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Balint Society

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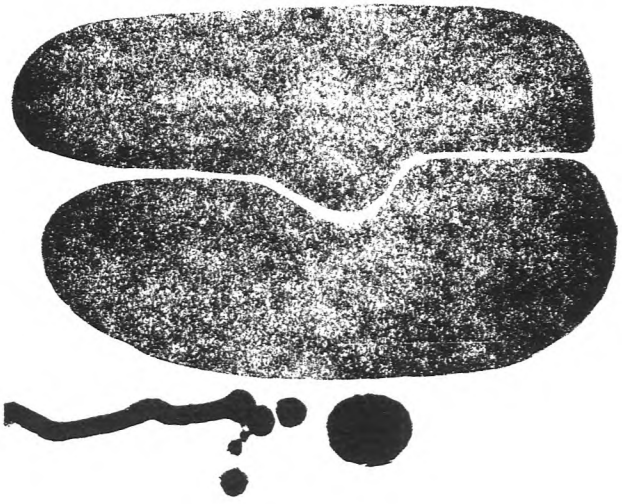

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Editor: Philip Hopkins

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The International Balint Congress, Exeter College, Oxford, 1998

The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There are also annual residential weekends at Oxford and Ripon and a study day in London for practice nurses.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

Editorial

The Seven Ages of Balint

Michael Balint expressed the view that the best time to join a Balint group was when you had been in practice for a few years: 'a general practitioner has the inestimable advantage over a medical student of having been knocked about by life'. Some of those who were members of his pioneering groups will testify that they had received quite a battering from general practice too; a few were on the point of giving up in despair and returning to the certainties of hospital medicine when they discovered Michael Balint. The idea that their patients' incomprehensible symptoms and exasperating behaviour could be telling the story of their lives and their feelings came as a revelation and enabled those general practitioners and their successors to find meaning and fulfilment in their daily sessions in the surgery.

All the same, you don't have to be a battle scarred veteran before the truth can be revealed to you. Students can benefit too, and Balint himself, always willing to reconsider his strongly held opinions, began a series of seminars for students at University College Hospital in the 1960s. In other countries such as Germany, Switzerland and the former communist states the traditional curriculum provided few opportunities for students to have direct contact with live patients. Many students welcomed the Balint group with great enthusiasm; it gave them an incentive to go and talk to patients on their own initiative and a place to go to discuss their feelings and frustrations about the way patients were treated by their seniors. The Student Balint meetings in Ascona (Switzerland) organised by Professor Boris Luban-Plozza have done a great deal to bring Balint into the lives of generations of young European doctors. Students are also invited to enter the annual essay competition organised by the Swiss Foundation for Psychosomatic and Social Medicine: the prizes are generous and there have been a number of winners from British Universities in the last few years.

It was a pleasure to welcome at our recent and very successful International Balint Congress in Oxford, two medical students from Romania and also, as a quiet and unofficial observer, a student from Oxford itself who had learned about Balint by entering for the Ascona competition and winning a prize. We must do more to encourage students to come to our regular Oxford weekends and to become members of the Society. In the words of Erica Jones, 'students are our future'. If they begin the difficult but rewarding process of understanding their patients and themselves at this early stage they may save themselves a lot of frustration and unhappiness later on. It is good to report that this year has also seen the foundation, in Geneva, of the International Junior Balint Federation, an organisation which exists to promote and encourage Balint groups and Balint work for students all over the world.

So, as Michael Balint finally realised, one is never too young to join a Balint group. Students have as much to gain as those who have been knocked about a bit. At the Oxford Congress we heard from and about people benefiting from Balint group membership in all sorts of different ways at different ages and stages of their medical careers. After the students come the GP registrars (or residents as the Americans call them) many of whom now have a Balint experience as part of their vocational training.

Next are the 'Young Principals' who are beginning to be knocked about and to feel a little bruised by general practice and are ready (if they only know it) for another dose of the Balint medicine. In the fourth age, maturity, our Balint doctor is probably a trainer or a course organiser and will have the opportunity to become a group leader. A few years on, he or she can join with some old friends, as members of our own Society have done, to form a research group to look at a particular aspect of the endlessly fascinating doctor-patient relationship. If frustration with the ever accelerating pace of pointless change in the Health Service is leading to cynicism and despair, the Balint group may come to the rescue of those lean and slippered doctors who want to reach retirement with their enthusiasm still brightly burning. We shall pass quickly over Shakespeare's final age and imagine instead the existence of a Balint Heaven where Balint doctors who have been good will be able to join all their old friends, sitting in comfortable armchairs and saying to each other: 'who had a case?'

JOHN SALINSKY

Reference:

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

Medical Freedom and Balint's Tradition

by Jonathan Sklar, Psycho-analyst, London

The twelfth Michael Balint Memorial Lecture given on 20th April, 1999

The Doctor, the patient and the illness, is presently undergoing a substantial attack within the so-called rationalistic evidence based medicine that is sweeping through clinical practice in this country. On the surface it appears to be directing the doctor's attention towards the more modern of medical practices, enlisting those matters that can apparently be known particularly for containing convincing evidence that has been measured carefully, evaluated and controlled in trials. An assumption is that this is something new, that doctors have only recently been thoughtful about. It is hard to see evidence for this at all as, to my knowledge, doctors have always examined the clinical evidence prior to making a therapeutic decision.

Evidence based medicine has positive associative links to state of the art scientific experiments, high technology medical evaluation and large double blind trials. It has a negative association in discarding the evidence of the doctor's own clinical evaluation, in an old fashioned sense of examining the patient – looking with care and seeing that which the non-doctor fails to notice. Valuable clinical evidence can be derived from the examination of one's own practice over many years.

The insidious underbelly of the new trend is not clinical confidence, but the saving of money. It emanates from the world of business, generated by the medical insurance fraternity who want to control the medical business for profit. If medicine can be commercialised in a more orderly way, such as the despatch of the same items of clinical treatment again and again, like the marketing of baked beans or coca-cola, then its cost base can be rationalised and made more clearly defined. Such business control creates the expectation of profits that follow. In order for this to happen, doctors who are not businessmen, need to be controlled to work in particular well known patterns: a sort of factory medicine mentality. If all doctors and patients could be forged together in a finite number of evidences, then the whole system could be profitably run. All one needs to do is to leave out the individuality of the doctor, the individuality of the patient and its relationship to the particular illness. Of course there is plenty of evidence for each of these evaluations but, for insurance based medicine, as I will now refer to evidence based medicine, these must not be part of the picture. Certainly the character of the doctor and the patient can only impede the easy running of the business. Balint has to be killed off precisely because it exposes insurance based medicine to simplistic logic. This may lead to, for instance, the mentally ill needing to have rationalised care. A well known insurance company has recently decided that six sessions of therapy is the treatment limit and is to be provided by psychiatrists and psychologists, rather than qualified psychotherapists. Under the guise of evidence, which actually does not exist, business is turning its back on appropriate, well tried treatment, which is then further ignored by young doctors just because this is not accepted by the present business establishment. Let us look further, child psychotherapy is not even recognised by the insurance company. It has been thrown into limbo and it is now an associative link to be perceived as worthless, disconnected from evidence.

However, a year's psychodynamic psychotherapy may save many more years of costly in patient treatments in the future. Business does not seem to like this kind of medical equation. It is more dominated by the expenditure during the current year and the ways in which this can be reduced. So let us look at a clinical vignette from a Balint group and examine some evidence. This is a case that has almost cost a great deal of money because of the way the evidence seemed to be misunderstood.

Report of GP Group

A GP presented a case of a 45 year-old woman who has been recommended for a single consultation, because she had spots on her legs. Dr A told us with some pride, that she had been doing a lot of dermatology, had become quite an expert and was known as the 'spot doc.' in the practice.

The patient had red spots on her legs and Dr A thought that it was either cellulitis or Erythema Nodosum. Whilst seeing her, Dr A 'phoned her former colleague, a consultant dermatologist, who recommended that it was most likely to be cellulitis and gave the patient on his recommendation, penicillin. However, Dr A did think that the other diagnosis of Erythema Nodosum was probably accurate. Three days later, blood tests confirmed that her diagnosis actually had been correct and she sent the patient to have an x-ray because of concern about Sarcoid. In fact the patient did have hilar nodes and then, to the GP's horror, the hospital suggested that she have a mediastinal biopsy and as this was complicated, she might even have to have a thoracotomy. Dr A rang the patient in some distress, thinking that she had come in with spots on her legs and suddenly she was being quite seriously investigated. In fact the patient was quite agreeable about it, saying that if there was something the matter, then it needed to be properly examined and in fact she had already had the biopsy.

Following this, a letter was received from the consultant, stating that the situation was odd because the biopsy stain did not look like Sarcoid and that it was probably TB. Despite the fact that

the case was becoming more complicated, Dr A initially accepted the Consultant's advice, that the patient should immediately start triple therapy for TB, even though the result of the cultures were not going to be known for several weeks. The patient then made an appointment to see the doctor and said that she was very worried as in the next three months, if this treatment was instituted, she would have to take 1600 tablets. The patient was concerned because she was actually feeling fine and she thought taking so many tablets would probably make her ill. This was the dilemma Dr A brought to the group.

Everybody in the group confirmed the idea that they thought the treatment excessive, given that waiting another few weeks, if she did have TB, would not make any difference at all, as there was no open lesion. Equally, if she had Sarcoid there was no treatment, but either way she did not need to have any urgent medication. This led the group to wonder what the doctor's problem might be in the case. When Dr A had been a student, the present consultant dermatologist was her registrar. Since that time and following a placement there, she has always looked up to this man. The doctors were then able to examine whether Dr A had been unable to be a competent middle-aged GP looking after her own clinical work and was not able to be in her own way, on a par with a consultant, or whether she was viewing this particular consultant as a "most superior being". Dr A thought about this and agreed that this was probably the case. It was very hard for her to realise that the particular consultant who, had always been in her eyes exceedingly good, caring, but above all conservative, was actually being perceived now, as being rather "gung ho" in rushing to medicate. Nonetheless, she found it very hard to actually approach the consultant and asked the group how they might discuss this with the consultant. Dr A was given the advice that some of them, knowing this consultant, thought he would have no problem in accepting the need to have a second histological opinion. It seemed that was the end of the case, but then Dr A said that she had been thinking even more about why this had occurred and wanted to tell us a story. The work and atmosphere in the group had freed up an unconscious memory in the doctor.

When Dr A had been a student, the very first patient she had clerked was a dermatology case. It was in the firm of a most eminent dermatologist, in which the present Consultant was at that time, a Registrar. The GP as a student appeared on the ward where there was a patient who had presented with a mild temperature and some redness on her body. However, the patient was exceedingly ill with this and the consultant commended that the young student would need to clerk the patient exceedingly carefully. The result was that this patient became exceedingly ill from something that had seemed so minor and was given, what seemed a huge amount of steroids. Dr A thought the patient had died of a steroid overdose given by the doctors. It now seemed clear that what was generating anxiety for Dr A in this case, was the ghost of an unconscious memory of her first clinical case, one which she discovered ws still in her mind. Dr A remembered the name of the patient and knew that she probably still had the original file in her office. This indicated the great anxiety that the present case was actually going to be a re-run of that awful first case, in which the "superior" consultant seemed to offer a massive dose of medication to a very ill patient, who then died. There seemed to be so many points of similarity in the two cases, that Dr A was most relieved to have been able to link the two and realise that her present predicament contained the ghost of her first clinical encounter, from which she had never recovered.

One of the main points of this vignette is to show the power and the impact of the first case on a medical student. If, as in this case something goes wrong, it leaves quite a psychological scar in some unmourned way in the clinical mind of the doctor, who is then left to unconsciously await the repetition, rather than working through something in a different way. In this case Dr A was most grateful to be reminded that she was no longer a medical student. She could actually speak 'doctor to doctor' to the consultant, who probably would understand in a far easier way than she had imagined the 'consultant on high' that she looked up to when a medical student in a dermatology unit. It is unknowable whether the dying patient was treated heroically, or was over medicated. Perhaps the doctor had never been able to reach an opinion, leaving instead an oscillation between cause and effect and a degree of vulnerability in herself. Now the doctor could be more thoughtful about questioning the urgent desire to provide medication.

Most of us as doctors have inside us, so to speak, our early cases, case observations and the impact of horror. Medical students are invariably young and less experienced of life and especially the minutiae of death. Of course this is not always the case – many of us are unconsciously brought into the profession by having had experiences of illness and death in our families as we grew up. The powerlessness of the child's position becomes galvanised as a direction to know and to heal others later on in life.

These early cases, unresolved and unmourned with no structure to locate, let alone contain the impact of a psychic wound – often observed as powerlessness and of death, invariably becomes a piece of unresolved mourning in the doctor. It gets buried soon enough. The doctor may have vague knowledge that certain medical subjects are off limits. Sometimes the early cases return, as in this instance to haunt the clinical work years later.

Second Case

Dr B presented clinical material about a family situation, which privately he found to be very

upsetting. Dr B felt that his feelings had been interfering with his usual clinical practice. An elderly man, who had been his patient for some years, had been diagnosed as having a brain tumour and was gradually dying. He was, nonetheless, mentally alert, despite physically deteriorating and was nursed at home. The GP had been visiting weekly and discovered that the usually ebullient lively man, who together shared an interest in sport with his doctor, had turned his face to the wall. The patient's wife seemed more concerned with the bedroom being moved to the ground floor living room. She had just arranged for the carpets to be cleaned and the doctor had been informed that, as the carpets were damp from cleaning, he needed to remove his shoes in case dog excrement was brought into the house.

Dr B thought the atmosphere was of the wife being cold and callous to her husband, telling the GP that now her husband could no longer speak. This was despite the doctor knowing that the patient could still have a very meaningful discussion with him. He felt that the wife wanted her husband dead, as he interfered with her obsessional sense of cleanliness and tidiness. It was as if both her husband and the GP needed to be got rid of, as if they were some sort of faecal mess. Dr B found himself feeling very angry inside himself towards the wife, especially as she clearly wanted her husband out of the house. He recognised that the way a family deals with death is their moral right, but he felt very distressed that the kind old man was being ignored at the end of his life. Dr B said that the man had toiled for all of his life to make lots of money for the family and that he did not deserve to be treated with such contempt after all that he had provided for them.

The doctor found the group a good safe place to express his feelings of rage. The patient had in fact been in a private hospital for diagnosis, but after five weeks, the health insurer, realising that the initial task had been achieved, declined to pay further only for nursing care on the acute ward. The doctor had felt that like punishing the wife by increasing home nursing, in order to keep her husband with her in the home. On discussion in the group, he knew from what the others expressed that this was not his right. Everyone thought that the home nursing was not necessarily the answer. In fact, the real issue of his imminent dying and death were being avoided. The doctor accepted this, including his pain of losing a patient who he had admired and enjoyed treating over the years.

Two weeks later he brought a follow up. The patient had been placed in a hospice. Dr B thought that this was to introduce a new regime, focused towards dying for the patient, but also thought that the family had needed respite. However, the patient was no longer facing the wall and was more alive within himself. It was unclear whether the hospice could continue to keep the patient as he was not imminently dying and it was clear that the wife did not want her husband to return home. The wife though, had begun having conversations again with her husband. The doctor continued to voice his contempt for the wife, even more vigorously. It was becoming understandable for the group. The clinical situation was improving, the patient was in good hands, work on dying was being approached by the hospice team and yet...!

