack his bags and go back to his country, and he doubts whether he would be able to adjust to life after so many years in England. He feels sad for her because she cannot enjoy life. His son is growing up and will leave home soon, and she is becoming incapacitated at a time when they could start enjoying life.

One morning before the eruption of shingles, Antonio's father died and was buried within forty-eight hours. He could not go to his funeral because he was applying for British citizenship at the time and had sent his passport to the Home Office. The last time he saw his father six months previously he was making good progress from a stroke he suffered a year earlier. He felt very sad. He had known his father as a child and as a young man but not as an adult. When he was arrested in his country he was only twenty seven

years old. He was released two years later and he emigrated the following year. So he felt that in his adulthood he was deprived of the opportunity to have a man to man relationship with his father. He always hoped that he could go back to his country and be able to enjoy the company of his father, his mother, his brothers and sisters. Now he worries about his elderly mother who lives alone. He tries to keep his worrying under control. He feels that he can switch off. He goes to work and he forgets about it. He considers himself a jolly person. He might get a little more irritable than usual and a little less sociable but he manages to switch off. However he often wakes up in the middle of the night and thinks and then he feels tired the next day.

The acute stress of the news of his sister's illness
Two days before the shingles erupted his niece rang from France to say that her mother, Antonio's elder sister, was found to have a brain tumour. She had been complaining of headaches for sometime and she consulted an optician who advised her to have a brain scan. The scan showed a brain tumour and the doctor recommended an immediate operation. Unfortunately the doctors were on strike and the operation could not be done immediately. She had to wait for a week.

Antonio thought that the tumour must have been a malignant one if the doctor recommended an immediate operation and he felt very sorry for his sister. She was a school teacher and emigrated with her husband one year before Antonio did. Her husband died of cancer three years later and she brought up her children alone. Recently she had become a grandmother and she was looking forward to this fulfilling experience. Antonio felt close to her. He used to visit her often and kept in touch regularly over the telephone. He felt very sad at the thought that the members of his family are reaching a critical age in their fifties and sixties and have started dying of horrible diseases. He feared that his wife will be the next to go.

Antonio is unable to cry. He did not cry when his father died nor when he received the news about his sister. He admits that sometimes when he watches a "silly" film his eyes water but this is all. He feels sad, but he cannot cry even though he would like to.

Unfortunately his sister died during the operation a week later despite the eminence of the surgeon. His shingles gradually got worse in the week leading up to her operation and the death so that he was unfit to travel to France for her funeral. Sarah went by herself and she had a several asthmatic attack as soon as she returned.

4. Phil

Phil is a sixteen year old schoolboy who is tall and slim and probably too streetwise for his age.

Shingles
One day he developed a cluster of blisters at the tip of his right scapula the size of a fifty pence coin and several more blisters, scattered between the scapula and his spine, corresponding to dermatome T1.

Background
He live with his mother, father, his twin brother, his older brother and foster brother in a large three storey house which allows each one of them to have his own room. He is very close to his mother and his twin brother who are his confidants.

Ongoing stress
One year before the eruption of shingles, his twin brother developed pneumonia and he became so breathless that Phil and his older brother had to carry him to the hospital where he was admitted for three weeks. This was a traumatic experience for Phil because he was afraid that his twin brother might die.

Seven months before the eruption of shingles his grandmother died. Her death was unexpected and his mother was very upset and was crying all the time. He tried hard to hold it all in, and be brave about it and not cry. At the funeral he found it very hard trying to comfort his mother and keep a stiff upper lip.

Phil sees himself as the conciliator who is holding the family together. His foster brother, who has the same age as his older brother, is schizophrenic, speaks with a Jamaican accent, smokes hash and gets a hundred pounds a week invalidity benefit. His older brother gets fifty pounds every two weeks unemployment benefit and he is envious of his foster brother. **Six months before the eruption of shingles** his older brother got drunk, had an argument with his foster brother and when his mother told him off, he flew off the handle and started smashing the house up and breaking windows in the bathroom. Phil who was in his own room with his mates at the time pushed his older brother out of the house and prevented him from causing any more damage. It was good thing that his father was not at home because there would have been a fight.

Phil is earning about a hundred pounds a week by doing a variety of jobs. He wakes up early in the morning and before he goes to school he goes to the local street market where he works for an hour helping a street trader set his stall up. After school he goes back to the market and works for another two hours helping another street trader to pack his vegetables away. On Saturdays he works at the market for about ten hours helping several street traders. He has been helping street traders since he was expelled from his secondary school two years before the eruption of shingles. He was thrown out because he was rude to teachers, he was fighting with his fellow pupils and getting into arguments. The teachers kept a record of all his misdemeanours and they compiled a booklet with all his wrong doings. It was horrible. He had not always been the conciliator. He used to be quite a handful at home too. He was out every night regardless of what his mum and dad said. However coming out of school was the best thing that could have happened to him. It made him more open minded and made him think about why he was thrown out. He thought about how to deal with situations and how not to get aggressive and throw his weight around. He found out that being quiet and minding his own business helped him cope with things better. He started going to a rehabilitation centre for three hours a day and with the encouragement of his parents he started preparing to go back to school.

Six months before the eruption of shingles he was also enrolled in a new secondary school and started a new term. Suddenly from working in his own time at a leisurely pace, he had a lot of deadlines to meet for essays, assignments, GCSE course work, and he found all this very stressful. Getting all this work done is very hard and there is not a day in the week that he does not think; God I have to do this, God I have to do that. Sometimes he leaves his work until the next day and the teacher demands the work and then he has to stay up until early morning trying to finish it in order to deliver it the next day. He has began to regret being kicked out of school. If he had held it all together he would not have had this break in his education which has left him ill prepared to face the demands.

The acute stress of losing his assignment
One day before the eruption of shingles, because he was behind with the delivery of an essay on Arthur

Miller's play 'A view from the bridge', his mum's friend was helping him to write it directly on the computer in order to save time. When he tried to save it, he pressed the wrong button and the essay was wiped off. He could not believe it. He spent five hours working for nothing. This was a complete let down and he was very annoyed. He felt like kicking the computer, but he did not dare to do it in front of his mother's friend. If she was not there he would have booted the computer clean off the table, but he had to hold it down. He felt mmm-mmm ... Five hours of his work wasted. He could not believe it. Fortunately his mum's friend was very comforting. She told him not to worry and she would help him to do it all over again. The following day as he was playing football his back started aching and itching and he thought that he had been stung by a bee. When he looked at his back later that day he was surprised the bite was so big.

5. Scot

Scot is a twenty-seven year old computer expert who works full-time in the technical support department of a computer company.

Shingles
One day he woke up feeling very tired as if he had run the marathon and he noticed that he had a small group of blisters under his left nipple. When he came to see me five days later, the rash had spread to occupy the whole of the T7 determatome, extending from his sternum, round his axilla, to his spine. The cluster of blisters under his left nipple had become infected and red lines were leading to his axillary lymph nodes which were swollen and painful. I treated him with a combination of antibacterial and antiviral antibiotics and invited him to participate in my research.

Background
Scot is slim, of average height, and looks younger than his age. During the interview he spoke hesitantly with a fixed smiling expression and he seemed to be very uncomfortable with personal questions. He was an only one year old child when his father died of a heart attack. He has never separated from his mother who never remarried. Their relationship is good but he avoids confiding in her because she always wants to know more than he is prepared to tell her. She is very nosy. However he feels free to come and go as he pleases and he finds living with her very convenient. His confidant is a man whom he talks to on the phone once a month and he sees once a year.

Ongoing stress
Three months before the eruption of shingles one of the three technical support workers found a better paid job and left. Since then he has to deal with an increased number of phone calls from customers who ring for advice and this is not the type of work that he enjoys. He finds it annoying having to repeat again and again the same thing for customers who do not understand his advice and it seems than an increasing number of customers ring to complain angrily that they have been billed wrongly. His job is to work out how much must be refunded to them before he passes them on to the accounts department. He has noticed that although his colleagues can tell immediately which of the customers are angry, he is rather insensitive to their anger and his unawareness helps him to stay calm. After all he cannot shove the money down the telephone line. Although he has been promised a rise, to compensate for his hard work, nothing has materialised yet and the company, rather than replacing the worker who left, are thinking of employing at low cost someone from the youth training scheme who is going to do most of the boring mechanical chores.

The acute stress of losing his files
The work that Scot enjoys most, is System Administration Programming and recently he had been working on a program that would automatically e-mail customers who were behind with their payment and this would relieve his work load. He had been working under a lot of pressure because he had to finish it before his approaching holiday and he was taking work at home every day. **Nine days before the eruption of shingles** he was using a program which unbeknown to him was corrupted by a virus and as soon as he had completed his files and pressed the button to save them, the program quit and he lost all his files. He felt very annoyed. He experienced his annoyance as an awareness of his tongue inside his mouth and his brain inside his skull. He pursed his lips, he inhaled sharply and his muscles tensed. When he realised that he could not retrieve his files he started all over again. It took him most of the week to rewrite the files he lost. He worked late into the night and over the weekend. **Two days before the eruption of shingles he managed to complete his work.**

6. Pauline

Pauline is a nineteen year old, first year university student, who is petite, with a round face, and large intelligent eyes. Her hair is drawn back in a bun and she talks in an animated lively way.

Shingles
One day she developed a small cluster of blisters surrounded by a red patch on the skin of the left loin. Six days later the blisters spread to occupy the whole T10 dermatome, extending from the spine, round the left loin, all the way to her umbilicus. The main sensation was itching and pain was minimal.

Background
When Pauline was three years old, her sister who was one and a half years older, developed a malignant cancer and died after a short illness. Pauline remembers almost nothing of the drama that surrounded these tragic events, except that she went to live with her grandparents during her sister's illness.

She became very close to them and spent most of her childhood with them until she was eleven years old, and continued to visit them for two hours every day after school.

When she was twelve years old she was involved in a road traffic and although she only sustained a whiplash injury of the neck, she subsequently developed epileptic fits which despite her taking antiepileptic medication still occur at the rate of one every ten weeks.

Two years before the eruption of shingles her grandfather developed cancer of the bowel and she became very upset when she was told so. She cried a lot and she could not bring herself to go and visit him in hospital because she did not like seeing people when they are ill. She was closer to him than her grandmother and when he died she cried inconsolably for a long time.

Ongoing stress
Three months before the eruption of shingles her grandmother had suddenly a heart attack. This time she found the courage to visit her in hospital with her mother, but it was quite a shock and she had an eerie feeling. Her stomach was turning upside down and she

almost cried. For the whole week that her grandmother was in hospital she was afraid that she might die and she did not want another grandparent to die.

Two months before the eruption of shingles, for the first time since the fits began, she has had more fits than usual, which to her is an indication of stress.

One month before the eruption of shingles her grandmother's sister died unexpectedly but she coped with her death much better than with her grandmother's heart attack.

Six months before the eruption of shingles Pauline got her A levels and she was offered a place at university, to study molecular biology. Although she was very sad to separate from her school boyfriend who went to university at another city, she made new friends and met David, a fellow student, who became her confidant and lover and with whom she has a very relaxing chatty relationship and has become a major part of her life.

The acute stress of the threat of losing David
Life at university is quite busy and she shares her living between her parents' home and the university hall of residence. She has to study hard and prepare for two practicals a week, two lectures every day and meetings with her tutor every two weeks. Unfortunately David is lazy. He does not like getting out of bed in the morning. She has tried kicking him out of bed and dragging him to lectures, but most of the time she fails. Very often she stays with him and they ask a friend to sign them for the lecture. David does not get on with his tutor and has been missing tutorials.

One week before shingles erupted David received a letter from the head of the biological sciences inviting him to go and see the Dean and discuss with him whether he had a future at the university. He read the letter in front of her and went all quiet. She said that it was not a very nice feeling. At the time they did not know whether he was going to be thrown out of university. If he was expelled he would have to go back to his parents in the North of England and she would lose him. He is her best friend and only lover and it would be quite a loss.

7. Shirley

Shirley is a forty-one year old graphic designer who is in the process of changing career to become an actress. She is slim and attractive, wears fashionable clothes, looks younger than her age and speaks with a sexy voice.

Shingles
One day she began feeling ill and developed pain in her right loin and thought that she was developing a kidney infection. Three days later she developed a few blisters in her loin and within the next four days the blisters spread to occupy the whole L1 dermatome from her loin to her groin.

Background
Shirley is the eldest of three children who is seven years older than her youngest sibling. Her father had a lot of financial worries and he was always short tempered and intolerant of noise. When Shirley became a teenager she felt that she was turned into a little mother so that her mother could go to work. She had to stay in, prepare meals and clean the house. Although she tried to please her, she felt that her mother did not know how to show affection and was not protective enough of her needs. When she developed anorexia at fourteen her parents did not show much concern for her health and did not take her to the doctor. She feels a resentful love for her mother and when she talks about her parents she becomes emotional because it makes her feel neglected.

Her father died of a heart attack at the age of fifty six when Shirley was twenty six years old and her mother who blamed her own infidelities for his death, started drinking excessively. She died of carcinoma of the oesophagus six years later, at the age of fifty-nine.

Shirley feels that there is a cold side to her, like there was a cold side to her mother and she is very scared of being involved in relationships. She separated from her husband six years before the eruption of shingles and he moved out of their house leaving her alone with six cats. They remained good friends and she continues to do some work for his company occasionally.

Ongoing stress
Three months before the eruption of shingles she went across the road to visit a neighbour for twenty minutes and when she came back she realised that her TV, her video and her hi-fi had been stolen. She suspected her next door neighbours for the burglary because of the various suspicious types that were going in and out of their house, but she had no proof. For a long time she lived in fear and loathing planning a revenge that would annihilate her neighbours so that they would not be able to retaliate. She felt so insecure in her house that she decided that she did not want to live there anymore and she put the house on the market. There had always been a problem with the house next door. When she first moved in the house with her husband seven students lived in it and made unbelievable noise. Then they were evicted and the house remained empty for a year and it was bliss. Then an Indian family with seven children moved in and they made a lot of noise and now this. The house seemed cursed.

The acute stress of feeling unprotected
She reported the burglary to the police and she was contacted by a policeman who was friendly and chatty, and who took her suspicions seriously making her feel very relieved that she was not just paranoid. However very soon it became clear that he was more interested in having an affair with her rather than finding out who the burglars were. Although she found him repulsive she hesitated for a few weeks before telling him that she was not interested in going out with him, because she was worried that by rejecting him she might compromise the investigation into her case. **Two weeks before the eruption of shingles** however she told him in on uncertain terms that she was not interested in him sexually and he passed her case on to someone else. She felt guilty for rejecting him and tainted for leading him on for so long.

Four days before the eruption of shingles another policeman came to see her who pointed out to her that he could not arrest or even caution her neighbours on her suspicions only. They would only deny her accusation and then she would have to continue living next to them and they might not be very friendly. At this point Shirley's heart sank and she felt vulnerable. Up until then she felt that the police were on her side because they were convinced that her neighbours did the burglary and they could at least tell them that they were under suspicion. Suddenly she felt that people could walk into her house and take things and go unpunished. She felt unprotected.

8. Lewis

Lewis is a forty-nine year old security contract manager for a security firm. He is of average build, speaks with a worried expression and looks tired.

Shingles
One day Lewis felt a twinge on his left shoulder radiating down the left arm and alarmed he went to casualty thinking he was having a heart attack. However all the tests were normal and in the next few days small blisters appeared on his shoulder and the rash spread to involve the whole of the C6 dermatome.

Background
Lewis was born in Ireland and he is the middle of three children. He married young and he had two sons and a daughter, but his wife never forgave him an affair he had, when she was grieving the death of her father. She left him four months after the death of his mother when Lewis was thirty years old. Lewis could not tolerate the distress of his children and despite the beginning of a promising career in the bank he decided to make a clean break, come to London and start his life all over again. He has not been in contact with his family ever since and he regrets the separation from his children who would be in their early twenties by now.

He lives with his second wife Jane, a legal secretary, who is eight years younger than him, and **three months before the eruption of shingles** they exchanged contracts on a house they liked and were in the process of packing their belongings in order to move. Unfortunately Lewis was too busy at work to help Jane.

Ongoing stress
Ten years ago Lewis started working as a security guard and because of his easy going character he was gradually being asked to take more and more responsibility until he got the job of security contract manager for several prestigious buildings. He is proud of his management status and his ability to manage three hundred contracts at any one time. With his hard work he has contributed to making the company successful and he has received commendations. However he is worried about the company's ethos which does not recognise the need to have enough security guards in order to cover all the sites. The position of the general manager is that if you need five men, hire two. The pressure to find enough staff to cover all the sites is magnified by the demand of certain customers for white security guards only, which means that to put the right person on duty he has to move several staff around. Occasionally he had to lie and place a black guard at a site where he is not wanted, hoping that the customer will not notice.

The chronic understaffing problem demands that at times, he has to ask his staff to miss their lunch break. He feels that this amounts to abuse of the people who work for them and although some staff accept it, some others protest and walk off leaving the place unmanned and then Lewis has to cover the site himself. He feels unsupported by the general manager who does not care whether Lewis can cover their lunch hour, and who can take time off whenever he wants to. His attitude is that if some security guard does not like the job we can find someone else who does. When I pointed out to Lewis that perhaps he is among those who are mistreated by the general manager he said that he is not concerned about himself. He has ways of fighting and getting round it, such as kicking walls!!! Many a time he has gone into a toilet and literally kicked the wall in frustration. He has had arguments with the general manager because he was not prepared to pay somebody to cover the lunch hours and therefore putting the contract at risk. He tells him that it is not his problem but Lewis believes that it is his problem because the guys who are working for them deserve their lunch hour.

Six months before the eruption of shingles he started sweating excessively and sleeping poorly because he is constantly worrying that he may not have enough workers to cover all the sites. Although he does not experience the feeling of fear he deduces from the sweating of his armpits that he is under stress. He sweats excessively when he goes to the office first thing in the morning and as the morning progresses and it all falls into place the sweat dries up. He does not sweat at home.