Spontaneously the doctor told the group that he knew why he was finding it so difficult. Suddenly the group found itself in the realms of the personal, a very difficult place to be in, as the focus is the doctor-patient relationship. The doctor's exploration however, could not be stopped and it was also very interesting.

Some years before, a good friend of his was dying. They had played much sport together, he knew that his feelings for his dying patient had re-awakened the memory of his friend. The fit was exacerbated, as his friend's wife had a similar obsessional world of cleanliness and tidiness at home and she too had detested the mess of her husband's dying. She too had ignored her husband and he too had turned his face to the wall, longing to die. Dr B, whilst not the GP, had eventually to speak to his friend's wife, due to concern for the deterioration in his state. Dr B suggested that his friend be nursed in a hospice rather than in the family. Since then, his relations to her were very cool. Dr B felt very unforgiving of the wife's distance during her husband's last few weeks.

The immense identification and the clinical picture was a most painful private matter for the doctor. Dr B's feelings for the patient's wife were clearly suffused with his still painful, rageful feelings towards his dead friend's wife. An aspect of his personal life had been unravelled by the clinical case and had been under his skin, preventing his usual careful approach, free of his own morality to his clinical work. The telling of the story was within the context of a very containing group of colleagues, where he felt safe enough to reveal an aspect of his work and private life, which he found quite humiliating. Yet the telling also released the doctor to be able to be free of his projections from his own past on to his patient. Now he could really see more of the differences and the similarities with his private anguish and was far freer to deal with the clinical situation, without being over involved.

It is difficult to conceive of such complex and yet such simple medical structures, deeply embedded within the core identity and character structure of each individual doctor, to be part of the new wave of evidence based medicine. The clinical case, however, was suffused with the unconscious related processes within the doctor. This is not just an added piece of insight, which is perhaps interesting; it is the way in which the doctor is able to treat his patient.

It is curious because in many ways, once explained, it is not difficult to understand. Nor does it take a long time to know about – yet, the resistance in this country to know about the inside

process of a doctor is erroneous and instead we are offered the one-dimensional mode of the "external" evidence. Both, together become a most powerful tool.

The Balint group can be a rare place in which this important piece of care of and for the doctor can be processed. Who can say that this is not evidence based medicine? This clinical work is based on the ordinary scientific platform of observation.

What happened in these cases? In the first, the doctor was able to make a conscious connection between an area of privacy of the self and his private relationships, both conscious and unconscious and its clash with and reactivation in the context of the painful clinical case. As often in life, we suffer from the return, in the present time of some past painful harsh bit of life. If it has never properly been psychically digested, it can stay awaiting an attachment to the present world, in order perhaps that the ghost can at last be laid to rest.

The general practitioner is not obtaining an analysis in this work, but there can be no deep understanding of the clinical situation without unconscious understanding of the character and mental structure of the doctor being party to the work in the clinical relationship within the context of the Balint group. The first case developed the theme of something left behind from medical training that emerged in a new form, relating to whether the doctor can be a hero, or destructive. Such a formulation covers over the ordinary prosaic way of straightforwardly speaking doctor to doctor, in order to obtain an appropriate atmosphere for a candid medical decision about treatment. For this the doctor had to realise again, that she had adult appropriate skills herself, rather than being the student onlooker at the life and death struggle, which was not an appropriate place for her clinical operation.

In the second case there was a confluence of connections between a family dealing with a dying father and its special private meaning for the GP, which stood in the way of his ordinary good medical practice. Yet both of these cases are very difficult to understand, unless we accept unconscious processes and the free association methodology derived from psychoanalytic treatment. This has been the value of the input from psychoanalysis in relation to general practice. It seems clear that if the link with psychoananlysis becomes more attenuated, then the clarity of its usefulness may well diminish. Many people are much more comfortable with counsellors and therapists who are not analytically trained and are suspicious of psychoanalysts. Some rather feel that psychoanalysts may bring mess into the house, like the patient's wife.

As I ponder my choice of two cases, I realise that together it has something to do with the need to give up a childlike relationship with a dead parent in order to understand it and move on in life. I am thinking of this in relation to the Balint Society having a relationship of homage ot Michael and Enid Balint, which needs to be beyond a relationship to wonderful, but now dead parents. Knowledge and technique needs to be understood by the present generation beyond the dead parents, in order for the work and the Society to stay alive and to move forward in its work, rather than to be remaining with an unmourned past. The work that the Balints achieved in relation to the Balint Society and for General Practice in this country and far beyond, has been immeasurable. I have no doubt that, to both of them, the idea of continuing beyond their work would be essential, as the only means of having a sense of being alive rather than being in a state of unconscious repetition. Thus, in the two vignettes, the old consultant who knew everything apparently, needs to have an accommodation again and again in our generation of knowing about this work and especially the need to link it with the next generation of young doctors.

In particular, I unconsciously thought of presenting the second case about how to deal with the death of the elder of the tribe. Michael in 1970 and Enid more recently in 1996. This is a painful task for each of us, as well as for the learned Society, that must of necessity, look forward within the context of knowing its great history. And to look forward to the next generation and the one beyond, bearing in mind the weight and responsibility of our history and of our learning in this wonderful area between general practice and psychoanalysis.

Slowly, carefully, a process can be seen about the clinical interaction. Occasionally one can also have the privilege of seeing a piece of the doctor's medical development history, particularly around a point of arrested affect. The observation, spoken about in the group linking the past clinical work with the present clinical difficulties is truly evidence based medicine.

The Balint Society can retreat to the inner citadel of knowing their methodology is sound – that we can possess an inner freedom of spirit, even while we suffer from merely external tyranny. As Isaiah Berlin put it in *Two Concepts of Liberty*, a negative libery is expanded when nobody stops us from doing what we want and reduced when we are stopped. I can see plenty of merit for describing the present direction of medical politics as being authoritarian and against the freedom of the doctor to practice his own competent medicine.

The Balint Society has a precious possession; it is about a medical freedom based on free association in respect of a process called unconscious thought, derived from psychoanalytic theory. Today, like psychoanalysis, general medical practice is under threat and for similar reasons. Like psychoanalysis, the concept of whole body medicine, including the mind as the link between psyche and soma, humanises medicine. The humanising function is particularly needed in our world of specialities, part body

functions, technologies and technocrats, all of which, have an overall effect of reducing our humanness and humanity to a particular correct status.

I do not intend to contrast one way as "good" and the other as "bad". Medical freedom needs to encompass the valued practice of both clinical positions, both Balint's whole person centred medicine and the super specialities of particular scientific evidences. It is the entwining of the two that makes for the best of medical practice; science with humanity, practised with freedom. Thus, the wisest course is for the doctor to feel free to practice the medicine that is his to practice. This may seem an obvious statement, yet, in times in which the direction is pointing towards the formulaic, specific items of clinical service, the near exact evidential occurrence, the doctor's freedom to practice, is his only defence from being an automatic technologist. What technologist would not pause for a moment at the interesting stories that we are privileged to hear and tell about in our medical practices?

Reference:

Berlin, Isaiah; "Two Concepts of Liberty": *The Proper Study of Mankind. Pimlico.* 1998.

The Observed Infant of Attachment Theory

Juliet Hopkins
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Introduction

The infant of attachment theory has been created to explain the behaviour of infants rather than to explain the free associations of adults on the couch. Consequently few psychotherapists have become attached to it. This would not surprise its originator, John Bowlby, who has recognised the need of our insecure profession to cling to established theories and to their parental figures rather than to risk exploring new territories. Our clinical work is fraught with anxiety and uncertainty, and we need to rely on familiar theories to sustain us as we work. As clinicians we value the security provided by the familiar, but in our role as scientists we must risk exploring the new. Attachment theory is centrally concerned with this in-built polarity between the need for security and the desire for exploration and mastery of the environment, a polarity that is most obvious in toddlers but is with us throughout life.

Why should psychotherapists explore this new territory and familiarize themselves with the attachment infant? One good reason might be a wish not to be left behind. Attachment theory is becoming the chosen language of an increasing number of development psychologists and of professional workers in child mental health, in both America and Europe. It is, for example, the development within psychoanalysis which is now widely adopted within the World Association for Infant Psychiatry. It has stimulated a significant advance in child development research and its contribution has been widely welcomed by child psychologists (e.g. Sroufe, 1986). A further good reason to explore it is the increasing relevance of attachment research for developmental psychopathology and for preventative mental health. The psychoanalysis of adults is unlikely by itself to give us further insights into the infantile origins of pathology. It is likely that more can be learned by relating these insights to observations of parent-child interactions. As Winnicott (1957) wrote, "By constantly co-operating, analysts and direct observers may be able to correlate what is deep in analysis with what is early in infant development."

In the course of Bowlby's work on attachment and its corollary, loss, he reformulated psychoanalytic theory in terms compatible with modern scientific thinking. His trilogy *Attachment and Loss* (1969, 1973, 1980) combines ideas derived from ethology, systems theory and cognitive psychology. The theoretical essentials of this new approach have been ably summarized by Hamilton (1985). In this article my emphasis is on empirical findings of attachment research, with reference to their clinical relevance.

Evolution and the need for attachment

Bowlby approached the early mother-child relationship from the standpoint of a biologist. He appreciated the need to formulate psychoanalytic thinking within the central biological theory of our time: evolution. Our ancestors spent some four million years as hunter gatherers before history began. They inhabited an environment in which only the fittest survived to reproduce. Our instinctive behaviour evolved to increase our chances of survival in these conditions. Bowlby avoids Freud's use of the term 'instinct' with its outmoded concept of some internal driving force, and prefers the term 'instinctive behaviour'. This is conceived as a pattern which is activated or terminated by particular internal or environmental conditions.

Attachment behaviour is an excellent example of such instinctive behaviour. Bowlby conceives of it as being separate from the instinctive systems subserving feeding and sexual behaviour. It is activated in infancy by the internal conditions of fatigue, hunger, pain, illness and cold, and by external conditions indicating increased risk: darkness, loud noises, sudden movements, looming shapes and solitude. When it is activated the child seeks contact with one of his particular attachment figures whom he has learned to discriminate.

Babies are clearly pre-programmed at birth to learn the specific details of a few caretaking adults. For example, they have been shown to recognize their mother's voice at birth; they have learned her smell by five days and they can discriminate her visually from a stranger from two or three days old. They show their capacity to discriminate by their preference for their mother's qualities. Although clear preferences develop from birth, the full intensity of the baby's attachment behaviour is only manifest from the latter half of the first year.

When attachment behaviour is activated at low levels it is possible for a mother to calm her infant by voice and proximity alone; but when the infant is very upset, only close physical contact can terminate distress. The aim of all attachment behaviour is proximity or contact, while its subjective goal is felt security. Anxiety is experienced throughout life when we are threatened either by a hostile environment or by the withdrawal or loss of our attachment figures. As adults, we still need attachment figures and we still seek physical contact at times of acute anxiety, trauma or loss.

In summary, Bowlby sees infants as being pre-programmed, given an ordinary expectable environment, to develop attachment behaviour which decreases the risk of danger and increases safety. A toddler's clinging to his mother in a strange situation is therefore conceived as an

adaptive action and not as a manifestion of cupboard love, greed, sexual possessiveness or omnipotent control, which some psychoanalytic theories have supposed it to be.

Bowlby's evolutionary perspective offers us a simple explanation of the development of infants' fears. In the second half of the first year babies become increasingly afraid of strangers, heights, the dark and solitude. This development can be understood as a maturational concomitant of the baby's new capacity for independent locomotion, a capacity which clearly increases the risk of encountering danger. Natural selection has equipped infants with a behavioural repertoire which increases their tendency to seek proximity to their mother at times of increased risk. There is no need to postulate the irrational project of hostility to explain infantile fears, although of course such fears could be increased by projection. Typically, the very timid, fearful baby is one who has learned to expect that his attachment figure will not be reliably available when he is distressed; this is certainly a realistic cause for both fear and anger.

The evolutionary approach also provides a simple explanation for the vast increase in infantile sleeping disorders in recent years: more infants than ever before are expected to sleep alone. Anthropological studies reveal that, in all primitive societies investigated, babies invariably sleep beside the said to be mother, often between the parents (McKenna, 1986); this practice is also the norm in Japan and China. It is interesting that parents in these societies, when told of Western sleeping practices, regard them as a form of child abuse. Babies are highly adaptable, but in evolutionary terms, being alone in the dark is a situation of high risk, and when babies become aware of their isolation they are liable to insist on parental presence. This is not to say that there may be no means of overcoming a baby's fears without sleeping beside him (see Daws, 1989), but pursuing the aims of Western civilization can prove exhausting.

Bowlby's initial research focussed on the effects of physical separation of young children from their parents, often in hospital or residential institutions. Later attachment research has focussed on the nature of the mother's availability when she is present – her sensitivity and responsiveness. Evidence shows that the toddler who knows his mother is reliably available when he needs her can use her as a secure base from which to venture to explore his environment. He can concentrate well and play independently because he feels safe. Recent research has also shown a strong positive correlation between the security of children's attachments and their capacity to co-operate with adults, to concentrate on play, to persist at problem-solving (Sroufe, 1986) and to be popular with peers (Sroufe, 1983)

The concept of security is not entirely new to psychoanalysis, in 1959 Sandler suggested the notion of safety as a feeling state quite distinct from sensual pleasure. He went on to describe how patients might thwart analytic work by regressing to childhood relationships associated with punishment or pain, because the security associated with these relationships made them more rewarding than the insecurity and isolation associated with new ventures. Thus, some instances of the negative therapeutic reaction can be understood in attachment terms.

Attachment theory sheds further light on the powerful attachment which an abused child can develop to an abusing parent. When the source of a child's security is also a source of pain and danger, the child is placed in a position of irresolvable and self-perpetuating conflict. "The situation is irresolvable because rejection by an established attachment figure activates simultaneous and contradictory impulses both to withdraw and to approach. The infant cannot approach because of the parent's rejection and cannot withdraw because of its own attachment. The situation is self-perpetuating because rebuff heightens alarm and hence heightens attachment, leading to increased rebuff, increased alarm and increased heightening of attachment ... In other words, by repelling the infant the mother simultaneously attracts him" (Main and Weston, 1982). The clinical outcome is an intense anxious dependency which is much harder to outgrow than the dependency experienced in a secure relationship.

Security of attachment: the observed infant

Attachment research has focussed on the parent-infant relationship. Since biologists have found each organism to be highly adapted to its environment, Bowlby has always supposed the infant to be more influenced by real aspects of parenting than by internal fantasy. This assumption has been supported by Ainsworth's research (e.g. 1985) which reveals that certain characteristics of a mother's parenting are more important for determining the infant's security of attachment at a year, than any innate quality of the infant that has yet been assessed.

But what does 'security' of attachment denote?

Ainsworth's (1971) "Strange Situation test" has been widely used to provide an assessment of infant security. In this standardized test the infant is left briefly alone in a strange room and then reunited with his mother; his reactions on reunion are considered indicative of the nature of his security, since they reveal the expectations he has developed about her physical and emotional availability.

i) Secure attachment

In general, patterns of behaviour on reunion with mother fall into two broad categories. The exact proportions of babies falling into each category vary with the sample (several nationalities have been assessed), but roughly speaking some two thirds of babies are rated as securely attached. On reunion these babies immediately seek contact with their mother; on being picked up they are

quickly comforted by her and they soon ask to be put down so that they can pursue their exploration of the toys provided. They may express some anger with mother, especially if she tries to interest them in the toys too soon, but their crossness is easily assuaged.

These babies can be said to have developed basic trust.

ii) Insecure attachment

The remaining third of babies are classified as anxiously attached. This category comprises two groups: those with avoidant and those with ambivalent or resistant attachments. These two groups appear to correspond with the two groups of adult patients whom M. Balint (1959) had designated as philobats and ocnophils respectively. Although Balint's terminology is not widely known, all psychotherapists must be clinically familiar with the distinction between these two solutions to insecurity. Philobats can be briefly designated as self-sufficient explorers who evade these contacts while ocnophils are dissatisfied clinging dependents who rely on physical proximity to feel safe. The revelation of Ainsworth's research is that these patterns of response to stress are clearly established by the first birthday. Informal observations in the home indicate that in some instances they may be established as young as three months.

a) The avoidant infant. The characteristic response of these babies on reunion in the Strange Situation is not to greet their mother, and, in some instances, not even to look at her. Any approaches tend to be abortive. If picked up they may lean away or squirm to get down. Frequently they divert their mother's attention to a toy or distant object. However, it is clearly perplexing that stressful events which normally heighten attachment behaviour apparently diminish it. Bowlby (1988a) interprets the avoidant response to indicate that "already by the age of twelve months there are children who no longer express to mother one of their deepest emotions, nor their equally deep-seated desire for comfort and assurance that accompanies it". Fearfulness, dependency and hostility are not expressed. Psychological defences must be assumed to be already active.

b) The ambivalent or resistant infant. These babies are intensely upset by the separation and are highly ambivalent to the mother on her return. They want to be close to her but are angry with her and so are very difficult to soothe. They cling, resist being put down and are slow to return to play.

As Ainsworth has pointed out, the psychological significance of the three patterns of attachment behaviour which she described rests upon their close association both with mother-infant interaction in the home, and with their persistence over time.

iii) Observations in the home reveal that the reaction of babies in the Strange Situation is closely related to the nature of the mothering which they have received during their first year.

a) Briefly, babies with a secure response have mothers who have proved responsive and accessible. These mothers are able to read their babies' signals and to respond to them sensitively and reliably. They easily accept their babies' bids for close physical contact. At home their babies are observed to be happier and more co-operative than babies who manifest an insecure attachment.

b) Babies with an avoidant response have mothers who are restricted in their range of emotional expression and who exhibit an aversion to close physical contact; these are babies whose bids for comforting have been consistently rebuffed. Their mothers hold and carry them less comfortably than other mothers do, tending to avoid close ventro-ventral contact. Their babies have been found to be no less cuddly at birth than other babies are, but by a year they neither cuddle nor cling but are carried like a sack of potatoes. Their mothers tend to express affection by kissing rather than by cuddling.

Elsewhere I have described the internal world of the avoidant child and the profound effect of the physical rejection which they have suffered (Hopkins, 1987). These children manifest a psychological constellation consisting of an acute conflict between the desire for and dread of physical acceptance, and a self-representation of being in some ways untouchable or repellent. Bick (1968) has described how some of these children develop a "second skin" as a means of holding themselves. Balint recognised that adult philobats depend upon an illusion of self-sufficiency to sustain their adaptation.

An avoidant attachment does not necessarily result in manifest pathology. Avoidant adaptation ranges from the self-contained and emotionally distant personality (said, for example, to be characteristic of the English upper classes) to the severely schizoid or autistic.

c) Babies with an ambivalent attachment have mothers who enjoy physical contact, but who provide it erratically, often in response to their own needs rather than in response to their babies' needs. They are in general inconsistently responsive and tend to be interfering and intrusive. Their babies' anger towards them can be understood as an attempt both to express frustration at their inconsistent handling, and to force their mothers to provide the care and comfort of which they know they are capable. Balint (1959) recognized that, as ocnophils their "real aim is not to cling but to be held without even needing to express the wish for it." He found that they had the illusion that as long as they were in touch with a safe object they themselves were safe. In view of the fact we now know that their mothers' moods have been very inconsistent and unpredictable, it is not surprising that ocnophils feel that physical contact is necessary in order to keep "in touch".

The difference between an ambivalent

and an avoidant view of life may be reflected in some of the differences between the theoretical infants of Melanie Klein and Anna Freud. Melanie Klein struggled to explain the intense involvement and the destructiveness associated with an ambivalent attachment, while Anna Freud endeavoured to keep the more detached, objective stance associated with an avoidant adaptation.

The Insecure Disorganized-Disoriented Attachment Pattern

This infrequent attachment pattern has only recently been described (Main, M. and Solomon, J., 1986a). It is normally found in conjunction with infant behaviour characteristic of one of the other major attachment categories. Whereas the avoidant and ambivalent infants have developed consistent strategies for dealing with stress, the disorganized-disoriented infants have not. In the Strange Situation, they reveal their inability to cope in a variety of individual ways. For example, the infant may freeze motionless, fall prone, exhibit tic-like stereo-topies or a simultaneous display of contradictory behaviour patterns, such as approaching with head averted. Much research remains to be done, but early findings indicate that the parents of these babies are either frightened or frightening; some have been abusive. Other parents are suffering from unresolved grief and mourning. As these infants grow up they are liable to cope with their helplessness by becoming very controlling of their parents, in either a caregiving or a punitive way.

Fathers

Fathers have so far had to take second place in attachment research because they so rarely are the baby's main caretaker and so are less available for study. However, one most important finding has emerged from the research. Contrary to psychoanalytic expectation, the infant's relationship to his father cannot be predicted from the nature of his relationship to his mother. It is independent of it and reflects the qualities which the father himself has brought to the relationship. This means, moreover, that the nature of the infant's security is not a function of his general temperament but depends on the history of interaction which he has had with each caregiver.

One common division of functions between parents is that father becomes the preferred play partner while mother is the preferred attachment figure. This means that when the baby is lively and happy he will seek out his father for play and entertainment, but when he is tired, ill or frightened he will want comfort from his mother. However, it should not be forgotten that when the child's relationship to his mother is insecure, father may well be the preferred attachment figure, even when he spends less time in child care than mother does. It is the quality of parental availability which determines security of infant attachment, not merely the quantity.

In 1938 Freud described the child's relationship to his mother as "unique, without parallel, laid down unalterably for a whole lifetime, as the first and strongest love-object and as the prototype of all later love relationships, for both sexes." Although attachment research has clarified that the early attachment to the mother is **not** the prototype for the attachment to the father, it has not yet been established whether Freud was right about its significance in determining later love relationships. The only study to date is in line with Freud's view.

Main (1986b) found that six-year-olds' representation of attachment, revealed in projective tests, was based on the relationship to the mother not the father. For these children mother had been the primary caretaker and it would be interesting to know what consequences follow when father plays an equal or major caretaking role. Without question, both the relationship to the mother and the father, together with those to other significant early figures, are brought forward into the psychoanalytic transference. But the relative significance of these relationships in sexual object choice is not sufficiently understood. Whatever the case, it seems possible that the prototypes of the earliest relationships which determine all later love relationships are based on those parental characteristics which determined the nature of the child's attachment; that is, on physical and emotional availability, sensitivity and responsiveness.

Changes in Attachment Pattern

Attempts to predict the course of child development from individual characteristics assessed during the first year have always failed, but the nature of the child's attachments both to mother and to father at the first birthday have emerged as factors with significant predictive power. This must be because the attachment pattern is an aspect of a relationship, not just of the child himself so as long as the child continues with the same relationship, the stability of the attachment pattern is high.

However, changes in attachment patterns do occur, especially in unstable populations, such as a deprived inner city sample. These changes are found to be a function of the availability of the parent concerned. For example, with regard to mothers, attachments are likely to become more secure if mother gets more support, whether from her husband, her mother, a friend or a professional worker. Attachment to mother may become less secure when mother goes out to work, gives birth to another sibling, is depressed or bereaved. However, as the child grows older his attachment pattern becomes increasingly a property of himself, and is less responsive to changes in parenting.

Several studies have shown that the provision of additional support for mothers during the baby's first year increased the likelihood of the development of secure attachment. Another

study which showed a marked effect on security has further practical implications because it involved the use of a ventral baby carrier (kangaroo-type pouch). Mothers who used these carriers became more sensitive and attentive to their babies than a control group, with very beneficial results (Anisfeld, 1987 and in press). Main (in press) believes that this result is not simply due to the effect of proximity on the mother's responsiveness, but also to the infant's response to continued close contact with the mother's ventral surface. The incidence and duration of breast feeding was not affected by the use of the carrier and the experimenters concluded that "carrying a baby close to the body in the first months of life has a more positive effect on the mother-infant relationship than does breast feeding."

The infant's contribution

What part do individual differences between babies play in the development of their security at a year? As already mentioned, infant temperament is not a significant factor in the development of security, as shown by the findings that security with mother and with father are independent of each other, and that either can change with changes in parental availability. Indeed the overall findings of attachment research are firmly weighted in favour of the over-riding influence of parental care in determining infant security. In addition to the examples already given one contribution of Ainsworth's (1977) is often reported. She found no correlation between infants' initial irritability and their amount of crying at a year, but a high correlation between mothers' ready responsiveness to initial infant crying and a marked reduction in crying over the year. Irritable babies do not create lastingly irritable mothers but are calmed by responsive ones.

However, statistical generalizations can be misleading when it comes to the consideration of individual cases. Attachment research has been carried out on samples of normal, healthy, full-term babies. Ainsworth herself has acknowledged that the effect of infant behaviour on the mother might be much greater among infants thought to be developmentally at risk.

As attachment research expands it is likely that much more will be learned about the infant's contribution. Already a few studies have reported positive findings. For example, the neonate's ability to orient towards a face has been found to be correlated with secure attachment at a year (Grossman et al., 1986), while babies whom neonatal nurses found difficult were more likely to be develop insecure attachment (Engeland and Farber, 1984).

Internalization

Bowlby developed the idea of 'internal working models' to resolve some of the difficulties inherent in the concept of internal objects and to explain the tendency for a child's attachment patterns gradually to become a property of himself. Although the family context continues to influence the child, the perpetuation of his attachment patterns becomes increasingly a matter of self-regulation. As Bowlby (1973) describes, "present cognitive and behavioural structures determine what is perceived and what ignored, how a new situation is construed, and what plan of action is likely to be constructed to deal with it. Current structures, moreover, determine what sorts of person and situation are sought after and what sorts are shunned. In this way an individual comes to influence the selection of his own environment."

It is proposed that the infant constructs models of the world which enable him to interpret events, predict the future and plan action. Because working models of relationships develop in transaction, the child internalizes both sides of the relationship, and the working models of the parent and of the self are complementary. For example, if a child has experienced reliably responsive caregiving he will construct a working model of the self as competent and lovable, but if he has experienced much rebuff he will construct a model of the self as unworthy of help and comfort.

It is possible to conceive of internal working models as composed of the RIGs (representation of interactions which are generalized) proposed by Stern (1985). Indeed, attachment theory is entirely compatible with Stern's work, and complementary to it, since it provides what Stern lacks: a psychology of comfort and distress and an explanation of the specificity of infant attachments.

For a relationship to proceed optimally each partner must have reliable working models of each other, which can be revised and updated in accord with communication between them. Here there is a striking difference between the directness of communication between the secure and insecure infants and their mothers. Secure couples show more eye contact, verbalization, emotional expression and shared interaction with toys than do insecure pairs. This disparity is even more marked when the infants are distressed. The secure infants remain in direct communication with mothers and express their anger, fear and desire for her, while avoidant infants only engage in direct communication when they are content.

These differences persist. Main's longitudinal study (1986b) found that at six years of age, children with mothers who had shown a secure pattern of attachment five years earlier, engage in free-flowing conversation, including a wide range of topics, personal issues and expression of feelings. Six-year-old children who had had an avoidant pattern with mother at a year had limited conversations which avoid both personal issues and feelings.

Such obstruction in communication indicates the operation of defensive strategies. Defensive exclusion is believed to occur in response to intolerable mental pain or conflict. As

Bretherton (1987) describes, "Clinical case material suggests that such conflict arises when an attachment figure habitually ridicules a child's security-seeking behaviours, reinterprets rejection of the child as motivated by parental love or otherwise disavows or denies the child's anxious, angry or loving feelings towards attachment figures. Under such circumstances, it is common for a child to exclude defensively from awareness the working model of the "bad" unloving parent, and retain conscious access only to the loving model."

In addition to the defensive strategies adopted by the child in response to the frustration of his bids for security, the child's self-model is profoundly influenced by how his mother perceives him. Whatever she fails to recognize in him he is likely to fail to recognize in himself. In this way major parts of his personality can be split off and unintegrated. The situation is further complicated if the mother falsely attributes to the child intentions and feelings which he does not have.

Bowlby (1980) points out that there is often a discrepancy between what a parent says and what a parent does. Severe psychic conflict results when parental generalizations clash with the child's actual experience, and defensive exclusion of personal feelings and/or memories may be used as a means of continuing to see the attachment figure in a good light, and so to maintain security. Infantile phobias can be understood as a means of preserving a secure relationship to an attachment figure while attributing fears belonging to the parental relationship to some external object. For example, a two-year-old boy developed a phobia of all books containing monsters after his mother had read him a story about a dragon which blew smoke and flames. In therapy it emerged that she had often controlled him with threats of cigarette burns and actually burned him on one occasion. Bowlby (1973) reinterprets Little Hans' phobia of horses in terms of his anxious attachment and terror of losing his mother.

Intergenerational Transmission

Psychotherapists will not be surprised to learn that there is a significant correlation between parents' representation of their own childhood attachments and the nature of their child's attachment to them. When interviewed about their childhood experience parents reveal as much by the nature of their communication to the interviewer as they do by the contents of their replies. Parents of both resistant and avoidant infants are alike in giving accounts which typically are characterized by unrecognized inconsistencies and contradictions, but their accounts also differ from each others in predictable ways (Main et al., 1986). Parents of resistant infants generally give a lengthy account of unhappy, entangled relationships, with ample evidence that they have remained entangled with their own parents or with memories of them. Parents of avoidant infants give much briefer accounts, partly because they minimize the importance of relationships and partly because they tend to have forgotten childhood experiences. They are likely to make generalized statements about having had happy childhoods, but to be unable to support this with evidence, which is either lacking or contradictory.

In contrast to the parents of insecure infants, parents of secure infants give a fluent, consistent and coherent account of their childhoods in which they treat relationships with significance and recall events with appropriate affect. The vast majority of these parents have had secure childhoods themselves, but among them are a number who recall childhoods of extreme unhappiness and rejection. They have though and felt deeply about their experiences and have tried to understand them. Some of them have remained very angry with their own parents while others have achieved forgiveness.

The outcome of this research clearly supports the clinical finding that the repetition of adverse childhood relationships can be avoided when adults come to terms with their unhappy past. It seems that this can happen when they recognize what happened to them, acknowledge how they felt about it and are aware that their parents contributed significantly to their unhappiness, which was not entirely of their own making. For example, a father who remembers with resentment being thrashed by his father is much less likely to beat his own child than a father who says, "He only thrashed me when I asked for it."