Although he is contracted to work sixty hours a week, **three months before the eruption of shingles,** two of the five contract managers left and were not replaced so that the remaining three had to do the work of five. He started working seventy hours a week and being on night duty every third week. When he goes home at night he is knackered. All he wants to do is sit in front of the TV.

The acute stress of being let down by the manager
Lewis had worked seventeen hours every day for fourteen days without a break, and was looking forward to his two days off when were to be covered by the general manager. **One day before the eruption of shingles** however, the general manager rendered him speechless by telling him that because he wanted to go to a cricket match, Lewis would have to work on his days off. He felt grrrrrrrr (and made a strangling gesture with his hands), the boss had done it again. This was the third time the general manager cancelled Lewis' time off in the last three months. Lewis says that the general manager is a version of God and there is no point arguing with God unless you want a confrontation. If he wanted a confrontation he would stand up and say: bugger you I am taking my time off. But Lewis is not the type of person to have a confrontation. If the general manager wants somebody to be in the office then he'd rather be in the office than stay at home. He does not mind. He feels that somehow it is his fault that he is so easily put upon. Although he did not consider himself to be a yes man, talking to me he realises that actually he is a yes man.

9. Don

Don is a twenty-eight year old courier who is short, strong and stout, has a closely cropped head and talks with a thick cockney accent. He was very defensive throughout the interview because he was not used to talking about himself to anyone.

Shingles
Don had stopped having asthmatic attacks since he gave up smoking two years ago and he was enjoying good health, until one day he experienced back pain and at the same time a sensation of wearing a very tight belt that was digging into his skin. Five days later, when he came to the surgery to have his pain checked out I found an extensive blistery rash extending from his spine round the left loin, all the way to the umbilicus, the territory of T12 dermatome.

Background
Don's parents separated when he was twelve years old and one year later his father died suddenly of a heart attack. His mother had a nervous breakdown and was admitted to hospital and since then she relapses every two or three years. Don had been living at home with his mother and his twenty-three year old sister until his girlfriend Jan became pregnant three years ago when her mother invited them both to go and live at her house.

Ongoing stress
Jan's panic attacks which disappeared while she was pregnant returned after the birth of their daughter

eighteen months ago. Don worries about her health and when she has a panic attack nearly once a week he feels helpless and stays with her until she feels better.

Although Don has been a courier for the local borough for eleven years his pay has not been sufficient to allow him to save or go on holidays. Therefore he decided to do an extra job and **five months before the eruption of shingles** he started doing minicabbing at night. He would return home from work at five in the evening, and would go out again at six, until one in the morning. He would return home, unwind for an hour and sleep for five hours until seven in the morning when he had to go to work again.

Two months before the eruption of shingles his mother relapsed and she was admitted to hospital. When he went to visit her he was shocked to see how drowsy the drugs she was taking had made her.

Acute stress
Minicabbing was stressful not only because it was depriving him of his sleep but also because occasionally some of his customers would not pay their fare and then he would feel gutted. **Three days before the eruption of shingles,** he was hired by a suspicious looking guy who wanted to go to a rough part of London. When they arrived at their destination he got out of the car and asked Don to put the locks on the doors and wait for him until he returned. Don suspected he was probably a drug dealer who went to collect drugs and he felt butterflies in his stomach. He was afraid that if the police stopped him and found the drugs, they might think that he was an accomplice.

10. Cathy

Cathy is a thirty-five year old secretary of average build who has greyed prematurely.

Herpes simplex?/shingles
One day she developed a small cluster of blisters the size of a fifty pence coin on the back of her chest at the level of T10. The pain was minimal and she complained only of itching. She has had a similar eruption in the past.

Background
Cathy is an only child whose father died of a heart attack when she was six years old. Her mother remarried but her stepfather was a violent man and the marriage did not last long. She is living with Thomas, the nine year old son from her first marriage, her second husband John, and their two children, two year old Tim and four month Anna.

Ongoing stress
One year before the eruption of herpes, she began feeling unwell. She was tired, she felt sick and developed a pain on her left side. When the doctor eventually diagnosed pregnancy she was shocked. After three terminations she thought she was being very careful with her contraception. She decided to keep the baby but at sixteen weeks of pregnancy when she was told that the screening test for spina bifida was positive she cried uncontrollably. Until the results of the amniocentesis and the detailed scan were known she tried to forget she was pregnant. She could not take the risk of relating to the new baby in case she needed to have an abortion. She felt that she could not give her children the attention and love they needed if all her energy was taken up by a handicapped child. Fortunately the results were normal and **four months before the eruption of herpes** she gave birth to Anna.

Two months before the eruption of herpes, Anna became unwell, went off her food and started vomiting. Cathy rushed her to casualty and by the time the doctor examined her she was floppy and lethargic and was breathing with difficulty. The doctors were very concerned and Cathy who by then was very frightened and in tears, thought that her baby was going to die. Anna was admitted to the intensive care unit with the diagnosis of bronchiolitis and eventually meningitis was ruled out. **Six weeks before the eruption of herpes,** she was discharged but one day later she relapsed and had to be readmitted for another week. Cathy felt that she was being punished for the terminations she has had in the past and was rather angry with the hospital doctors for discharging Anna prematurely.

Thomas, her eldest son, who had been very jealous about all the attention his little sister was receiving blamed himself when Anna became ill because a few days before her admission to hospital he had gone to a party and come in contact with a child who later developed meningitus. **Five weeks before the eruption of herpes,** Cathy had an urgent call from his school informing her that Thomas had fallen in the playground and had broken his tibia.

The acute stress of the retrieval of an old memory
Two days before the eruption of herpes, she had a phone call from Lina, her confidante. 'Guess who had the police here at half past two in the morning?', she told her. Cathy was shocked to hear her story. She had always considered Lina's husband to be a quiet and peaceful man, but he had found a telephone number he did not recognise in the telephone's memory and suspected that his wife was having an affair. That night he woke her up at two in the morning, told her to come with him to the kitchen and there he pushed her against the wall, and threatened to slit her throat with a kitchen knife. Fortunately Lina's little daughter heard the noise and came downstairs and when she saw what was going on she started screaming, and he switched off and walked away. After this experience Lina called the police and because she could not trust him any more, went to live with her parents in another part of London away from Cathy's home, so that they could not meet daily when they were taking their children to school as they used to.

Hearing about this knife episode stirred up Cathy's memories of her stepfather's cruelty and she became quiet and withdrawn for some time afterwards. Her stepfather was jealous of the attention his wife used to give to Cathy and when she was out to work he used to lock Cathy in her bedroom, show her a knife and tell her that if she tried to get out of the bedroom he was going to cut her up in little pieces. One day when she was eleven she was reading comics in bed and because the ink had rubbed on her fingers, he dragged her out of bed and beat her so hard that she ran to a friend's house for shelter and she was afraid to go back home. Her friend's mother called the police who told her mother to take an injunction against this man so that he was not allowed near Cathy again. This frightening experience made her decide never to hit her children and even watching violence against women and children on TV gave her flash backs.

11. Winnie

Winnie is a forty-seven year old Jamaican woman who was unemployed at the time of the interview and who looked much younger than her age.

Shingles
One day she presented with an elongated cluster of blisters at the back of her right chest which was more itchy

than painful and extended ten cm down, from the tip of her shoulder blade across dermatomes T1 and T2.

Background

Winnie is the eldest of two children and was born in Jamaica. When she was eight years old her parents emigrated to England and she was left in the care of her paternal aunt. She was very sad for separating from her mother and she was afraid that she might not see her again. She did not get on well with her carers who thought that she was a strange child and at the age of sixteen her parents asked her to come to England to join them. Her mother was an ambitious woman who was always very busy working as a hairdresser and she did not point her in the right direction. Instead of pursuing her education and going to university she married early and had three children.

Her mother died of kidney failure at the age of forty four, sixteen years after they were reunited and her father died ten years later at the age of sixty six.

One year after her mother's death, she divorced her violent husband and she had to go to work in order to support her children. Eight years before the eruption of herpes, she went through a very stressful period around the time her children were leaving home and she developed asthma and hypertension. Although she has a boyfriend, she prefers to live on her own and she does not discuss her problems with anyone. She always solves her own problems.

Ongoing stress

She is fed up always scraping the bottom of the barrel and struggling to pay the bills. The forty five pounds a week income support she receives is just enough to buy crisps for her grandchildren. She would like to earn enough money to buy nice clothes and save in the bank, in order to go back to her own country as soon as possible and enjoy life.

Hoping to improve her chances of finding a good job she went to college for three years and **one year before the eruption of herpes** she got a BTEC diploma in business and finance with distinction. Her tutor urged her to go to university, but she felt that qualifying at fifty one would not improve her job prospects.

However despite her qualifications she has not had much luck with job applications. She has experienced a lot of prejudice in her life but recently she has become very conscious of her age. She has been to many interviews but the jobs are given to younger persons who do not have her qualifications and she finds this humiliating and unfair. She feels very angry when she is treated unfairly. When she was younger she used to go mad and get into a lot of arguments and fights. But gradually she has learnt to contain her anger, keep it inside her and have an attack of asthma instead.