The need for early intervention

Resistance by psychotherapists to attachment theory is likely to persist, not only because of its novelty, but because some of its findings are unpalatable and its implications for adult psychotherapy are unclear. Bowlby (1988b) has recently tried to remedy the absence of any significant contribution to the therapeutic process, but much further thinking on this issue remains to be done. Meanwhile, it is probably the finding that the effect of parental behaviour on the infant is much greater in making for individual differences than the effect of the infant on the parent, which is difficult for some psychotherapists to accept. However, since parents can be changed more readily than innate endowment, the message is optimistic and the implications for preventive intervention are obvious. Clearly there is a need for major change in cultural attitudes towards mothering and the provision of support for parents. As far as psychotherapists are concerned, it is to be hoped that more members of our profession will become involved in infant-parent psychotherapy (Fraiberg, 1980; Cramer and Sterm, 1988; Hopkins, in press). In this psychoanalytic approach, parent(s) and infant are seen together, and their relationship can usually be improved more rapidly and effectively than when a parent is

given individual help. Insecure attachments can often be lastingly transformed into secure attachments in the course of a brief, focussed intervention. Results are rapid because the baby's internal working model of the relationship is not yet self-regulating and is still able to change responsively to changes made by the parent. The therapy and its outcome can be richly rewarding.

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References:

Ainsworth, M. D. S. et al. (1971) Individual differences in strange situation behaviour of one-year-olds. In *The Origins of Human Social Relations* (Ed. H. R. Schaffer). London: Academic Press.

Ainsworth, M. D. S. (1977) Social development in the first year of life: maternal influences on infant-mother attachment. In *Developments in Psychiatric Research* (Ed. J. M. Tanner). London: Hodder & Stoughton.

Ainsworth, M. D. S. (1985) Patterns of infant-mother attachment: antecedents and effects on development. In *Bulletin of New York Academy of Medicine*, **61**, pp. 771-91.

Anisfield, E. et al. (1987) Infant carrying, breast-feeding and mother-infant relations. Letter to *The Lancet*, Feb. 14, p. 379.

Balint, M. (1959) *Thrills and Regressions*. London: Hogarth.

Bick, E. (1968) The experience of the skin in early object relations. In *International Journal of Psychoanalysis*, **49**, pp. 484-486.

Bowlby, J. (1969/1982) *Attachment and Loss, vol. 1: Attachment.* London: Hogarth.

Bowlby, J. (1973) *Attachment and Loss, vol. 2: Separation.* London: Hogarth.

Bowlby, J. (1980) *Attachment and Loss, vol. 3: Loss, Sadness and Depression.* London: Hogarth.

Bowlby, J. (1988a) The role of attachment in personality development. In *A Secure Base: Clinical Applications of Attachment Theory*, pp. 119-136. London: Routledge.

Bowlby. J. (1988b) Attachment, communication and the therapeutic process. In *A Secure Base: Clinical Applications of Attachment Theory*, pp. 137-157. London: Routledge.

Bretherton, J. (1987) New perspectives in attachment relations. In *Handbook of Infant Development*, (Ed. J. Osofsky) 2nd edition. New York: Wiley.

Cramer, B. and Stern, D. N. (1988) Evaluation of changes in mother-infant brief psychotherapy: a single case study. *Infant Mental Health Journal*, **9**, pp. 20-45.

Daws, D. (1989) *Through the Night: Helping Parents and Sleepless Infants*. London: Free Associations.

Egeland, B. and Farber, E. A. (1984) Infant-mother attachments: factors related to its development and changes over time. *Child Development*, **55 (3)**, pp. 753-771.

Freud, S. (1938) An outline of psychoanalysis. In *Standard Edition*, **23**, pp. 144-207.

Grossman, K., Grossman, K. E., et al. (1986) Maternal sensitivity and Adenborns' Orientation as related to quality of attachment in Northern Germany. In *Growing Points of Attachment Theory and Research* (Eds. I. Bretherton and E. Waters). Monograph **50** of the Society for Research in Child Development, Serial No. 209, pp. 233-256.

Hamilton, V. (1985) John Bowlby: an ethological basis for psychoanalysis. In *Beyond Freud: A Study of Modern Psychoanalytic Theorists* (Ed. J. Reppen) pp. 1-28. New York: Analytic Press.

Hopkins, J. (1987) Failure of the holding relationship: some effects of physical rejection on the child's attachment and on his inner experience. In *Journal of Child Psychotherapy*, **13**, pp 5-17.

Hopkins, J. (in press) Infant-parent psychotherapy. *Journal of Child Psychotherapy.*

Fraiberg. S. (1980) *Clinical Studies in Infant Mental Health: The First Year of Life*. London: Tavistock.

Main, M. and Solomon, J. (1986a) Discovery of an insecure disorganized-disoriented attachment pattern. In *Affective Development in Infancy* (Eds. T. B. Brazelton and M. W. Yogman). New York: Ablex.

Main, M., Kaplan, N., Cassidy, J. (1986b) Security in infancy, childhood and adulthood: a move to the level of representation. In *Growing Points of Attachment Theory and Research* (Eds. I. Bretherton and E. Waters). Monograph **50** of the Society for Research in Child Development, pp. 66-104.

Main, M. (in press) Parental aversion to physical contact with the infant. In *Touch* (Eds. T. B. Brazelton and K. Barnard). New York: International Universities Press.

McKenna, J. (1986). An anthropological perspective on the sudden infant death syndrome. In *Journal of Medical Anthropology*, **10**, No. 1.

Sandler, J. (1959) The background of safety. In *From Safety to Superego*. London: Karnac Books, 1987.

Sroufe, L. A. (1983) Infant-caregiver attachment and patterns of adaptation in preschool: the roots of maladaptation and competence. In *Minnesota Symposium in Child Psychology*, (Ed. M. Perlmutter), **16**, pp. 41-81, Hillsdale, N. J.: Erlbaum.

Sroufe, L. A. (1986) Bowlby's contribution to psychoanalytic theory and development psychology. In *Journal of Child Psychology and Psychiatry*, **27**, pp. 841-849.

Stern, D. N. (1985) *The Interpersonal World of the Infant: A View from Psychoanalysis and Development Psychology*. New York: Basic Books.

Winnicott, D. (1957) On the contribution of direct child observation to psychoanalysis. In *The Maturational Processes and the Facilitating Environment*. London: Hogarth Press, 1965.

Hanging by a Thread: The History of Balint in Britain – 1972-1999*†

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In March 1972, 423 delegates from 17 countries came together in London for the first International Balint Congress. Michael Balint had died only recently (December 1970) and the Congress was both a celebration of his work and a mourning of his passing. Although Hungarian in origin, he had lived and worked in Britain since 1939 and all the early work with family doctor groups leading to the publication in 1957 of *The Doctor, his Patient and the Illness* had been done in London.

Following the example of the French Société des Groupes Medicales Balint, the family doctors who worked with Michael and Enid in London had already inaugurated the Balint Society. The aim of the Society was to provide a focus for continuing the work, developing the ideas and spreading the word as widely as possible.

The Balint group had transformed their own professional lives and they wanted as many colleagues (and patients) as possible to share the benefits. There was already a good deal of interest in other European countries and in the next few years Balint Societies would also be started in Belgium, Holland, Italy and Germany. The formation of the International Federation was to follow and bring in a considerable number of other countries. But in 1972, London must have seemed the most fitting place to discuss Michael Balint and his work.

After the Congress

The Congress was a great success, but when all the guests had gone home, if anyone had counted the number of doctors and psychoanalysts actively engaged in Balint work in the country where it all started they might have had quite a shock. The Tavistock Clinic, where the Balints' work started, continued to have three or four groups running (although they preferred to surround his name with quotation marks to make it clear that, in their view, this type of psychoanalytically guided case discussion group was not the invention of Balint alone). Enid herself was leading two groups in London and in other parts of the country there were a very small number of groups (perhaps three or four) clinging precariously to existence.

It seems that despite the success of the book and the enthusiasm of the participants at the London Congress, the overwhelming majority of family doctors (GPs) in the United Kingdom were not really interested in being in a Balint group. And those who were interested would often have great difficulty in finding an analyst to lead them. It seems that British analysts were, with very few exceptions, not very enthusiastic about using their skills to help family doctors with their work.

The National Health Service in Britain has never encouraged GPs to provide formal psychotherapy for their own patients and hence there was no incentive to undergo psychotherapy training of which Balint work might be an important component, as in Germany. The only exceptions to this rule were the Family Planning (Contraception) Clinic doctors, some of whom were also GPs. From the earliest days, in the 1950s, the Balints and some of their analytic colleagues had provided groups for those family planning doctors who were interested in helping their patients with psychosexual problems. This led to the formation of the Institute of Psychosexual Medicine which established a network of groups in many parts of the country and an effective structure for training both novices and new leaders. These groups were able to focus on the narrower field of sexual dysfunction rather than covering the all inclusive territory of general practice.

How did Balint work survive in family practice?

Far from prospering in his adopted country it must have seemed to an objective observer that the Balint's work within general practice was unlikely to survive his death by more than a few years. Surprisingly and fortunately Balint has survived in Britain if only 'by the skin of its teeth'. Its survival is the result of a number of factors, all of which play an important part in the history of Balint in the UK after 1972.

1. The Balints' Pupils

Michael and Enid's pupils were full of enthusiasm and determination to continue the work. These were the GPs who had been in the Tavistock groups in the 1950s and 60s. By 1972, the College of General Practitioners had been formed and many of its leading members were Balint graduates. They were deeply involved in the new schemes for providing a proper postgraduate education for general practice which was now seen as a discipline in its own right. The new educational ideals included enthusiasm for all kinds of small group work (which had the blessing of the experts in adult education) and it was only natural for the Balint graduates to want to introduce their young pupils to the benefits of Balint groups.

Once again there were very few psychoanalysts available to help and so the GP Course Organisers had to become group leaders themselves. Although Michael Balint had always maintained that a group leader must be an analyst, Enid seemed to take a more pragmatic view. She

* Address given to the Balint Society on 16 March 1999.

thought that if someone had been through the experience of working in an analyst led group for a few years, something of the analytic way of thinking (including awareness of unconscious process) would have been absorbed. Enough to enable a Balint trained GP to become a group leader – with the distinct advantage that he or she would already know a good deal about general practice – which an analyst leader might not.

So we have, in the early 1970s, a small band of original Balint group graduates who are GP Vocational Training 'Course Organisers'. They are in charge of small groups of young GP trainees which meet once a week for a day or a half day for an educational session. Part of the day is allocated to group work and if the Course Organiser is a Balint graduate, the group is a Balint group. The training schemes only last three years and often it is difficult for those in the first two (hospital) years to attend regularly, but the leaders stick to the principles they learned with the Balints as far as possible. Often they lead in pairs for mutual support and sometimes the co-leader is a psychologist or psychotherapist. Some of the GP leaders have spent a year as an associate leader with Enid or another analyst in order to learn their craft. Once every two months there is a Group Leaders' Workshop, chaired in the early years by Enid herself. Here, group leaders can bring transcripts of their group sessions for discussion among their colleagues and for guidance from Enid.

2. The Balint Society

The Balint Society was established in 1970 as a result of the efforts of Dr Philip Hopkins, a member of the first GP Balint group, who became its first president. The Society had (and still has) a membership of around 150 family doctors. Psychoanalysts could become associates but not full members. Perhaps the founders wanted to prevent the analysts from becoming too influential: in the event there were never very many psychoanalysts involved with the Society, so the rule may have been counter-productive. The active members were a core group of about 15-20 enthusiasts who lived and breathed Balint. Most of them lived in London where the Society had its meetings. They were, for the most part, the same enthusiastic graduates of the early groups who were leading GP Trainee groups and meeting at the Group Leaders' Workshop.

The aims of the Balint Society were to promote Balint's ideas and to provide a forum for the encouragement of research and the interchange of ideas. Members were offered a programme of evening lectures and discussions, an annual dinner and, every second year, the Balint Memorial Lecture. All meetings were held in London making it difficult for members living outside London to attend. The Council of the Society did its best to encourage the formation of new groups for established GPs but with very little success. Either there were not enough doctors to sustain a group or a group was ready to start but failed to find a suitable leader in a provincial city. A few groups started but all foundered after a few years.

3. The Oxford Weekend

In 1978 the council of the Balint Society began to think about putting on a weekend meeting outside London in order to give people a 'taste' of the Balint group experience; if they enjoyed it, the hope was that they would be motivated to start regularly weekly groups in their own city or region. After two exploratory weekends in 1978 and 1979, the first Balint Weekend in an Oxford College was held in 1980. The weekend was accredited for postgraduate education with expenses reimbursed; the venue in a beautiful historic building was attractive and there was enough curiosity about Balint to attract over 100 family doctors.

The weekend began with a demonstration group, led by Enid Balint and followed by a general discussion. In the next two days the participants were able to work in the same small group for four sessions. Living and eating together in between sessions seemed to break down barriers very quickly (something which happens in all kinds of residential course) and it was noticeable that the groups made more progress in four sessions than a weekly group would make in several months. There were two analyst leaders, but most of the groups were led by a pair of GP leaders, members of the same little band of disciples who ran the Society, and GP Trainee Groups and attended the Leaders' Workshop.

Many of the doctors who came to the weekend acquired a lasting interest in Balint work despite the fact that very few were able to find an ongoing group in which to continue. But the weekend was repeated every year and some of these new converts came regularly. The Balint Society received a welcome tranfusion of new and younger members and for the first time family doctors living outside the capital were able to experience and benefit from the Balint method. The Oxford weekend continues and although the numbers attending are now smaller (about 50) the enthusiasm and enjoyment are as great as ever.

4. Enid Balint and the Research Groups

Another reason why Balint work in General Practice survived was Enid's drive to continue the research which had always been part of the 'Training cum Research Seminars' as Michael called them. To the end of her life, Enid was determined to pursue her own exploration of the nature of the doctor-patient relationship in family practice. She wanted to know as much as possible about the subtle ways in which patients sought psychological help from their family doctors – and often received it. She wanted to help family doctors to tune in to their patients' feelings and be able to understand and serve them better. To continue the research which she and Michael had begun, she needed the Balint Society's active

members (I shall call them 'The Core Group') to provide the clinical material and contribute to the thinking.

The Core Group members were equally willing to participate. This was their chance to continue working with each other and to continue to benefit from Enid's immense skill as a Group leader. Michael Balint's last research group was the one which led to the book *Six Minutes for the Patient* (1973). This was followed by two further groups under Enid's leadership. The first of these, which met in the early 80s, wrote *While I'm Here, Doctor* (1987) and the second produced *The Doctor, the Patient and the Group* (1993).

As time went by, some of the original group members retired or, sadly, died. They were replaced by younger enthusiasts, never in large numbers, but sufficient to maintain a little band of 15 to 20 GPs who ran the Balint Society, kept the Balint flame burning in GP Training Schemes and were available, if invited, to take part in Enid's researching groups.

Theoretical Developments

Six Minutes for the Patient, published in 1973, was the last book to record the work and conclusions of a group led by both Michael and Enid. The book attracted a lot of attention in many parts of the world, perhaps because it seemed to promise a solution to the eternal problem of the family doctor's shortage of consultation time. There was a lot of excitement about the concept of 'The Flash'. This was a kind of epiphany in the consultation in which doctor and patient suddenly and simultaneously achieved an almost miraculous insight into their relationship and hence into the patient's problem. However, flashes occurred fairly infrequently and it was difficult to make them happen to order. When they did happen the doctor was still uncertain what to do next.