Eight months before the eruption of herpes, her daughter told her that she was pregnant again and Winnie was very disappointed that she decided to have another baby so soon after the first one. She wanted her to have some further education and get on with her career. She helped her with the first baby and she was not prepared to help with the second one because she wanted to find a job and earn some money.

Six months before the eruption of herpes she came home one day and found the door of her flat kicked in. Burglars had searched her flat but had not stolen anything. She went mad and started shouting at anybody and everybody and told the police that they had better book a cell for her in Holloway prison because if she catches the burglars she would kill them. She calmed down after a few days and **five months before the eruption of herpes** she found a job as a receptionist with additional light cleaning duties at a local general practitioner's surgery. **Four months before the eruption of herpes,** whilst she was still learning the job the senior partner saw her photocopying a certificate for a patient and told her off angrily in front of the other receptionists. Winnie managed to keep her anger inside and not shout back but she told him in no uncertain terms that she did not like being made to feel stupid in front of her colleagues. When the practice manager asked her a few days later why she was so mad at the doctor, Winnie replied that if she had been mad at him the practice manager would have to go to India to pick him up, because this is how far she would have kicked him. She demanded to be treated with respect or else they would see the other side of her which is not very nice. She told the practice manager that the job was not so important to her that she would have to put up with humiliating behaviour. She had qualifications and she could find a job elsewhere. After this episode she became progressively dissatisfied with her job because the practice manager was putting pressure on her to do more and more cleaning work for the same salary.

The acute stress at the second workplace

Three weeks before the eruption of herpes, she took a cleaning job for two hours every morning starting at five thirty, on top of her job as a receptionist. Very soon she felt unfairly treated however, because the supervisor gave her more work to do than the two cleaners who had already been working there and who wasted a lot of time laughing and joking with each other. **One week before the eruption of herpes,** she complained to the manager, who saw her point and tried to divide the work equally between all three of them. One of the cleaners however started shouting and being grumpy and soon went off on sick leave with back pain. Winnie had to cover the duties of the absent worker and face the supervisor and the other cleaner who were hostile to her. She felt under a lot of stress and when she told the supervisor that her doctor had diagnosed an infection with the chickenpox virus the supervisor told her to take sick leave and stay away from her because she had a young baby at home.

Conclusion

The above stories illustrate that shingles does not erupt out of the blue, but is preceded by a number of stressful events and difficulties which produce a baseline of negative emotions magnifying each other and leading to an emotional experience of toxic intensity. In this emotional climate anything can push a person beyond the limits of tolerance.

Donald Nathanson has pointed out that when in the context of a social or interpersonal situation emotion is piled on emotion, one magnifying the other continuously, the resulting intensity of emotion can be unbearable and the person could become inconsolable. Just as the heat of a nuclear fusion engine bears little relationship to the flames in our fireplace that heat us in winter, emotion at its highest realms of magnification is nothing like the basic innate emotions and represents a dysregulation of affect which in turn can dysregulate other bodily systems, including the immune system.

Although none of the patients I have seen so far have developed post-herpetic neuralgia, it would be foolish to claim that my psychosomatic approach protected them. To research such a possibility would involve the study of a greater number of shingles patients than a general practitioner can see in a life time. However my findings so far suggest that shinges follows the kind of life disruption that could also precede a potentially serious disease like pneumonia. Armed with the above knowledge we can offer patients who

develop shingles more help than an accurate diagnosis and antiviral medication of doubtful efficacy[35]. We can ask them whether they have had any losses or been under stress recently and then listen to their story with interest, sympathy and understanding. This medical activity can provide solace and induce calm, as Michael and Enid Balint have repeatedly demonstrated. More recently Howard Brody, a professor of primary care and Michigan University, in a very interesting paper has argued that the general practitioner has the power to implement symbolic healing by listening carefully to a patient's story and engaging with the patient in the joint task of construction of narrative[36]. The doctor who listens carefully to the patient's story of his suffering lays the groundwork for the important dimensions of symbolic healing which include: an explanatory system, care and compassion and mastery and control. Giving the patient an accurate explanation of his disease or illness allows him to participate more actively in medical care, demonstrating care and compassion may give the patient the reassurance that he needs to participate in this way and finally instilling a sense of power and control is vital if the patient is truly to feel empowered and to take specific actions that will promote health and ameliorate symptoms. Also the joint construction of narrative might contribute to the cognitive processing of traumatic emotional memories that had been stored in non declarative memory so that they can be stored in declarative, or narrative memory, retrieval from which is not accompanied by the strong physical manifestations of traumatic emotions.

The patterns of stress in shingles

Cases	Early Loss/Adversity	Early Loss/Adversity	Acute Stress
1. Mary 48	Baby sister died when Mary was 1 year old. Parents separated when she was 10 years old.	Husband's infidelity. Infertility.	Fear of childlessness. Anger with husband for being unfaithful.
2. Rita 73	Emigrated to England in her 20s. Mastectomy for breast cancer 15 years before shingles.	Hostile husband Worry about husband's health. Worry about daughter's health.	The daughter's fear that she might have breast cancer brings back her own fear.
3. Antonio 50	Jailed and tortured in his 20s. Emigrated to England in his 20s.	Worry about wife's health. Grief about father's death. Increasing work load.	Fear of dying like his sister.
4. Phil 16	Expelled from secondary school when 14.	First year at new school. He has to work to deadlines. Continues to work for the street traders before and after school.	Anger at the loss of his essay.
5. Scot 27	Father died when Scot was 1.	Increasing work load at work.	Anger at the loss of his files.
6. Pauline 19	Older sister died when Pauline was 3.	First year at university. Worry about grandmother's health. Worry about boyfriend's laziness.	Fear of losing her boy friend.
7. Shirley 41	Neglectful mother.	Worry about living next door to the burglars.	Fear that home is not a safe place.
8. Lewis 49	Lost contact with his first wife and his children 20 years ago.	Worry about coping at work with limited resources. Lack of support from manager.	Anger with manager for cancelling at the last minute his time off.
9. Don 28	Parents separated when he was 12. Father died when Don was 13. Mother mentally ill.	Sleep deprivation. Worry about mother's health. Worry about wife's health.	Fear that he might be mistaken for a drug dealer.
10. Cathy 35	Father died when she was 6. Physically abused by cruel stepfather when she was 11.	Worry about daughter's health.	Fear following retrieval of memory physical abuse.
11. Winnie 47	Separated from parents when she was 6 years old. Emigrated to England at 16.	Worry about finding a desirable job despite qualifications. Feeling exploited and not respected at work.	Anger with supervisor for expecting her to do more than her fair share.

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Words & Windows in the Psyche

There is never enough time …
Where has it all gone?
It is easier to *Save* a *Document*
Than to save time …
Can you click *'Save As'*
For a *Database* of experience?

Print-out is a captured moment
It's already done
Stop! Two-way communication with the Printer
Has been lost.
A little *Mouse* will lead you
Back through the *Gateway.*

You think you have *Deleted* items;
But they still lurk in your *Recycle Bin.*
There are no *Short-cuts*
However much you may *Edit*
Create or *Modify.*

This poem does not *Scan.*
No matter.
Not everyone can *Excel.*
You can't empty Life's *Recycle Bin*
Till you *Log Off* and *Shut Down*;
And it's too soon to *Exit.*

You long to imitate your *Icons,*
Or *Log On as a Different User*
With different *Options.*
Maybe you dream at the *Window* …
It would be bliss to *Browse*
In a sunny *Field.*

Paint your own *Picture*
With the *Help of Wizards.*
Yes, you may *View* the *Toolbars,*
Add *Colours* to the *Shadowed Text*
Quick, before it slips
Back into the *Default.*

Why is *Auto* always black?
You *Can't Re-do*, nor *Undo*;
But perhaps *Restore.*
So we just *Drag and Drop*
Our *Files* to tidy them.
And make *New Folders.*

Who dares *Open* the *Hidden Files* …
Or *Explore* the *Programs*?
Is that a *Screen-saver*
Or a screen *Memory*?
Only one thoughtless moment
Brings repeating patterns.

The *Memory Manager* is in *Control*;
Anything might be *Justified.*
Wrap your *Text* round the *Embedded Objects*;
Click on them, shrink them down.

But there could still be *Highlights*:
Click on a patch of empty *Screen*;
Maybe a new *Menu* will appear.
Cut, Copy & Paste!
Every day is a *New Document* …

SUE HOPKINS

Secretary's Report: 1997-98

The year began with a Balint-weekend at Exeter College, Oxford, on September 12th-14th. There were 39 delegates, including two medical students, forming 4 groups. Visitors from abroad, included Alan Johnson from Charleston, South Carolina, who led a very successful group with John Salinsky, together with a regular friend, Katrin Fjeldsted from Iceland.

It will be sad to miss this intimate meeting this year, but nevertheless good to welcome a larger number of delegates from many countries, who will be coming to the Eleventh International Balint Congress this year, also at Exeter College (see page 33).