A much more important and lasting result of the Six minutes group and its book was the change in emphasis to what could be achieved in short, ordinary length consultations. Long interviews, once *de rigeur* for any doctor presenting a case in a Balint group were now out of favour. Michael Balint refers rather scathingly in the book to 'The Detective Inspector' doctor who interrogated the patient and tries too hard to dig up the root cause of the patient's problem. The emphasis now was on allowing the patient to dictate the pace and the agenda; the doctor was to be an observer, rather than an inspector and the patient was encouraged to 'use' his doctor (a phrase which must have made many doctors shudder) in the way he needed at the time.

These ideas were very influential and not only in the United Kingdom. As a result of their adoption, Balint doctors began to give up trying to be psychotherapists and concentrated instead on being sensitive family doctors. Their aim shifted subtly from a determination to change the patient to a desire to listen, to empathise (a word adopted from the counselling movement) and, now and then, to offer an observation.

While I'm Here, Doctor

The next research group, and the first to be formed since Michael's death, was started by Enid in 1981. After the group had been working for three or four years, Enid became seriously ill and had to withdraw. The group continued meeting and eventually produced the book called *While I'm Here, Doctor* (1987) to which Enid was able to contribute a chapter. The group used the usual method of discussing cases brought by the doctors from their every day work in the consulting room. They soon became interested in what they called 'moments of change'. These were occasions in the consultation when the doctor suddenly began to see the patient in a different way. It was less dramatic than a flash and did not involve an interpretation. The moment of change might happen if the patient said something unexpected, or if the doctor, perhaps feeling tired or impatient said something a little abrupt or unprofessional. In one incident, a doctor accidentally upset a stack of dishes which crashed noisily to the floor and made a gloomy patient laugh.

Moments of change sometimes led patients to talk more openly about painful feelings; sometimes the doctor was able to feel closer to a patient with whom he had previously felt detached or indifferent. Enid, in her chapter, discusses the nature of what she calls 'identification' and others might now call 'empathy'. She says that this must be 'a biphasic process' in which the observer (i.e. the doctor) having identified closely with the patient and her feelings, must be able to withdraw and re-establish his objectivity.

She goes on to observe that, after a moment of change, a patient may be able to 'unload her feelings in to the doctor'. If the doctor is able to hold on to these feelings for a while, the patient may be freed to become more active, to 'tune in to other parts of herself' and even to change. This may be more effective than telling the patient she should change or 'telling her what she is like'. Without using technical language Enid seems to be alluding to the psychoanalytic idea of Projective Identification and saying that, if the doctor can accept the patient's projections, this in itself may be liberating. Interpretation, in this context is unnecessary and may be counter-productive.

The Doctor the Patient and the Group – Balint revisited

Enid's last research group with her pupils ran from 1984-87, although the book did not appear until 1993. The aim of the group was to reappraise what Balint work had to offer GPs in th 1900s and, if possible, to make use of modern ideas about qualitative research. In the course of its work, the group developed further the concepts from the previous group about 'moments of

change' and 'identification'. They discovered that 'surprise' was an important element in moments of change: the doctor had to retain the capacity for the patient to surprise him and shake up his thoughts and feelings. Another important topic was 'the observer error'. The group used this idea, borrowed from physical science, to describe the mistakes, omissions or misconceptions that the doctor might have about the patient as a result of a kind of interference from his personal experiences – especially when these resonated with those of the patient. An example was a doctor who had difficulty in accepting the idea of a woman of 43 having a termination of pregnancy because his own mother had given birth to him at the age of 42. Another doctor is a little severe with the mother who thinks her child is 'faking' deafness. It emerges in the group that, as a child, he had an episode of abdominal pain which he was thought to be faking but which turned out to be acute appendicitis.

It is interesting to see that this group seems to have found itself wandering into the area where the personal and the professional self overlap. In obedience to Michael Balint's rule that personal material should not be explored (lest it lead to personal therapy – heaven forbid!) they carefully label the personal material 'observer error' and leave it undisturbed. They didn't really want to explore the personal factors which disturb the doctor-patient relationship any more deeply.

Enid also contributes a chapter on the role of the analyst as group leader, which for non-analyst leaders, throw some light on the special qualities which an analyst can bring to the work. She says that her training enables her to see connections in the material and to hold on to the information without verbalising it too quickly. This, she says can be hard to bear.

She can sometimes help the group members to see an important connection, as for instance the link between a patient's dream and her symptoms, without making a very specific interpretation. The choice of words, when links are made for the patient is vital and here too the analyst is in a position to advise. Analysts are also trained to hold contradictory ideas about a patient at the same time – something which doctors with their more sequential way of thinking find more difficult.

Finally, in this chapter, Enid emphasises that the task of the analyst in a Balint group is to help the doctors to do the work rather than instructing them: 'helping mainly by telling the group what it has said rather than by interpreting underlying meanings'.

This is a very good chapter to read if you want to know what it is that someone trained as an analyst can bring to leading a Balint group which might be difficult for the rest of us.

Further research

During the last few years, another research group under the leadership of Michael Courtenay and Erica Jones has been considering the subject of 'Doctors' Defences'. This work takes as its starting point a paper (originally a Balint Memorial Lecture) by Dr Tom Main called 'Some Medical Defences against Involvement with Patients' (1978). Dr Main argues that defences are absolutely necessary to protect the doctor against too close and too painful exposure to the patient's distress. On the other hand, if they are too rigid and thoughtless, they may prevent the doctor from using his subjective responses in a way which can help the patient without damaging the doctor. Clearly, defences are especially necessary when the doctor's own personal sorrows or pains are evoked by those of the patient. This latest research project has involved a greater willingness on the part of the group members (and the leaders) to explore the territory where the personal and the professional self overlap. Preliminary results were presented at Oxford and we are now in the process of writing it up fully with a view to publication as a Balint Book.

Have the Research Groups influenced the style of Balint groups in the UK?

Evidence of a direct influence of the research books on the way groups function and are led is hard to come by. Certainly, the groups now in existence are mainly concerned with the ordinary GP consultations rather than long 'psycho-therapy' cases, although these are still presented now and then. This may reflect the influence of *Six Minutes for the Patient.*

On the other hand, most of our leaders have either belonged to the Leaders' Workshop started by Enid, or were trained by leaders who took part in it. Here the emphasis was always on the ordinary everyday cases. Most of the groups were (and are) composed of young GPs in training who were unlikely to be embarking on psychotherapy. Interpretation and attempts to explain the meaning of the case have diminished considerably and most leaders are happy to encourage their groups to reflect on the feelings aroused by the patients and to see if any new thoughts emerge. This is in line with the ideas and conclusions of the two later books, but is also a reflection of the fact that most of our leaders are no longer analysts. Having no training or expertise in psychoanalytic theory they are free of the temptation to teach their group members.

The Leaders' Workshop developed a consensus style under Enid's guidance in which the leaders aimed to stay quiet and encourage the group members to do the work. In particular, they tried to deflect 'interrogation' of the presenting doctor by inviting the questioners to 'tell us what *you* think'. Other important functions of the leader were to protect group members from unwanted intrusion and to guide the discussion back to the doctor-patient relationship whenever it strayed too far away.

These ideas about group leadership are shared by Balint leaders in many other countries and form the basis of the International Balint

Federation's Guidelines for Leader Accreditation. It seems likely that the common factor has been the influence of Enid Balint through her writing, her talks and above all by her example when leading groups herself as she did in many countries.

Has Balint a future in the UK?

Balint doctors are incurably optimistic. They have found their groups so enormously helpful themselves, that they cannot imagine why all their colleagues have not seen the light and formed themselves into Balint groups without further delay.

Ever since the 1950s the UK Balint doctors have continued to hope and believe that there will be, one day, a great expansion and spread of Balint groups throughout the profession. When Vocational Training began in the early 1970s it was hoped that all GP training schemes in the country would have Balint groups. Sadly, although most schemes have some sort of small group work, those with recognisable Balint groups remain a small minority. Balint doctors receive considerable respect in GP education circles and are generally listened to with interest. I think this interest and respect are relatively new and are growing as a result of the Society's activities.

There are still some non-Balint Course Organisers who will come to Balint Society workshops in order to learn something about the 'Balint style' of leading a small group in case discussion. However, the majority seem to feel that while Balint has an important position in the history of GP education it was always too time consuming and required too much dedication for general use. It has been superseded, they believe, by other, more up-to-date methods of 'teaching the consultation' which use the analysis of video-taped consultations in various ways.

However, despite languishing as a minority interest, Balint has survived and seems likely to continue. The core group, the members of the Balint Society who were trained by the Balints themselves or by their original pupils, continues to be energetic and enthusiastic. They get together regularly at Balint Society evening meetings, at leaders workshops and at the Oxford weekend. They lead groups whenever they can. The participate in research groups. The Balint Society Journal is published annually thanks to the devoted work of its editor, Philip Hopkins and is alwas full of interesting material. The UK Balint Society also plays an active part in the International Federation and hosted the very enjoyable and successful 11th International Congress in Oxford in 1998.

The survival of Balint work in the country where it all started hangs by a slender thread; but it's a pretty strong thread – maybe made of steel – and it's not going to break easily.

†The material in this paper was first published as a chapter in *Grundlagen der Balintarbeit* (1998) Luban-Plozza, B., Otten, H., Petzold, U. and E. (eds). Germany, Adolf Bonz.

References:

Balint, M. (1957) *The Doctor, his Patient and the Illness*, revised 2nd edn. London, Pitman Paperbacks.

Balint, M. and Norell, J. (eds) (1973) *Six Minutes for the Patient: Interactions in General Practice Consultations.* London, Tavistock.

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993) *The Doctor, the Patient and the Group: Balint Revisited.* London, Routledge.

Hopkins, P. (ed) (1972) *Patient-Centred Medicine.* London, Regional doctor Publications Ltd.

Elder, A. and Samuel, O. (eds) (1987) *'While I'm Here, Doctor.* London, Tavistock.

Main, T. (1978) Some Medical Defences against Involvement with Patients. *Journal of the Balint Society,* 7, 3-11.

Questions which might be relevant to student understanding of ill people

Nigel Oswald
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1. How important is understanding in terms of compassion and effectiveness of doctors?
2. Is understanding a specially crucial quality for primary care doctors?
3. How powerful are single experiences with patients and doctors?
4. How powerful and persistent are the influences of role models?
5. Are they equally powerful when the influence is 'good' or 'bad'?
6. Are strong personal beliefs a help or a hindrance?
7. How are we to take account of cultural identity?
8. What expectations should we have of students' ability to understand? Will it be as variable as students themselves?
9. How mutable are students' attitudes? At what stage do students' attitudes become relatively fixed?
10. If understanding of illness from other people's point of view is important, how should this be addressed and assessed a) at undergraduate level b) at postgraduate level.
11. Does understanding need to be reinforced in CME? If so, how?
12. How important is the emotional reaction patients induced in students?
13. If students like some patients and dislike others, does this affect their ability to understand?
14. If students like some patients and dislike others, is this natural and inevitable or a problem which needs to be addressed?
15. Are we comfortable with our own likes and dislikes among patients, and do they affect our own ability to understand?

Questions posed for discussion by Professor Oswald at the Balint Society meeting on 15 February, 1998.

The Empathic Holding of the Patient's Psychosomatic Anxiety in the Consultation

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Introduction

I am a General Pracitioner who works in a busy training practice and I have an interest in psychosomatic medicine and psychotherapy. In the psychotherapy setting however the fifty minute hour is the norm whereas in the general practice setting is not unusual for me to see fifty patients on a busy day. As a general practitioner therefore with an interest in psychotherapy I face the challenge of how to do psychotherapeutic and humane work whilst working at an inhuman pace.

The Three Influences on My Work

In my struggle to meet this challenge[1-8], I have found inspiration in the work of Michael Balint, Donald Winnicott and the work of affect theorists such as Graeme Taylor and Donald Nathanson, who emphasise the importance of emotional development and affect regulation for understanding psychosomatic problems.[9,10,11]

Michael and Enid Balint were the first to appy a psychodynamic approach to primary care, and it was Michael Balint who asserted that the field of whole person medicine is the province of the general practitioner. His own holistic approach was based on the notion of the "basic fault".[12] It is important to stress that he used the term "basic fault" in a geological sense rather than in the sense of blame. He believed that the early months of a child's life brought about an inevitable mismatch between individual needs and environmental care. This resulted in constitutional vulnerability or "basic fault" in the psyche/soma of the individual: the depth of the fault depended on the content of the mismatch and on individual temperament. The "basic fault" predisposed an individual to problems which could be psychological and/or somatic and which tended to appear at times of stress. Michael Balint (and later Enid Balint) began to lead training groups with general practitioners in the 1950s. This work resulted in the book *The Doctor, his Patient and the Illness*.[13] Gradually, over the years, his ideas evolved and research groups under the guidance of Enid Balint developed the "Balint approach". This was a move away from elaborate assessment and analytic interviews, to study of the here and now relationships with the doctor. The doctor's increased understanding of the relationship with the patient enables him to become more tolerant and more receptive to what the patient is telling him, without necessarily attempting to challenge their defences or make interpretations. The resulting improved relationship with the doctor can lead to a therapeutic change in the patient[14,15].

Donald Winnicott, who was a paediatrician for many years before he became a psychoanalyst, studied the interaction between mother and baby and wrote in detail what the ordinary devoted mother does naturally in order to prevent the mismatch between the needs of her baby and the caretaking environment. He also found an analogy between the activities of the ordinary good enough mother who provides a facilitating environment for the development of her baby's maturational processes, and the activities of the good enough doctor who provides a supportive environment for the unfolding of the patient's innate tendency for integration and self healing. I found his concept of holding particularly relevant for my work.[16,17]

Winnicott used the concept of **holding** to describe what is essential for infant care. At the beginning of life, the term holding refers not only to the actual physical holding of the baby's body but also to the qualities of **concern, reliability and adaptation to the baby's needs** that the good enough mother can offer when she is preoccupied with the baby's care. At this early stage he thought that it is necessary to think of the baby as an immature being who is all the time on the brink of unthinkable anxiety. **Unthinkable anxiety** is kept away by this vitally important function of the mother. That is: **her ability to put herself in the baby's place** and to know what the baby needs in the general management of the body and therefore of the person. Love at this stage can only be shown in terms of body care. Unthinkable anxiety, according to Winnicott, has only a few varieties: **Going to pieces, falling for ever, having no relationship to the body, have no orientation.** At later stages of development he expanded the meaning of the term to include a **metaphorical sense of holding that is conveyed within a relationship with a therapist when the therapist by using the right words gives the patient the feeling that his deepest anxieties are understood.** A correct and well timed interpretation in an analytic treatment gives a sense of being held physically that is more real than if a physical holding or nursing had taken place. Understanding goes deeper and by understanding shown by the use of language the analyst holds physically in the past, that is at the time of need to be held, when love meant physical care and adaptation[18].

So holding has a dual meaning. It refers both to the care of the body and to the qualities of concern, reliability and adaptation to need which are intimately related to the ability to put ourselves in our patient's shoes, understand empathically their anxieties and find the right words to name them.