The congress ended with the Annual General Meeting of the Society, electing officers and members of the Society's Council (see page 65), and outlining the new procedure for the accreditation of Balint-group leaders in the U.K. (See the Journal, Vol. 25, page 36).

The lecture series presented at the Royal College of General Practitioners consisted of four speakers, the first on 25th November, 1997, was Dr Chess Denman, Consultant Psychotherapist at Addenbrooke's Hospital, Cambridge, who gave a clear account of the theory and practice of Cognitive Analytic Therapy (CAT). This is a technique that could well bring psychodynamic work within the budgets of modern health-care systems.

On 10th February, 1998, Dr Jane Ogden, PhD, a health psychologist working at Guy's and St. Thomas' Hospital, presented her fascinating paper describing her research dealing with the difficult question, 'Why do sick doctors not seek help?' She studied the types of conditions which general practitioners thought their patients could be helped by counsellors and psychotherapists, or psychiatrists and other mental health workers, and then looked at the increasing stress-related conditions suffered by the doctors themselves. It soon became apparent that we have a double standard about what is good for our patients, and what might be good for our own problems!

Our response to the next lecture given on March 10th, about 'Balint work in Germany', by Dr Heide Otten, Secretary of the German Balint Society (see page 16), seemed to show that we were seeking answers (how stupid can we get!) from the German Balint Society as to how we can make our work more widely known and accepted.

I felt that two major points were made. The first and most important, that it is essential for any doctor wanting to become a general practitioner in Germany to attend a minimum of 15 Balint-group sessions. Secondly, many doctors stay in a Balint-group for a number, often 10 or more, years. Such groups may eventually become quite intimate, allowing more mutual and personal support for each other, confirming what some-of us have found in the U.K. Many German doctors will be attending the International Congress at Oxford, so doubtless we will hear more about this.

The last lecture was given on April 28th, by a much respected council member, Dr Sotiris Zalidis who is a general practitioner in Hackney, East London, and is well known for his many other publications in this journal and elsewhere. On this occasion, he presented a preliminary report about a research project concerned with the importance of emotional factors preceding the eruption of herpes zoster, which he has been pursuing in his practice for the past nine years (see page 43). He presented consecutive cases from his practice where almost all the patients seemed to have short term severe emotional triggers, as well as long term emotional upsets (probably unresolved losses). Discussion was excited.

On May 28th, I ran a Study day for Nurses which was very well received (see page 66).

The group-leaders' workshop, organised by Dr Peter Graham, has met only once this year because of the lack of transcribed group-meetings to discuss. We hope to start meeting again in the autumn, particularly as it is an essential ingredient of ongoing group-leadership accreditation for Balint-group leaders in the U.K., in line with guidance from the International Federation of Balint Societies.

The Research Group on *Doctors' Defences,* sponsored by the Society has continued to meet and will present a preliminary report at the Oxford Congress in September, and hopes to complete something more substantial later on.

This year's Annual Dinner at the Royal Society of Medicine on 23rd June 1998, was enjoyed by a larger gathering than we have had in recent years. The evening ended with a very interesting and stimulating after-dinner presentation by a well-known London psychoanalyst, Helen Taylor Robinson, whose paper can now be read by those who were unable to come to the meeting to hear it at the dinner (see page 61).

I am now looking forward to our hosting of the Eleventh International Balint Congress in Oxford from September 9th to 13th, 1998.

David Watt

From the Annual Dinner, held on 23rd June 1998

Address by Helen Taylor Robinson
Psychoanalyst, London

Thank you for the honour you do me in inviting me to address you this evening. Before I begin, I want to set the following quotation before you: 'My discoveries are not primarily a heal-all. My discoveries are a basis for a very grave philosophy. There are very few who understand this. There are very few who are capable of understanding this.' (Hilda Dolittle: *Tribute to Freud*, Carcanet Press. During this poet's analysis with Freud in Vienna, in the late thirties, this is a statement attributed to Freud.) I ask you to hold this is mind in what now follows. You give me, this evening, the opportunity to join with you in acknowledging and celebrating the creativity of a doctor and psychoanalyst, Michael Balint, who has contributed, in the tradition of another great doctor and psychoanalyst, Freud, to the thought and understanding of the mind, primarily to the unknowable or unconscious mind as it sits alongside the so-called conscious or knowable mind.

And I feel I can do the Balint Society, and Michael Balint no greater honour than to submit to your minds, the thought and understanding of the unconscious alongside the conscious mind, just as Michael Balint inculcated in his practice, writings and research on behalf of the medical practitioner and his patients, these ideas were also presented by another great doctor or healer of the mind, and psychoanalyst, or could we say analyst of the psyche or soul, Shakespeare.

As a prescript to what I have to say, I will remind you, since many of you will know well, of a paper that Balint gave in lecture form and published in the International Journal of Psychoanalysis in 1966. It is the predicate for what follows and it is entitled 'Psychoanalysis and Medical Practice'. It is a paper which embraces psychoanalytic thinking, and alerts the reader to the responsibility for that thinking and its consequences. In the wider than psychoanalytic setting, in this case, medical practice.

The paper contains seminal observation, reporting and the creative use of the psychoanalytic mind, in the difficult setting of medicine. It is a model for good psychoanalytic process for it places at the centre of its argument the work that may be gained at any one time in the process of psychoanalytic research and understanding of patient and doctor, and the work that must be accepted as lost; that is what must and will remain beyond the scope of our understanding. A large part of the paper is accepting of what cannot be done, and taking responsibility, thereby, for what can.

Balint argues, as any psychoanalyst will, for the centrality of the unknowing or unconscious mind of the doctor, focusing there and nowhere else, and upon the relevant observation of the work of arriving at that central unconscious or unknowing of the doctor in relation to the patient. He argues that this unknowing can be delivered to use that can make a significant and abiding difference to the doctor and patient together. A case history, like a good parable, is offered for material. The hazards of abandoning such a focus and such a position, that is the attention to the unconscious of the doctor, carefully and appropriately handled, are also indicated.

Towards the close of the paper he says, movingly: 'In this way, I think the presenting doctor was helped to realise more fully what his individual way was in contrast to other ways voiced in the discussion and also the largely unconscious motives for his ways.' I hope that this opened up new possibilities for him to choose other ways and drove home that it was his responsibility to choose a way which was therapeutically more effective. From another angle instead of being lectured to or taught, he was induced to experiment and to discover on his own and at his own peril. At the same time he was allowed to choose what he felt was congenial to him, but he was made to feel that it was his opportunity as well as his responsibility to choose well.

Our position as physicians, Balint reminds us, whether we be doctors, analysts and in my view, artists, those other physicians of the soul, is the perilous position of 'not knowing', experimenting, discovering on our own and at our peril. This, in one sense, is the human condition. And it can be a therapeutic position, Balint persuades us, the position of exploring the 'not known'. Balint, like all creative practitioners, you will note, speaks of what he 'hopes' will be possible for the doctor, following his work, and that that is all he can appropriately express, 'hopes'.

And that is why, or shall I say, in this sense, Balint honours Freud in his work, that is in recognising that the not-understanding of physicians also, and in addition to their knowing, be, as far as possible, their guide.

It is by way of this prescript or predicate, that I come to the contribution of Shakespeare to the understanding of the 'not known' and the placing upon the audience who bear witness to or read his plays, the opportunity as well as the responsibility, in this case, to choose to think well, for our own humanity and its well-being, as to whether the not-known *can* be attended to, and thereby become its own healing, indeed treatment and care. Attendance of, adherence to the process or human mind and suffering, the poetic equivalent of the surgery where physician sits with patient, that curative act is Shakespeare's too. His mind sits alongside human suffering, observes and reports and interprets, from the

same position, and for many, his poetry, cradling and sustaining the human psyche in its broad arms, is health indeed.

If not understanding, and not being able to understand are recognised for their contribution to the health of the psyche, what, in this area, has Shakespeare perhaps to offer?

I am now going to read a tiny fragment from 'King Lear', Act IV, scene 7.

A scene in the French camp

Enter Cordelia, Kent, Doctor and gentlemen.

Cor: O thou good Kent! how shall I live and work
to match thy goodness? My life will be too short,
And every measure fail me.

Kent: To be acknowledged, Madam, is o'er-paid.
All my reports go with the modest truth,
No more nor clipp'd, but so.

Cor: Be better suited:
These weeds are memories of those worser hours:
I prithee, put them off.

Kent: Pardon, dear Madam;
Yet to be known shortens my made intent
My boon I make it that you know me not
Till time and I think meet.

Cor: Then be't so, my good Lord. (To the Doctor). How does the King?

Doct: Madam, sleeps still.

Cor: O you kind Gods.
Cure this great breach in his abused nature!
Th'untuned and jarring senses, O! wind up
Of this child-changed father.

Doct: So please your Majesty
That we may wake the King? He hath slept long.

Cor: Be governed by your knowledge and proceed
I'th'sway of your own will. Is he array'd?

Enter Lear in a chair carried by Servants.

Gent: Ay. Madam, in the heaviness of sleep
We put fresh garments on him.

Doct: Be by, good Madam, when we do awake him;
I doubt not of his temperance.

Cor: Very well.

(Music)

Doct: Please you, draw near, Louder the music there!

Cor: O my dear father! Restoration hang
Thy medicine on my lips, and let this kiss
Repair those violent harms that my two sisters
Have in thy reverence made!

Kent: Kind and dear Princess!

Cor: Had you not been their father, these winter flakes
Did challenge pity of them. Was this a face
To be expos'd against the warring winds?
To stand against the deep dread-bolted thunder
In the most terrible and nimble stroke
Of quick, cross lightening? To watch – poor *perdu*!
With this thin helm? Mine enemy's dog,
Though he had bit me, should have stood that night
Against my fire. And was thou fain, poor father,
To hovel thee with swine and rogues forlorn,
In short and musty straw? Alas, alack!
'Tis wonder that thy life and wits at once
Had not concluded all. He wakes; speak to him.

Doct: Madam, do you; 'tis fittest.

Cor: How does my royal Lord? How fares your Majesty?

Lear: You do me wrong to take me out o' th' grave;
Thou art a soul in bliss; but I am bound
Upon a wheel of fire, that mine own tears
Do scald like molten lead

Cor: Sir, do you know me?

Lear: You are a spirit, I know; where did you die?

Cor: Still, still, far wide.

Doct: He's scarce awake, let him alone awhile.

Lear: Where have I been? Where am I? Fair daylight?
I am mightily abused. I should e'en die with pity
To see another thus. I know not what to say.
I will not swear these are my hands: let's see;
I feel this pin prick. Would I were assured
Of my condition!

Cor: O! look upon me, Sir,
And hold your hand in benediction o'er me.
No, Sir, you must not kneel.

Lear: Pray, do not mock me:
I am a very foolish fond old man,
Four score and upward, not an hour more or less;
And, to deal plainly,
I fear I am not in my perfect mind.
Methinks I should know you and know this man,
Yet I am doubtful: for I am mainly ignorant
What place this is, and all the skill I have...
Remembers not these garments; nor I know not
Where I did lodge last night. Do not laugh at me,
For, as I am a man, I think this lady
To be my child Cordelia.

Cor: And so I am, I am

Lear: Be your tears wet? Yes, faith. I pray, weep not:
If you have poison for me, I will drink it.
I know you do not love me; for your sisters

Have, as I do remember, done me wrong:
You have some cause, they have not.

Cor: No cause, no cause.
Lear: Am I in France?
Kent: In your own kingdom, sir.
Lear: Do not abuse me.
Doct: Be comforted, good Madam; the great rage,
You see, is kill'd in him: and yet it is danger
To make him even o'er the time he has lost.
Desire him to go in; trouble him no more,
Till further settling.
Cor: Will't please your Highness walk?
Lear: You must bear with me.
Pray you now, forget and forgive:
I am old and foolish.

Exeunt Lear, Cordelia, Doctor and Attendants.

This scene opens in the key of goodness, compassion and its honouring.

Cordelia is its symbol and speaks the opening:
'O thou good Kent! how shall I live and work
To match thy goodness?'

It is Shakespeare's injunction to us, to move, into that key which will sustain all suffering.

The fragment I have read you ends with the outcome of goodness and compassion sustained, which is redemption. Lear, mind and body is transfigured, redeemed through the attendance and sustenance of goodness and compassion, Kent, Cordelia and the Doctor administering, and he is able to voice that redemption.
'You must bear with me.
Pray you now, forget and forgive: I am old and foolish.'

Every line that falls between the beginning and the end of this fragment speaks in the key of suffering borne, suffering attended, in words and deeds. Cordelia expresses that life is too short and all measures fall in the living out and working for the good. Kent reminds the listener that acknowledgement of good is already overpayment, since to be noticed for good done, rare as it is, (in this play, Edgar, Cordelia and Kent, suffer repeatedly for their possession of virtue, of goodness,) is already going too far. This is the awareness of course that virtue, noticed or noticed is its own reward, though the reward in this life may still be death. Kent, like all goodness, chooses to pass unnoticed to effect his plans, ('to be known shortens my made intent'), for goodness noted is goodness attacked and destroyed, as Edgar learns from his brother Edmund.

But now the Doctor is addressed. He is asked for help, as doctors are, and he focuses the audience and Cordelia upon the ailing King, the patient in his care. We are in the area of bodily need, at this point, sleep holds the King, and the Doctor seeks to waken him, with permission, not with authority. Cordelia invests him with authority. 'Be govern'd by your knowledge, and proceed I' th' sway of your own will'. But this authority, this knowledge we learn is not that of all-knowing.

The Doctor's care is processive, cumulative, coming in small doses. He asks that Cordelia be by as the king wakes, the intuition of her needful presence as mother to waking infant. It is physical care of the psyche, the body supported as the mind fails, He attends, watches over 'How does the King? Madam, sleeps still') and administers to Lear, in his carried infant state, and he assists Cordelia in the cure that he knows she alone will effect. He does not propose, he does not 'know', he does not urge a treatment. He does not offer a diagnosis. In his seemingly background, yet pertinent way, he helps, with Cordelia to effect one. To me, in theory, he is the outcome of the work that a group under Balint's guidance might have enabled a doctor to achieve. Shakespeare makes him, for the purposes of my argument, the *representation* of the unconscious assisting in delicate work. He is, in his position and in his actions in this scene, a background figure effecting a foreground shift or change in health. In this sense, he is the near to silent, scarcely manifest process that works behind and below the scenes of the psyche, while Cordelia works more consciously, in words of great power at the forefront. She is helped to consciousness, by the assistance of the unconscious. For the Doctor appears to know, though he does not claim to know, that Lear's health may recover through the restoration of the rejected child to her proper place with her father. In other words she must return and be acknowledged by her father.

He directs the whole from the sidelines, the transition from the rage to the sleep and then to the waking, with no claim to knowledge. In this subtly orchestrated setting, which the Doctor sustains diligently, through intuition, through the unconscious, rather than through conscious knowledge, the expression of the call for pity, compassion and mercy, which has been so removed and denied in this play can then be given room. It can be invoked. (Had you not been their father, these white flakes did challenge pity of them). (Mine enemy's dog, though he had bit me, should have stood that night against my fire) When the king wakes it is the Doctor who substitutes Cordelia for himself (He wakes; speak to him", says Cordelia. 'Madam do you', says the Doctor 'tis fittest'. And when she falters as Lear comes through not-understanding, slowly towards understanding the Doctor brings forward her less conscious stance of dropping back, of bearing with, rather than urging on, in fear. ('Still, still, far wide,' Cordelia fears, 'He's scarce awake – let him alone awhile' the Doctor answers) again the right key of compassion in the bringing together of this fragile pair. Then Lear can attest to the fullness of his not knowing, his utter perplexed and troubled self 'Where have I been? Who am I? I know not what to say.' In this place he can voice, with the Doctor's and Cordelia's

and Kent's benign assistance, his ignorance his weakness, his newly-found self as infant, old and foolish, in need of forgiveness. When there is a little loss of ground, momentarily, when Kent answers Lear that he is still in his own kingdom, not in France and fled from torment and struggle, as he would wish, and when the King begs that he does not tell him such unwelcome news 'Do not abuse me', again the Doctor sustains the struggling couple.

'Be comforted, good Madam: (for Cordelia fears his mind is still elsewhere and in rage)

'The great rage
You see is kill'd in him'

The key of this is the comfort instinctively proferred, not loudly prescribed. It is the tone and healing, offering comfort, showing evidence to those who fear.

He adds: 'and yet it is danger
To make him even o'er the time he has lost.'

Even here, the Doctor appears by a small and inconsequential remark to strike true, and this central truth, centrally upheld in this scene, that we cannot make the accounts even with our past losses, only redeem them, that it bears us no good to repeat and repeat our injuries in the hope that someone will step forward and take the punishment due to them, that suffering is enough and is its own treatment, and that care and restoration of care is the only way towards health, all this, the Doctor, in his deeds and words upholds. And all this is, in condensed form, in one tiny fragment of the play which repeats and repeats this truth, is why Lear is a great tragedy, that places at its centre, redemption, born of pity for loss, and holds that redemption, despite low on earth, (Lear and Cordelia and soon Kent die, or are to die, as must we all) is all we can attain in our lifetime. That we hold our hands in benediction over one another, the play invokes, that we offer pity, as these characters do, and that way pass through life.

And the tiny and peripheral role of the Doctor, the inclusion of this figure at the critical transition, the awakening of Lear towards a hoped-for health, is in my view no accident. At this point of not-knowing, of all understanding seeming to have foundered and been lost in this play, at this point where no answers have been found, and meaning of a compassionate kind appears in disarray, Shakespeare introduces an assistant towards health, a setting in which recovery of meaning may begin.

That we, the audience, are largely unconscious of the greater part of all of this, the fragment and its meaning, is also paradoxically and primarily its great and powerful truth. That of which Shakespeare seeks to make us aware in his writing, by the virtue of his writing, is that of which we would otherwise pass largely unaware, and we are brought by this play, this great work of art, closer to our unknowing and helped to yield however fearfully to its understanding. This truth Balint upheld, as Freud did, the paradox of the curative effect of yielding to our unknowing, and submitting ourselves to that unconscious area for the task it sets us.