One of my favourite papers is Winnicott's "Hate in the countertransference"[19]. In it he makes the statement **"that as an analyst he has ways of expressing hate. Hate is expressed by**

the existence of the end of the hour"! I often wondered what the implications are for the general practice setting, where there exist from six to twelve endings in one hour and where I feel that every ending involves the assertive affirmation of the doctor's boundaries. This affirmation can do some violence, at least to the patient's unrealistic expectation that the doctor will give him the unlimited amount of time that he needs, or to the hope that the doctor will do some magic to rid him of his symptoms.

Also in the same paper he states that the psychoanalyst who wishes to analyse psychotic patients in order to understand the emotional burden of treating them, must have his own hatred extremely well sorted out and conscious.

Mastery of anger is essential in general practice too. The general practitioner needs to harness his aggression in the service of assertively and politely protecting his boundaries and ending the consultation on time. **The psychosomatic approach however, and by that I mean understanding the emotional context within which physical symptoms arise,** requires mastery not only of anger but of all emotions. Recently the construct of emotional intelligence has identifed the emotional skills that are implied in the term emotional mastery[20]. These are: being able to recognise one's feelings, being able to distinguish between them, being able to regulate one's mood, being able to resist the impulse to express an emotion in action, being able to keep emotional arousal from swamping the capacity to think, being able to hope, being able to motivate oneself, being able to understand other people's feelings, being able to persist in the face of frustration and being able to give credit to oneself. Among these skills, the capacity to distinguish between different competing emotional states and between our own mood and our emotional response to the patient's feelings, is another factor that helps to protect our boundaries by distinguishing where we end and where the patient begins and avoiding the confusion of boundaries created by the emotional contagion of the patient's feelings. The safeguarding of our boundaries is particularly important because the combination of time pressure, social need and the fact that a considerable minority of our patients do not speak English sometimes makes me feel that our surgery is an outpost of *Médecins sans Frontières.*

It is from the work of affect theorists that I have learnt the significance of affect mastery or lack of it, for understanding psychosomatic problems and for developing a psychosomatic approach that is appropriate to the general practice setting.

A modern understanding of emotions

I find the scentific language of emotion science very helpful in understanding the patient's anxieties and the emotions they arouse in me. Although emotion science is riddled with controversy, there is consensus among affect theory and contemporary psychoanalysis in considering affects as primary motivating factors and the basic system for assessing and communicating the state of the self at any moment in time. Silvan Tomkins, the founder of affect theory, pursuing Darwin's theoretical framework[21] identified nine basic 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 imporant to the concept of innate emotion, Tomkins gave tham all paired names to indicate the range over which each emotion might be expressed. He identified six negative emotions: Fear-Terror, Anger-Rage, Distress-Anguish, Shame-Humiliation, Disgust-Revulsion, Dismissal-Shunning; two positive emotions: Enjoyment-Joy, Interest-Excitement; and one neutral: Surprise-Startle.[22,23,24,25] Each affect consists of three responses that carry the totality of its informational contents: 1. A neuroendocrine or physiological response which uses the chemical language of hormones and neurotransmitters to communicate with other parts of the organism. 2. A behaviour response that relates to the impulse to express an emotion in action and is communicated through body language. 3. A cognitive response which is communicated through verbal language and refers to the meaning of an emotion and the story behind it. In other words emotions are psychosomatic. Trying to understand the common experience of not always being aware that one is having an emotion when in the grip of an affect, emotion theorists have described an epigenetic model of emotional development. So Lane and Schwartz proposed that emotional awareness is the consequence of cognitive processing of physiological emotional arousal during development which in turn determines the structure of subsequent emotional experience. They described five levels of emotional awareness[27] 1. Awareness of bodily sensations only. At this level the awareness of the separate existence of the other is minimal or non existent. 2. Awareness of bodily sensations and action tendencies. 3. Awareness of individual feelings. 4. Awareness of blends of feelings. 5. Awareness of blends of blends of feelings. At this level the major advance if the development of empathy.

Henry Krystal, an American psychoanalyst who has made attention to emotional development a central theme in his treatment of patients with severe psychosomatic disorders such as drug addicts and victims of Nazi concentration camps, has pointed out that a development view of emotions contributes significantly to our understanding of psychosomatic illnesses and to finding appropriate ways of treating them.[28] He postulated that all emotions attain their mature form after a lifelong development from affect precursors. The new born baby experiences emotions as internal tensions which are perceived as diffuse excitement on an undifferentiated sensorimotor level. This very quickly becomes differentiated into two general types of affect precursors. A

state of contentment and of generalised distress. Out of the patterns of contentment and tranquility develop the positive affects and out of the agitated state of distress evolve the negative emotions. The somatic component of these primitive emotions is very strong and affects are experienced as physical sensations. At birth the affective display of the newborn is the only mode of non verbal communication with his mother and affects are essentially signals for another person. As emotions mature they can become signals for ourselves. The idea of affects as signals conveying information is central to the idea of self regulation, but initially the baby relies on the mother's tender holding and sensitive handling of his body for regulation of his emotional arousal. According to Krystal emotions mature along two developmental lines and in the process their somatic components become less intense. These are: Affect differentiation and Affect verbalisation with concomitant desomatisation. These affective developments take place within the facilitating environment provided by what Winnicott called "a good enough mother" and are made possible by the parent's empathic holding, which helps the child identify and name correctly his emotional states.

The development of language and symbolisation is the fundamental event in the development of cognitive and symbolic elaboration of emotional arousal. As verbal skills and symbolisation develop, the precision and effectiveness of words demonstrate language to be the preferred way of handling affects. As the affects mature and differentiate it becomes clear that the cognitive aspect of an emotion has a meaning and a story. The more precise the recognition of one's feelings the greater their utility as signals to oneself, carrying information about one's relationship to oneself and to others, and the more likely they are to contribute to the powers of self monitoring and self regulation. It is the mature, adult, well regulated type of feelings that are best suited for signal functions. Such feelings are minimal in the intensity of their physiological components, are appropriate to the circumstances in which they arise and for the most part they are cognitive, or idea-like.

Therapeutic Implications

In my effort to develop a psychosomatic approach which will be appropriate to the constraints of the general practice setting I have been inspired by the work of Henry Krystal, who has devised several modifications of technique for making psychoanalytic psychotherapy more helpful to patients who find it difficult to process cognitively their emotions and therefore are not aware of their feelings. He objected to the term emotional discharge because it implies riddance or evacuation. And indeed many patients come to the general practitioner demanding help with getting rid of an unpleasant sensation that may be part of an emotional state. Once we renounce the idea that we can help anybody get rid of their emotions we are glad to find out that we can be helpful in other ways, such as helping patients to tolerate and manage their emotions better; helping them to identify, name and differentiate their emotions and to obtain maximum information from them. Patients need to be acquainted with their emotions as signals, often unpleasant but manageable and essentially self limiting. In other words, to treat emotions as a valuable part of ourselves, as signals conveying information about our relationship to ourselves and to others. This therapeutic activity is comparable to a mother's task of helping her young child to identify, differentiate and verbalise feelings. It has been called emotion coaching by John Gottman and I think it is an essential part of the empathic holding of the patient[29]. This is a tedious and slow process but the patient will begin to know his own feelings only as he learns to express them verbally. Gradually he may come to use his feelings as an additional and valuable source of information about his daily experiences. George Vaillant in his book *The Wisdom of the Ego*, posed the question, how do we learn to master powerful affects? How do we adults learn to say and to appreciate not that we are "tired", or "upset" or "feeling anyhow", but that we are angry or sad or embarrassed or humiliated? He concludes that often we learn to do so only by having another person who can hold us emphatically and help us to bear and identify our pain[30].

Robert

This 42 year old mature, final year medical student came to see me one day with a five minute appointment and complained that for three months he had been feeling tired, very tired. His symptoms felt like the flu but without the aches and pains. His concentration had become poor and his stamina had been reduced and all this was affecting his ability to study. Usually he is athletic and likes going jogging and playing badminton, but recently he had felt too weak to do any of these activities. His sleep was good, his weight steady and his bowels regular.

I asked him whether his symptoms worried him and he said he was afraid that he might be anaemic. I told him that this was easy to check and I ordered a battery of tests including full blood count, ESR, thyroid function tests, urea and electrolytes and liver function tests. I asked him to come back in two weeks with a half hour appointment to discuss the results.

When we met again, I gave him the good news that all the tests were normal. He was rather disappointed that he was not anaemic and he asked me whether he could have a look at his test results to check for himself. I showed him the results and he looked at them in silence for a few moments. He said that he felt weak as if he was lacking in something and if he was anaemic he could have taken some iron to make good the deficit. He was puzzled by the normality of his tests and could not think of an explanation for his symptoms. I wondered whether his symptoms

might have something to do with being a mature medical student and I asked him to tell me something about his circumstances. He told me that he was married to a dental student who was also in her final year doing her finals and they have a two year old baby boy. In order to give themselves some uninterrupted time to study they take turns looking after the little boy so that one of them can concentrate entirely on studying. However the little boy seemed to always seek the attention of the parent who was not available to him and kept interrupting his studying. I asked how he felt about it and he said that he felt frustrated. I asked him how he handled his frustration and he said that he usually went jogging, but recently he did not have the energy to jog any more.

Also in order to make some more time to study over the weekend he asks some relatives who live in London to look after his son for a few hours during the day but obviously when this arrangement does not fit the schedule of his relatives they let him down. If his parents were in London they would have been of much more substantial help. He also has a big debt because he had to sell his house at £30,000 negative equity and the bank is breathing down his neck.

Sometimes he has doubts whether he made the right decision to go into medicine. He is afraid that the way he feels now may stop him from passing his exams and he may find himself in a difficult situation.

I pointed out to him that it sounds as though he is deficient in positive emotions at present. Unlike joy or interest, which are activating emotions giving us the feeling of having a lot of energy, doubt and fear are deactivating emotions. They can make us feel drained and weak. I wondered therefore whether experiencing these emotions could be an explanation for his tiredness. Also I acknowledged that being a medical student is very demanding even when someone is young and with no commitments. In his position he has to make a greater effort in order to succeed.

He looked at me surprised and was interested to hear my point of view.

"What can I do about it"? he asked.

The first step is diagnosis; I replied. Identifying and naming the emotions you experience is important in order to understand what is going on, so that you can make the necessary adjustments and changes. You have come that far and I am sure that you can complete your studies.

His eyes lit up and thanked me for this new perspective of his problem. He asked me to pray for him and I asked him to come and see me again if his symptoms did not improve.

Bernadette

Bernadette was a 63 year old woman who had been registered with our practice for at least ten years. She was a known asthmatic and a heavy smoker who used to come to the surgery with a short five minute appointment every two weeks for repeat prescription of her diazepam medication on which she was dependent. She used to wear a woolly hat and large, dark, ski sun glasses that hid her eyes and in which I used to see a distorted reflection of myself. She used to come to the surgery with her dog, her only companion, which she used to leave tied outside the waiting room. She was always complaining of various physical symptoms and over the years I had become used to her style of presenting many physical symptoms using dramatic verbal language in a totally unemotional vocal tone and body language. It was not unusual for her to start the consultation by saying that she was dying because of a nasty cough, a terrible back pain, gasping for breath etc. She had had various investigations over the years which had always been normal and usually she was content to leave the consultation with her repeat prescription.

One day, four weeks before Christmas, she came for her usual prescription and, by the way, she also complained that for the last week she had had a headache and double vision when she looked to the right. I could find no abnormality on a quick examination and thought no more of it.

A week later however she came back as always with a five minute appointment and told me that she had spoken to the Co-op general practitioner about her symptoms and had been told that she needed a brain scan!

I felt annoyed for the embarrassment I experienced at the implication that I was missing a serious medical conditon and I asked her to describe her headache. She said that she felt red hot searing pain on the right side of her skull which made her feel sick and shaky and woke her up at night. It was relieved only when she pressed that side of the head.

My facial expression was probably displaying some disbelief because she looked at me reproachfully and said: "My headache is not psychosomatic you know".

"So what is your fear then"? I asked.

"My fear is cancer in the head and lungs".

"Why cancer"? I asked. "Has any of your friends or relatives died of cancer"?

She said that a friend of hers, Mary, had a cancerous growth in the head, which was dissolved initially, but then it was found that she had inoperable cancer of the lung. She died four weeks before Christmas seven years ago. She was her closest friend. They used to go on holidays together twice a year. Mary's husband, Jonathan, died of myocardial infarction a week previously, and Mary's daughter-in-law developed a lump on her shoulder and it was found that she had leukaemia. She died three days before Jonathan.

"Gosh! Who is going to be next"? I exclaimed with a sense of shock.

"I think it is going to be me"! She said in a dead pan way.

I asked whether she had been able to cry for these losses but she admitted that she had

difficulty crying. She shed all her tears when her brother died of hepatitis B seven years ago.

I had spent more than five minutes with her and was painfully aware of the complexity of the case. On the one hand I was aware of the theme of grief and identification with her dead friends which had become very strong as a result of the complex confluence of events; the anniversary of the death of her best friend compounded by the recent death of her relatives. On the other, I was aware of this woman's difficulty in expressing her grief in tears and I knew that grief that has no vent in tears makes other organs weep. Also I was aware that there was a strong possibility that she might have metastatic cancer of the lung.

As I could not refer her for a brain scan I thought that the quickest way of checking the possibility of cancer, would be to send her for a chest X-ray, I was hoping that the result would be normal but to my dismay the X-ray showed a shadow in the right upper zone which could represent a malignancy.

As soon as I had the result I rang her up to inform her that the X-ray showed something abnormal, which could be caused by a chest infection and for which she must take an antibiotic. I also told her that I was making an appointment for her with the chest specialist just in case the chest X-ray did not clear with the antibiotics.

When she came back to see me five days later she said that the headache had eased and her chest felt clearer and she asked me whether the chest X-ray showed cancer. I had to explain to her that X-rays showed only shadows and it is not possible to know for sure without further tests. She said that she wanted to know whether she had cancer before Christmas. "If I am going to die" she said, "I will spend all my money, go on a nice holiday and if I see a young man I fancy, I will pay him. Then I will come back and die disgracefully complaining and moaning every inch of the way. I am only 63; I have not lived yet". "No"; she contradicted herself and felt confused. "I have lived. I have done everything I could have hoped to, including getting married three times". She saw the specialist a week later. The headache was as bad as ever and as the shadow had not cleared, he arranged a lung and brain scan and he gave her an appointment for Christmas Eve in order to discuss with her the results of the tests. Four days before the appointment at the chest clinic she phoned me at the surgery to complain that she could not move the right eye outwardly and when she tried to look to her right she saw eight of everything. I noticed her exaggeration and I asked her to come to the surgery where I examined her briefly and I confirmed a sixth nerve palsy on the right. She continued to complain of headache and the next day she rang me at work tos ay that she could not face going to see the specialist. Could I please phone him and find out the results and then inform her what they were. I asked her what her fear was and she said that she was afraid that if he told her that she had cancer she would break down and cry uncontrollably.

I rang the consulant and discussed the results and it turned out that the diagnosis was still far from obvious. Histological examination was essential for the diagnosis and planning of treatment and the only way to obtain the tissue was to ask the thoracic surgeon to remove the lesion in its entirety because a percutaneous biopsy would be hazardous. I explained all this to Bernadette over the phone and said that because it was essential for her to meet the consultant, I would come along as well. **"As long as you are there to catch me when I fall"** she said.

On Christmas Eve, we met at the chest clinic and saw the consultant together. The CT brain scan wsa normal and so we had no explanation for the 6th nerve palsy as yet. She was so relieved to hear that she was not dying of cancer and that even if she had cancer she could still be cured, that she felt keen to get on with her last minute Christmas shopping.

When she came to see me in the new year, without an appointment and one week before her appointment with the neurologist, she was still complaining of a headache. I reminded her that the reason she did not want to go to the appointment with the chest specialist was her fear that she might cry. It was as if she was more afraid of crying that dying. I asked how she would feel if she cried in front of the specialist and she said that she would feel terrible. I wondered whether she meant embarrassed and she thought that the word was an accurate description of her emotional state. I said that it was as though she was afraid she might die of embarrassment. She laughed in recognition of her mortification. I asked her then why she was so embarrassed about crying. She told me that she remembered switching off her emotions when she was in her early teens and her parents kept quarrelling between them and using her as go-between. She felt that neither of them was at all interested in the way she felt and even if she did show emotion neither of them would take any notice.

She came again for the second time in a week complaining of vomiting and falling about in her flat because she could not see properly on her right side. She had began to find it difficult to look after her dog. She found her disability so distressing that she had cried the night before. I asked her whether she felt any better after crying but she had not. It sounded more and more as though the sixth nerve palsy was a false localising symptom due to raised intracranial pressure even though the brain CT scan was normal. After discussion of her case with the neurology registrar I started her on dexamethasone 1 mg four times daily. Two days later she came back to see me a few hours before her appointment with the neurologist and told me that she could not take the tablets for two reasons. First they made her very sleepy and second because of her vomiting. She had began to get dehydrated and

exhausted. I gave her a letter to give to the consultant in which I expressed my concern and asked him whether we should be considering admission in order to bring her symptoms under control.

She was admitted to hospital but unfortunately her physical condition continued to deteriorate as more cranial nerves became involved and a diagnosis of malignant infiltration of the meninges from a small cell carcinoma of the lung was finally established. She died in hospital within three months from the onset of her symptoms.

Discussion

Patients usually visit their GP when they are worried about their symptoms or when they need him in his administrative role. In some cases, particularly when time is limited and the cause of the symptoms is far from obvious, inviting the patient to tell us what he is afraid may be wrong with him can provide a unique opportunity to learn what the patient's anxieties are that brought him to the surgery, so that we can concentrate our efforts in exploring the concerns of the patient.

Encouraging the patient to use verbal language to name and identify his emotions could help him recognise that some physical symptoms may represent the body language of these emotions and this can have a soothing effect because as a rule nameless fears and the fear of the unknown are far greater than the fear you can name.

Also, because verbal language encourages thinking, it could lead to finding a constructive way to explore and understand the fear that may be reassuring to the patient. Creating this opportunity for the patient to identify, name and talk about his feelings in an accurate and precise way is part of the experience that Winnicott has called holding. The two patients I have presented represent the opposite poles of the spectrum of holding. The consultation with Robert could have ended with my giving him the normal results and leaving him alone in his incomprehension. He could have come back then, to me or another doctor, with the same or different symptoms, demanding more and more investigations in order to find a medical explanation for them. I decided however to invite him back for a longer consultation in order to explore the emotional setting in which the symptoms arouse because I wanted to make a positive diagnosis for his state of tiredness and was keen to practice the kind of medicine that takes into account the totality of human nature and does not limit itself to nosology. Unfortunately we cannot always reassure our patients. Sometimes their worse fears come true and they develop serious disease. In that case the emotional context within which the physical symptoms arise is complicated by the emotional response to the disease. In Bernadette's case for example the fact that the clinical findings suggested the possibility of metastatic carcinoma of the lung, did not deny the possibility that some of her symptoms could be contributed to by the physiological component of emotions activated by the deaths of her loved ones. In real life we can very rarely if ever separate the physical from the psychological. Although Bernadette talked about the loss of her friends and the fear of her own death in a dead pan way, I often wondered whether her severe headache that drove her to come to the surgery frequently, although probably caused by metastatic cancer, was also a way of expressing her distress. She was a lonely person living in a foreign country who was grieving for the loss of her friends and afraid that she too, may die soon. Putting myself in her shoes and imagining how I would feel in her place prompted me to move, like every doctor does when confronted with a patient who has severe physical disease, to a position of one who responds to need with concern, reliability and adaptation. I had to adapt my routine way of working and accommodate to her urgent need to consult me without an appointment about her intractable symptoms almost every day and go with her to meet the chest specialist in order to ensure that she would participate in the management plan rather than withdraw in fear. With her comment "as long as you are there to catch me when I fall" she acknowledged my holding function and gave an indication that one of her "unthinkable anxieties", the fear of falling, was related to the mortification of losing control of her body and her emotions and crying helplessly in front of a stranger. Although she had never cried in front of me she had said that she would not be embarrassed to do so. With her physical condition deteriorating however, there came a time when the holding I could offer in the general practice setting was not enough to meet her needs and she needed the physical treatment and nursing of inpatient hospital care.

Conclusion

The general practitioner during the consultation has to manage at least four variables. The presenting symptoms, the patient's feelings, his own feelings and time. The doctor who is capable of adequate reflective self awareness and sensitive self observation is in a good position to use his emotional response to his patients as information about his own sensitivities and about the patient's conscious or unconcious motives in trying to promote certain reactions within him. This capacity can help the doctor to preserve his boundaries and may facilitate the management of the limited time in the consultation. In a few selected cases, however, becoming interested in the patient's feelings can give the patient the experience of having someone who values him and respects him as a unique individual. This experience amounts to emotional support of a special kind which has been called "holding" by Winnicott. It can give the patient the feeling that he is not alone in his suffering and that there is someone who will catch him and stop his fall. This can be a healing experience.

Bibliography:

1. Zalidis,S.(1991) Psychosomatic encounters and the scope for interpretation in general practice. *Journal of the Balint Society,* 19, 16-22.
2. Zalidis,S.(1992) Holding in general practice. *Journal of the Balint Society,* 20, 4-7.
3. Zalidis,S.(1994) Handling hyperventilation in general practice. *Journal of the Balint Society,* 22, 8-21.
4. Zalidis,S.(1994) The value of emotional awareness. *The imaginative body. Psychodynamic therapy in health care.* Erskine, A. Judd, D. Eds. Whurr Publication London.
5. Zalidis,S.(1996) The human face of general practice. *Journal of the Balint Society,* 24, 25-32.
6. Zalidis,S.(1997) So if there is nothing wrong with me, why does it still hurt? *Journal of the Balint Society,* 25, 7-14.
7. Zalidis,S.(1998) If your eye offends three pluck it out. Some thoughts on the relationship between eye pain and emotion. *Psychoanalytic Psychotherapy.* Vol.12, No. 2 131-140.
8. Zalidis, S.(1998) The emotional context preceeding the eruption of herpes zoster: Research in progress. *Journal of the Balint Society,* 26, 43-57.
9. Taylor, J,G.(1987) *Psychosomatic medicine and contemporary psychoanalysis.* International Universities Press. Madison, Connecticut.
10. Taylor, J,G. Bagby, M,P. Parker, J,D,A.(1997) *Disorders of affect regulation. Alexithymia in medical and psychiatric illness.* Cambridge University Press.
11. Nathanson,D.(1995) *Shame and pride. Affect, sex and the birth of the self.* Norton and Company. New York, London.
12. Balint, M.(1968) *The basic fault.* London: Tavistock Publications.
13. Balint, M.(1957) *The doctor his patient and the illness.* London: Pitman Medical.
14. Balint, E. and Norell, J,S.(Eds)(1973). *Six minutes for the patient. Interactions in general practice consultations.* London: Tavistock Publications.
15. Elder, A. and Samuel, O.(Eds)(1987) *While I'm here doctor. A study of the doctor patient relationship.* London: Tavistock Publications.
16. Winnicott,D,W.(1975) *Through paediatrics to psychoanalysis.* The Hogarth Press. London.
17. Winnicott, D,W.(1972) *The maturational processes and the facilitating environment.* The Hogarth Press. London.
18. Winnicott,D,W.(1988) *Human nature.* Free Association Books. London.
19. Winnicott, D,W.(1947) Hate in the countertransference. In: *Through Paediatrics to psychoanalysis.* The Hogarth Press (1975). London.
20. Goleman,D.(1995) *Emotional intelligence. Why it can matter more than IQ.* Bantham books. New York, Toronto, London, Sydney, Auckland.
21. Darwin,C.(1872) *The expression of emotions in man and animals.* Chicago: University of Chicago Press. 1965.
22. Tomkins,S,S.(1962) *Affect imagery and consciousness.* Vol.1. The positive affects. Springer Publishing Comp. Inc. New York.
23. Tomkins,S,S.(1963) *Affect imagery and consciousness.* Vol.2. The negative affects. Springer Publishing Comp. New York.
24. Tomkins,S,S.(1991) *Affect imagery and consciousness.* Vol.3. The negative affects. Anger and fear. Springer Publishing Comp. New York.
25. Tomkins,S,S.(1992) *Affect imagery and consciousness.* Vol.4. Cognition. Springer Publishing Comp. Inc. New York.
26. Sternberg,M,E. and Gold,W,P.(1997). *The mind body interaction in disease. Scientific American.* Mysteries of the mind. Special issue pp 8-15.
27. Lane,R,D. and Schwartz,G,E.(1987) Levels of emotional awareness. A cognitive developmental theory and its appliation to psychopathology. *American Journal of Psychiatry.* 144, 133-143.
28. Krystal, H.(1988) *Integration and self healing. Affect, trauma, alexithymia.* Hillsdale N J. The analytic press.
29. Gottman,J.(1997) *The heart of parenting. How to raise an emotionally intelligent child. Bloomsbury.* London.
30. Vallant,E,G.(1993) *The wisdom of the Ego.* Harvard University Press. Cambridge, Massachusetts, London, England.

"Empathy-based Medicine"

by Don Bryant, Psychotherapist

Joint prizewinner of the 1999 Balint Society Essay Competition

The best medicine is a mixture. By this, I don't mean something you take, like cough mixture, There's more to Medicine than medicines[26]. By Medicine, I mean the practice – part art, part science – of relating to people who are unwell, or concerned with their health, by applying a series of processes – like diagnosis, prescription, treatment, monitoring, prevention – that enables them to get better or stay well.

Medicine, in this sense, is basically about a relationship between two parties – the practitioner and the patient: often, however, other parties – like specialists[1] and relatives[26] – get into the act and they can affect the relationship.

It is the prevalence of this practitioner-patient relationship – and the complications likely to arise from the involvement of these other parties – that militates against one intensive, overall 'disease-orientated' approach. Instead a mixed strategy, basically 'patient-orientated' is proposed. The best medicine, it will be argued, is a mixture of several bases of approach, at least three or four, probably more. Three main bases of approach are considered here:

- Evidence (or evidence-based medicine)
- Experience (or experience-based medicine)
- Empathy (or empathy-based medicine)

These three bases of approach to patient-orientated medicine are not mutually exclusive. They may overlap to some extent. It is not being suggested that they are required in exactly, or even roughly, equal proportions in every case. To be effective all three will be required in substantial measure in any practitioner-patient relationship, the optimum properties of each varying with the particular situation. In addition to empathy-, evidence-, and experience-based medicine, there will almost certainly be other types of approach which may be appropriate in certain cases. (What form these other types might take is speculative and will not be considered here. John Balint[28] has reviewed five current models of the patient-physician relationship and has proposed a possible new model.) This essay will focus on the threefold mixture of approaches to the practitioner-patient relationship with the main emphasis being on empathy-based medicine. Before we look in detail at the contribution of empathy, however, we need to look briefly at the roles of evidence and experience.

The importance of evidence in medicine is predicated on its reputation for being knowledge-based and founded on scientific principles. While acknowledging the power of the scientific method and the value of evidence in medicine, however, Illich[3] warns of the dangers of scientism and of promoting the interests of science at the expense of the patient. Nowhere is the need to heed the value of evidence-based medicine so vividly illustrated as in the prescription of drugs. Prescription provides a dubious rationale to the notion that "progress consists of buying one's way out of everything, including reality itself"[3]. Balint[2] points out that two thirds of the drugs that were repeatedly prescribed without any technical justification were offered on the physician's own initiative.

Science has been defined as "disciplined scepticism" and conventionally insisting on generalising, whereas Balint also leans on anecdotal evidence[26]. An example of evidence-based medicine is Balint's attempt to establish proper criteria for judging success in handling patients: conventional evidence such as "freedom from symptoms" or "no further attendance" is not enough (since these be may signs of a flight into health); neither is a pleasant relationship between practitioner and patient (which is not the same as empathy) which might well hide the presence of awful relationships in the world outside. All these criteria would need to be combined.

The importance of experience-based medicine is well-illustrated by Balint[25]. Experienced General Practitioners have had the time to assess the value and limitations of what they have learnt at medical school and hospital, as well as experiencing both the frustrations and successes of general practice and seeing enough of human suffering to make them sensitive. (In this respect they are much better material for psychotherapy training than young medical students). Psychotherapy – of which empathy is a key component – is a new skill for the GP, who must use his own current experience as a basis for learning this new skill. Past experiences are not enough.

The salience of experience in psychotherapy training for General Practitioners is borne out in Gosling's account[5] of Balint group work[4]. The language of how people treat one another was more akin to that of object relations theory than that of Freud. Some of the catch-phrases that became current were later elaborated in Balint's book[1]: the drug "doctor" (i.e. the doctor himself as the pro-active prescription); the collusion of anonymity (between GP and specialist); the apostolic function of the GP; having the courage of one's own stupidity. Three powerful aspects of Balint's model of experience-based medicine stand out: Michael Balint himself as a model of the practitioner who listens; his firm adherence to task boundaries; his encouragement to those GPs who wanted to go further into the realms of professional psychotherapy (although later he realised that here was another boundary that needed closer monitoring). His signal contributions were to communicate a conviction that the unconscious is at work in all of us – practitioners

as well as patients – and to encourage patients to think more deeply about their own predicaments. This latter idea, which contrasts with the usual situation in which patients expose themselves to be examined by the practitioner, stems from Balint's recognition of the centrality of the therapeutic alliance between patient practitioner. The dynamics of this relationship are further explored by Casement[7] - learning to recognise how patients offer cues to the therapeutic experience for which they are unconsciously searching. (A further development is the concept of "Patient as Doctor", as wel as that of "Doctor as Patient", of which there are hints later in the case study.)

Learning from experience was a key feature in Balint's repertoire that applied no less to himself than to his students and patients. In the course of his group work with GPs for example, he learned the lesson, that it was only the reliance on their own professional experience and judgement as to what was useful or not in working with their own patients that would save the GPs from some inappropriately fanciful flirtations with psychoanalysis. Less vivid than the dangers of 'wild analysis' was a transient loss of some of the GP's older, well-tried responses to their patients' needs. Again, the value of the GP's everyday experience and professional judgement needed to be keep in balance with his other newly-learned skills.

The need for balance between experience and new skills is neatly described by Winnicott[10] in contrasting the responses of different types of doctor to a child upset at the arrival of a new baby. A doctor who doesn't understand the process underlying a child's unwellness will think out a diagnosis and treat the illness as determined by physical causes. A doctor who knows a little psychology will guess the underlying cause and take active measures like advising the parents not to make a difference how they treat the child after the baby's arrival. A doctor who understands even more psychology will merely hold a watching brief, and do nothing at all beyond being a friend. However, the doctor who has experience as well as psychology behind him will also be on the lookout for evidence of physical disease co-existing with 'normal unwellness' arising from emotional upset.