The Enid Balint Institute of Psychoanalytic Psychotherapy (E.B.I.P.)

Background

In 1980 a Three-Year Training Course in Psychoanalytic Psychotherapy was established at Queen Mary's University Hospital. Since then, it has met the training needs of 70 students. That Course was created as an essential aspect of the activities of the Association of Psychoanalytic Psychotherapy in the National Health Service, which was formed also in 1980 by a group of Psychoanalysts holding Consultant Psychotherapist posts in the National Health Service.

Over the years, the Course has developed in many ways and these developments are now incorporated in the E.B.I.P.

Administration of the Training

The Course is organised and provided by a Training Committee consisting of psychoanalysts and psychoanalytic psychotherapists. It is based at the Enid Balint Centre, which is a separate building within the grounds of Barnes Hospital, South Worple Way, London, SW14 8SU. The academic part of the training extends over three years. Following qualification students are admitted to membership of the Enid Balint Society of Psychoanalytic Psychotherapy (E.B.S.P.).

Applicants must possess a University Degree (or equivalent) in a relevant discipline and should be between 25-55 years of age. (This rule may be varied in exceptional cases).

Intake is limited to a maximum of ten students per year.

Full details and Application Forms are available from:

Barnes Hospital, South Worple Way, London, SW14 8SU.
Tel: 0181 878-4981; Fax: 0181 876 5471.

The Enid Balint Psychotherapy Trust

The Trust was established in September 1994 in Enid Balint's memory and the funds are used for the promotion of psychoanalytic psychotherapy, including grants to assist in the training of students.

The International Balint Federation, 1998

Since my last report, the International Balint Federation has held council meetings in Miercurea-Ciuc, Romania and Freiburg, Germany.

The meeting in Romania was held in September 1997 during the Romanian Balint Society's International Conference in Miercurea-Ciuc, a town in the province of Transylvania (see page ??). The council meeting was attended by delegates from Croatia, Germany, Hungary, Sweden and the UK, as well as Romania. The Council formally accepted the International Guidelines on Leader Accreditation (see the Journal, Vol. 25, page 36). Individual Balint Societies will remain free to develop their own methods for training and accrediting leaders but we hope that these will always be in accordance with the principles set out in the guidelines.

The meeting in Freiburg was held in March 1998, during the German Balint Society's annual weekend there. This is only one of some twelve weekends which the German Society holds in a different location every year. Freiburg is a charming small city in the heart of the Black Forest region of Germany. Those of us who attended were able to observe one of the fishbowl groups; Erica Jones (who is fluent in German) co-led another group with Dr. Margarethe Stubbe. In addition to the Balint work, we enjoyed the food, the shopping, the magnificent cathedral and the other attractive buildings of Freiburg, and a brief visit to the snowy peaks of some local mountains.

The Council meeting was attended by delegates from Belgium, Croatia, France, Germany, Hungary, Switzerland and the UK. The following were nominated and elected to serve as officers with effect from the end of the Oxford International Congress:

President:	Dr. Michèle Lachowsky (France) (to succeed Professor Frank Dornfest, who will retire after Oxford).
Vice-Presidents:	Dr. Margarethe Stubbe (Germany) (re-elected). Dr. Kornélia Bobay (Hungary).
General Secretary:	Dr. John Salinsky (UK) (re-elected).
Treasurer:	Dr. Michel Delbrouck (Belgium) (to succeed Dr. Roger van Laethem (Belgium), who will retire after Oxford).

Dr. Heather Suckling reported on plans for the forthcoming and eagerly anticipated 11th International Congress to be held in Oxford, England in September 1998. It was decided that the next (12th) Congress should be held in 2001. Possible locations might be Croatia, France (Paris), Poland or Slovenia. The next Council meeting will be at the end of the Oxford Congress on 13 September 1998.

JOHN SALINKSY

The Balint Society
(Founded 1969)
Council 1998/99

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Dr. John Salinsky
Lenka Speight
Dr. Pat Tate

London Balint Study-Day for Nurses

May 1998

The Society held a meeting for nurses again this year, at the Conference Centre at the Hospital of St. John & St. Elizabeth in St. John's Wood, London.

It had been decided last year to invite only nurses, rather than a mixture of doctors and nurses. Participants came only from practices with members of the Balint Society working in them, despite wider advertising in the Nursing Times, to both Practice Nurses, District Nurses and Health Visitors. One group was formed with six nurses led by myself and Mary Burd, psychologist in Tower Hamlets, who worked for many years with Erica Jones on the London Hospital Vocational Training Scheme Group (which Mary and I continue to lead). The group was very lively with a wide range of cases, both typical of general practice, and particularly to practice nursing.

In the plenary session, the participants hoped we could run another group sooner than next year, but agreed that participation might realistically only be improved by word of mouth, by themselves, the nurses who came last year, and by members of the Balint Society.

Please encourage your nurses to come along to the next Nurses Study Day.

DAVID WATT

Balint Prize for the Field of Health and Nursing Care, 1999

To promote relationship-orientated care, based on the Ascona Model (WHO), prizes will again be awarded for papers in 1999.

This model has its foundations in the work of Michael Balint, in whose honour for the first last five years a prize has also been donated in the field of health- and nursing-care and annually awarded in Ascona, Monte Verità.

The award of Sfr. 8,000 – has been made available by the Foundation for Psychosomatic and Social Medicine in Ascona and by the Swiss Red Cross.

Papers of maximum 20 pages (30 lines per page and 60 letters per line) will be judged according to the following criteria:

1) Exposition: Papers presented give an account of a personal experience within a nursing care relationship to a patient and its possible development.
2) Reflection. The author should take into account in his/her reflections, his/her own feelings, fantasies (which are often suppressed) and manner of behaviour as well as the relationship to co-workers, institutions and to the patient's relatives.
3) Action and Progression. The author points out the knowledge gained by the analysis of the experience and shows how this can be integrated into everyday care.

Closing date for entries: 31st December 1998.

Three copies of each paper in German, French, Italian or English should be submitted to:
SWISS RED CROSS, Department of Vocational Training, P.O. Box 3001, Bern, Switzerland.
The awards will be presented on **12th April 1999** in the Monte Verità Centre, Ascona, Switzerland.

Balint in Romania

John Salinsky
General practitioner, London

The Balint Association of Romania held its fifth National Conference and First International Conference from 18-21 September 1997 in the town of Miercurea-Ciuc, home of Dr. Albert Veress who is the president and founder of the Association. Miercurea-Ciùc is a substantial town which nestles in the foothills of the Eastern Carpathian mountains in the province of Transylvania. From Bucharest airport you drive North through the town of Ploiesti with its oil fields and permanent smoke pall, but surprisingly pleasant town centre. The road gets quieter and starts to climb up into the hills. Farm carts, pulled by horses or bullocks and loaded with hay, become a familiar sight. The soil looks rich and fertile. As you get higher the scenery becomes alpine, and the air cool and fresh. You can stop off and visit the old Saxon town of Brasov with its Austro-Hungarian Baroque houses huddled around the central square with its famous 'Black Church' which is decorated inside with Persian carpets. The country road continues past a succession of attractive villages, with the varied architecture that reflects the region's complicated history and its settlement by Germans, Hungarians and Szekels.

Miercurea-Ciuc is a little over one hundred kilometres beyond Brasov. At first sight, it seems rather drab, after Ceausescu summarily ordered a large swathe of its buildings to be razed in the 1980s, and replaced by monotonous and unattractive concrete blocks.

However, after driving a little further on, you come to some of the original traditional buildings which were spared by the late dictator. There is a medieval looking fortress with a sturdy bastion at each of its four corners, which now houses the museum of ethnography. There is the Orthodox Church with its black and white marble walls and cluster of domes. A little further on, you come to the large Franciscan church at the foot of an impressive wooded hill. Beside the church is an attractive group of new, white painted low rise buildings, the Jacob Antal Study Centre: welcome to the International Balint Conference!

The meeting was well attended by family doctors, psychiatrists, pharmacists and medical students from all over the country. To provide the international flavour, there were also visitors from Austria, Britain, Croatia, Germany, Hungary, Sweden and from Russia, in the impressive person of Professor Alexander Rotov, who had travelled all of 4,500 kilometres from Tomsk in Siberia, to be with us.

On the first evening, there was a welcome party, with a delicious buffet supper, including many local dishes. I particularly recommend the stuffed cabbage with sausages which appeared quite late in the evening; I thought I had finished, but it proved irrresistible. The local people in Transylvania speak Hungarian as well as Romanian. Sadly, I am not much good in either language, and some of our hosts had only limited English. Poor Professor Rotov spoke only Russian, but he beamed expansively at everyone with his deep blue eyes and recorded everything with his state-of-the-art video camera.

Fortunately we had the help of two experienced multilingual interpreters: Dr Almos Trif who is a consultant physician with an interest in Balint, and the irrepressible Csaba Bodor. Csaba (pronounced 'Choba') is a man of many talents, and acts as a sort of Puck to Albert's Oberon. Csaba is not a doctor, but he is a founder member of the Romanian Balint Society, having been their official translator from the beginning. He is a telephone engineer, an English teacher and a considerable musician, as we were to hear later.

The following morning, the conference started with a welcome from the Mayor of Miercurea-Ciuc, Dr Csiedo, and a few introductory words on behalf of the International Federation from Margarethe Stubbe, our vice-president, Jack Norell, our Ambassador to Eastern Europe and myself. Then the conference proper began with a session of lectures. I had been given the job of giving the first lecture so at least I did not have to sit there feeling nervous for very long. I need not have worried, as the audience were very sympathetic and the non-English speakers were clutching copies of a translation provided by the ever helpful Csaba. My talk was about orchestras and conductors and if you cannot guess what that has to do with Balint, you will have to read the printed version. Jack Norell described his early days working with Michael Balint, and he recalled the way in which he had been able to learn something important from his trainee. Kornélia Bobay (Hungary) gave a delightful description of how she had measured the way the doctors in the group move closer to each other as the group develops. Professor Muradif Kulenovic gave a fascinating account of the psychological stages which doctors go through as a Balint-group matures. Finally we heard from Dr. N. Vlad who has been amazingly energetic and successful in getting over twenty Balint-groups going in his region of the country.

After coffee there was a demonstration group-session, led by Nellie Bobay and myself. When you lead a fishbowl group, you have to be prepared for a really strange case to be presented, but the Romanian family doctor who spoke up at this one, left us all shocked and temporarily speechless. 'A strange man raped my dog' he said. The man in question, who was not yet a patient and might never become one, was a solitary woodcutter who had come to work in the village. Some member of the community reported

a sexual assault on the doctor's female dog although it was difficult to tell whether anyone had actually witnessed anything. The local people felt threatened, and expected the doctor to do something: either make the man accept treatment for his bizarre behaviour, or report him to the police. Some members of the group thought the stranger was a case for treatment; others thought that he was the victim of group paranoia on the part of the villagers. As Nellie said, it was like a Grimm's fairy tale.

In the afternoon, we divided into small groups and I found myself leading one in a mixture of English and Romanian with Dr Trif as interpreter. Our group contained a mixture of general practitioners, psychologists and students who all worked well together, in spite of the language problems. This time we had a typical Balint-case of a lady with a long history of physical symptoms (abdominal pain and nausea) for which no cause or cure could be found. The doctor regarded her pleas for help with revulsion, and everyone found it difficult to empathise with this demanding patient who could only communicate her feelings in the language of the body. In the group discussion, we used the technique of asking the presenting doctor to move her chair back a little way after the initial questions from the group, so that she can then listen to the group discussing her case without taking part. This method, originally used by the German Balint Society, seems to be very effective in preventing too much interrogation of the presenter and allowing her to reflect on what other people are saying.

That evening we had a recital in the Franciscan Church: Dr V Gered played the organ and also accompanied his daughter, Cecilia, who is a talented soprano. Another daughter joined them with some very musical flute playing in some of the pieces. After dinner Dr Gered gave a talk about the Church organs of Transylvania which was liberally illustrated with colour slides and interpreted by the indispensable Csaba.

On the second day (Saturday), there was another morning program of short lectures. Dr Istvan Fejéregyházi spoke about his experiences leading Balint-groups in Hungary; then Dr Almos Trif asked whether there were any limits to what could be discussed in a Balint-group. He concluded that while confidentiality must be respected, the group can discuss any professional problems which trouble the minds of its members. Dr Johanna Hegyi, a Romanian psychologist, showed us a model of the personality which had a central core surrounded by concentric layers. She argued that the 'reflexive' questions we ask our patient can penetrate all the layers and enable him to start thinking and feeling about the nature of his illness in a way which promotes healing. Finally, Dr Gh Paina described the way in which the Balint process benefits the doctor ethically and psychologically, as well as helping the patient.

In the afternoon, there were further small group-sessions and also the Council Meeting of the International Balint Federation (see minutes on page ??). We then had a late afternoon tour of Miercurea-Ciuc, including a visit to the hospital where Dr Albert Veress is director of psychological medicine. All the visitors were very impressed and moved by the way Albert has triumphed over desperately limited resources, and made his hospital a place where people suffering from severe mental illness can be treated with warmth, humanity and respect. Albert has a sign over the door which amends Dante's gloomy warning to read:

'Those who enter here: do NOT give up hope!'

In the evening, there was a grand banquet with all kinds of diversions between the courses. There was a classical guitar recital given by Csaba, who showed us yet another side of his talent as an interpreter. There was a display of folk dancing by two charming children accompanied by their father on the violin, and their mother on a strange instrument which looked like a home-made cello but was hit with a stick to provide the rhythm. Albert announced that the winner of the poster competition was Dr Åsa Bläckberg from Sweden. Her poster described the work of a Balint-group for women general practitioners in the North of Sweden, and featured a little model of a log cabin which was of great significance for the group. Åsa very generously donated her prize money for the needs of Albert's women patients. Presents were also distributed to the guests from abroad including terracotta pottery masks whcih we all immediately put on with bizarre and hilarious effects. And of course, there was dancing until about 1 a.m.

Unfortunately, my colleagues (Lenka Speight, Heather Suckling and David Watt) and I had to miss the last morning of the conference because we had to drive back to Otopeni airport to catch our plane back to London. But we all enjoyed the conference immensely and made many new friends.

Our thanks go to Albert and Eva, and all the members of the organising committee for inviting us and for making the conference such a resounding success. We hope to see you all again very soon.

Albert Veress writes: On the last day we had one more large group led by Nellie Bobay and Eva Veress. At the end, as an external observer, I pointed out that the one who brings the case should not translate his own words. And I also made some remarks about the necessity of being patient enough not to interfere intemperately in the dynamics of the group.

The final festivity followed with words of gratitude and good will from the members of the organising committee, and from the representatives of the participating countries. At the end, the mayor of the town presented the *'Pro Urbe'* diploma to Dr Jack Norell for his services in the development of the Balint movement in Romania.

The Balint Society Prize Essay, 1999

The Council of the Balint Society will award a prize of £500.00 for the best essay on:

Empathy-based medicine.

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; preferably on A4 size paper, with double spacing, and with margins of at least 25mm. Three copies are required.

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.

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article.

All references should give the name and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of *Index Medicus*; year of publication, volume number, and the first and last page numbers.

We welcome the submission of documents on 3.5" computer disk. IBM compatible files only please. If possible, please send files in Microsoft Word for Windows version 6 or 2. Other acceptable files are WordPerfect versions 5.0, 5.1 or 5.2; Wordstar versions 3.3 to 5.5; Word for MS-Dos 3.x to 5.x. Authors should put the name of the file on disk. Please send three hard copies with the disk.

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 30th Annual General Meeting in 1999.

Entries must be received by **1st April, 1999** and sent to: Dr. David Watt
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS.

International Balint Award 1999 for Medical Students

For more than 25 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. Owing to their influence on medical training in medical schools these seminars are acknowledged as the 'Ascona Model' (WHO), and their main purpose consists in Balint teamwork, 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.** will be made to the author 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. **Reflexion.** A description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. **Action.** The student's perception of the demands he (or 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.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st of January, 1999** to the following representative:

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

The presentation of prizes will take plce at the Monte Verita Centre, in Ascona, Switzerland on 12 April 1999

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

Programme of Meetings of the Balint Society for the Twenty-ninth Session, 1998-99

The Eleventh International Balint Congress
Doctors and Patients in the 21st Century
(at Exeter College, Oxford: see page ? for further details) — **9 to 13 September 1998**

The 29th Annual General Meeting of the Society — **13 September 1998**
(At 2 p.m.)

The 12th Michael Balint Memorial Lecture
Dr. Jon Sklar, Psychoanalyst, London — **20 April 1999**

London Balint-Day for Nurses, 1999
(at the Hospital of St John & St Elizabeth)

Balint Society Annual Dinner, 1999
(at the Royal Society of Medicine)
(Full details of these meetings will be announced later)

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

Mrs Juliet Hopkins, Psychoanalytic Psychotherapist,
The British Association of Psychologists, London.
'Attachment Theory' — **10 November 1998**

Professor Nigel Oswald, Professor in Primary Care,
University of Teeside.
(Title to be announced) — **15 February 1999**

Dr. John Salinsky, General Practitioner, Wembley.
'Hanging by a Thread: The History of Balint in Britain 1939-1999' — **16 March 1999**

All meetings are PGEA approved.
Further information is available from Hon. Sec. Dr. David Watt.

Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to Dr. Philip Hopkins, the Editor.

Style

Articles should be typewritten or word-processed, on one side of the paper only, double-spaced and with margins of at least 25mm. Abbreviations must be explained. Use approved, not proprietary names, when referring to drugs.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

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Alternatively, manuscripts may be supplied, typed or word-processed in Arial or Times Roman 12 point, ready for electronic scanning.

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