While there is not much explicitly about evidence-based or experience-based medicine as such, the literature abounds with explicit references to empathy[7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22]. There are also many implicit references to empathy, notably in the works of Balint[1, 2, 6, 23, 25] and his supporters[4,5] and, more obliquely, in Winnicott[10].

Despite this long list of references to empathy in the literature, there is still confusion as to what it is. Being empathic is not the same as being sympathetic. Sympathy has more in common with pity, compassion, and condolence, all fully human traits, but not particularly appropriate in medicine. Sympathy, along with kindness and approval, can lead the practitioner into behaving compliantly in response to the patient's behaviour and getting bogged down in identifying and colluding with the patient's experience.

Perhaps the two leading proponents of empathy in the helping process are Egan[11] and Rogers[14, 15]. Egan distinguishes between empathy as a *way of being* and empathy as *a way of communicating.* As a way of being, empathy is a mode of human contact. A helper cannot communicate an understanding of another's world without getting into contact with that world.

Huxley[16] notes that it is metaphysically impossible to get inside another so as to experience the other's reality: "...sensations, feelings, insights, fancies – all these are private and, except through symbols and at second hand, incommunicable." Yet he believes empathy to be both possible and necessary: "...To see ourselves as others see us is a most salutary gift. Hardly less important is the capacity to see others as they are themselves." Huxley then describes empathy as an attempt to penetrate the "metaphysical aloneness of the other".

Empathy can be seen as an essential part of caring; not a sentimental value but tough and action-orientated. I remember vividly being told by my tutors, while working on the oncology ward of a major teaching hospital, how, in learning how to care, one also had to learn how not to care. Later on, in my psychotherapy training, I was to come to grips with that bit of myself, as in all carers, that experiences hatred in the counter-transference with our patients, especially those that are most needy and demanding of our care.

Rogers[14] talks about basic empathetic listening – being with and understanding – as "an unappreciated way of being", because even so-called experts either ignore it or are not skilled in its use. Empathetic listening means entering the private world of the other and being at home in it. It involves being sensitive to the fear, rage, blindness or confusion in the other. It means, temporarily, living in the other's life, moving about in it delicately without making judgements.

Empathy itself is seen by Rogers[15] as a potent healing agent, releasing, confirming bringing even the most frightened into the human world. "If a person is understood, he or she belongs."

The very labels we learn in our training can militate against empathetic understanding[10]. Kleinman[17] distinguishes illness from disease. Illness consists of the patient's subjective experience of their distress and concerns the ways they talk about them. Disease, however, is the product of theorists and practitioners, a re-working of the patient's experience into the language and terms of the profession. The tendency is to strip away the "illness" to find the "disease". The disease is understood, the patient is not.

I shall now give an illustration from case material of the different styles of empathy - and

the lack of it - as experienced from a patient's perspective. But first a note on the methodology of presentation may be in order. The usual convention is for one practitioner to present one or more case studies related to one patient (sometimes to several patients). Balint's point of departure in his seminal work[1] was to present case studies of several patients, as noted by several doctors, and to comment on differences, not so much between the content of the cases themselves as between the styles of the different doctors (In his chapter 2 in particular, Balint draws attention to the differences between the notes of two doctors regarding the same patient. He also compares and contrasts four case studies where each of the doctor/patient pairs was different, noting however that each doctor acted and behaved as objectively as possible and in accordance with the rules of Medical Science).

Case Study:
In this case study I shall present part of the case history of just one patient but drawing on her own notes and reflections on her interactions and experiences with many doctors, specialists, helpers and carers.

The Patient: Muriel, now in her early seventies.
This patient was referred to me by a pastoral counsellor from Muriel's local church. She was divorced, with two grown-up children of whom she has seen very little since their early childhood. Her presenting problems were to do with difficulties in sleeping and holding down food. She reported having come from a long line of doctors, GPs, specialists over many years.

Early background
Muriel was an only child, from a middle-class background. Her family had been in a light manufacturing business of a traditional, household-name product, for several generations. She was sent at an early age as a day-pupil to a "good girls' public school". She saw little of either parent: her father she recalls as remote and preoccupied - "always too busy to be bothered with me"; her mother she remembers only dimly if at all.
At age 7, she went to hospital for an emergency eye operation and was afterwards told she nearly lost her life. She was not visited by her parents while in hospital. In fact, by a tragic coincidence, it was her mother who died suddenly while Muriel was in hospital. Only when she returned home after several weeks' convalescence was she told that her mother had died and it was never explained to her how she had died. She soon found that another woman, Eva, her former Sunday School teacher had been installed in the family home. Her father soon after married Eva and tried to encourage Muriel to call her 'Mummy'. Muriel recalls this episode as something "she could not stomach". She was then sent away to boarding school at which she was relatively happy, but always upset when she had to go home during the school holidays.
She joined the WRNS during the war to get away from home, and took up nursing after the war, qualifying as an SRN and working in a major London teaching hospital. She got married in her mid-20's to Fred, a physical training instructor in the army, by whom she had two children, Angus and Daphne, following a couple of miscarriages and a stillbirth. Muriel enjoyed married life, having children, and making a home, although she claims she was "inexperienced in the physical side" and quite naive about life, despite being in the navy and her nursing training and experience.

Pre-recent history
In 1959, Fred began to work later and later, to stay away overnight and some weekends, and to become irritable, going for weeks without saying much except to grumble if his meals weren't ready when he wanted them. (Eventually he left home to go and live with another woman).

Late 1959:	Muriel goes to see her GP.
Dr Vanhelm (GP):	What is your problem?
Muriel (Patient):	Doctor, I can't keep any food down.
Dr. V:	Better get you to a hospital for a consultation.
Later that week at Mosswick District Hospital	
Dr Ergot (Consultant):	Better do a lumbar puncture.
Result:	No abnormality detected.
Dr E:	You'd better stay in hospital for observation.
Several weeks later:	
Dr E:	You are eating better in hospital, you should go home now.
One week later, back to GP.	
Dr V:	What seems to be the trouble now?
Muriel:	I was eating while in hospital, but at home I reverted to the previous pattern - not keeping food down, everything makes me sick.
Dr V:	So what's the difference between home and hospital?
Muriel:	At home, my marriage is going wrong, but no one asked me about that!
Dr V:	Perhaps you'd better see another consultant.

Muriel (thinks): [I think I may have embarrassed him - I shouldn't have mentioned my home life. He's a doctor, a man of science, good on broken legs, but he doesn't want to be bothered with my tales of woe.]

1960: at Mosswick District Hospital again

Dr Cupitt
(another consultant) I think you will do better if you go into the cottage hospital for six weeks' rest. Someone better look after your children while you are there.

Muriel (thinks): [Don't want to leave the kids, but perhaps its all for the best if this rest really helps.]

6 weeks later, at Middlington Cottage Hospital

Dr Barlow (consultant): How are you feeling now?

Muriel: Rested, but there's nothing to do here. No work, no occupational therapy, no treatment, nothing but rest. I feel overwhelmed by thoughts I can't cope with: it's as though there is something right on top of me; I don't know how to deal with it.

Dr B: You don't seem to have made much progress, I think you'd be better off back home.

Muriel (thinks): [I seem to be a disappointment, I suppose I must seem ungrateful to them]

2 weeks later, back home:

Dr V: Why have you come? What happened at Middlington?

Muriel: No one spoke to me or asked 'How are you?' so I didn't do anything: There was no communication, but I must have eaten something there - with hindsight now, I must have needed a break, but I've had hardly any sleep: just too much time to think over my troubles. Middlington sent me home - and now I'm back to square one.

(Thinks): [I bet he thinks I'm just complaining; I don't think he wants to know how I feel]

Dr V: I think I'd better send you to Queenstown General Hospital to see another consultant - someone who specializes in these things. I'll make an appointment, it may take a few weeks.

Five weeks later, at Queenstown General Hospital.

Dr Goodlane
(another consultant) I've read your notes - what's your story?

Muriel (tells the same story as she has told the others)

Dr G: I want to be helpful; I want you to take these two tablets. One is called Nordil, it's an anti-depressant, MAOI; the other is a tranquilliser, Librium. Keep taking the tables and keep coming here as an out-patient and we will see if they are any help. Let's see you in ten days.

Muriel (thinks): [He seems really nice. At least he tells you things and explains things, I find that really helpful.]

Ten days later, at Queenstown General Hospital

Dr G: How are you now, after ten days on the drugs?

Muriel: Very much improved: after ten days I feel so much better and am holding food down.

Dr G: Yes, you are better, but you had better see a psychiatrist. I'll make an appointment. Could be a week or two.

Muriel: OK, You're the doctor; if you think that's going to be helpful.

(Thinks): [Oh dear! I wonder what this will entail. I've never had a psychiatrist before. Maybe he'll be more understanding.]

Three weeks later, Queenstown General Hospital

Muriel (thinks): [I'm feeling quite nervous - seeing a psychiatrist. His name is Dr B-----, sounds foreign - hope he can understand English]

Dr B-- (psychiatrist) Come in.

Muriel (thinks) [It's a nice big room. He sits at a big desk, lots of books behind him. He's not wearing a white coat, just a cream short-sleeved shirt, dark tie, and with a biro pen in his breast pocket. He is bald, very brown looking, glasses, doesn't smile or say anything. Looks more African than Indian. I wonder if I should sit down. There is a chair in front of his desk.]

Dr B: Good afternoon.

Muriel Good afternoon.

(Thinks) [What now? Should I ask or shall I just sit down? I've forgotten his real name. It's quite long - sounded Indian, but I'll always think of him afterwards as Dr Inkblob.]

Muriel (thinks): [O God! This is awful. At least ten minues of silence - could be longer. that bir pen of his in his pocket is leaking – a great big circular ink blot is getting bigger and bigger on his shirt. More silence.]

Dr Inkblob (says nothing but makes a note on his pad)

Muriel (thinks) [I wonder if he knows about his inkblob, should I tell him?]

Dr Inkblob Well, I'll see you in three weeks' time.

Muriel (just nods and retreats, baffled)

Next day, back to Dr Vanhelm.

Muriel I've been to see the psychiatrist at Queenstown. We just sat in silence – nothing happened, just this great inkblob on his shirt getting bigger and bigger. I was transfixed by it. He said come back in three weeks.

Dr V Well, that's something.

Muriel That's nothing – no help; no support! I've got the next three weeks to get through, on my own, and two kids to look after.

Dr V We'd better get a second opinion. I'll arrange something with Mosswick.

Two days later, Mosswick District Hospital

Dr Mellow Do come in, sit down, and tell me what this is all about.

Muriel (tells the story so far)

(Thinks) [He is nice, understanding, I feel listened to for the first time. He helps me to get over what I want to say.]

Dr M Yes, it is quite a story. I'd better get you to come into North Vale Hospital for three weeks for a rest.

Muriel North Vale?

(Thinks) [Oh no! North Vale is the local mental hospital. All sorts of stories about it. People call it 'the bin'.]

Dr M Yes, North Vale, but don't worry – it's OK nowadays. There's a special little place there like a village in the country – it's called Fairhaven.

Muriel (thinks) [I've heard it called the 'Funny Farm']
If you think that's going to be best for me; what about my two children?

Dr M Can't your husband look after them for a while?

Muriel He's always busy at work and away a lot, but I'll ask him.

Two weeks later, Husband Fred takes Muriel to North Vale for a three-week rest. (In the event, she stays there seven years.)

At the end of a total of seven years

Muriel (thinks) [Here I am now, no husband, children in care, what next? Am I here for ever? What future is there? I hear there's a new psychiatrist coming, a Dr Hassani, another foreigner. I bet I won't be able to understand.]

First interview with Dr Hassani.

Dr Hassani (smiles) Hullo, I'm Dr Hassani, your new doctor. I'm from Pakistan, but I'm very fond of the English way of life. I enjoy cricket. Do you mind if I smoke my pipe?

Muriel (thinks) [He feels like a real person. He really is kind and has such a nice smile]
No, please do smoke.

(Muriel then bursts into tears)

Dr H I'm sorry – I didn't mean to make you cry. Are you sad?

Muriel No. It's just your kindness has brought tears to my eyes. They are tears of joy and relief. Most of the staff here are distant. Not really meaning to be unkind, just thoughtless. No insight into our needs and what we are undergoing.

Dr H Well, let's see how we get on.

The last six months in North Vale

Muriel recalls that from that first interview with Dr H, things start to improve. She says Dr H was 'pill-happy', most of his drugs seemed to work, but they all made you feel a bit weird. The best 'drug' was Dr H himself. After their first few interviews, Dr H moved Muriel from the 'dolls' house' to Swanfield, a kind of half-way house. Then he upset Muriel by moving her to the dreaded Nelson ward in the main building. She was cross with him about that, and told him so.

Last interview with Dr H

Muriel I'm very cross with you. You've put me back with all the loonies. Not only that, but the staff are noisy, the charge nurse slams doors, so I told her off.

Dr H I think you're getting better.

Muriel (thinks)	[He's always the same, just puffs his pipe. He never asks about my history, but deals with the here and now, my current feelings.]
	Anyway, Doctor, I've got a part-time job in town, and I need my sleep, because I have to work next day.
Dr H	Let's talk about that next time.

One week later, Muriel walks out of North Vale after seven years. She leaves a note for the ward sister and for Dr H, she finds a room in the next town to stay in, and a full time job. She felt very shaky at first. She later heard that all the staff thought she would be back soon, but she never did return. Dr H got in touch, and suggested she came to see him as an outpatient. This she did and he continued with his drugs until after a few years Muriel asked if she could stop taking them, to which request Dr H reluctantly agree.

The present scene

Muriel has now been off prescription psychotropic drugs for four years, although she has become a devotee of herbal and homeopathic remedies. She has seen many other general practitioners, counsellors and a cognitive psychotherapist. Her most recent pronouncement after a course of diet testing for allergies was "this has nothing to do with my childhood – it's all to do with my chemistry."

There is a lot more to be told of Muriel's story, including what happened in the months immediately following her walk-out from North Vale, the attitudes of her employers, and the reactions of various medical practitioners when they discovered that she had absconded from a long-stay mental hospital. Enough, however, has been said to give a flavour of the different styles of empathy, as they were perceived by this patient, and their effect on her life.

Conclusion

There are many different caring professions in addition to GPs, but the psychodynamics of any helping relationship may be universal. We need to learn to be open to the 'otherness' of the other – being ready to feel whatever feelings result from being in touch with another person, however different that person is from outselves. Empathetic identification is not enough, as it can limit us to seeing what is familiar or similar to our own experience. We therefore need to develop the knack of being open to and respecting feelings and experiences that are very different from our own.

The best medicine is indeed a mixture, a mixture of experience-based medicine, evidence-based medicine, and above all empathy-based medicine. If we, as practitioners, have the experience and the evidence, we have the power to do much for our patients, but if we have not empathy, we achieve little. We are, to paraphrase Paul (1 Corinthians 13), but noisy gongs or clanging cymbals. So experience, evidence, and empathy abide, these three; but the greatest of these is empathy.

References:

1. Balint, M. *The Doctor, his Patient and the Illness.* London, Pitman, 1957, Second Edition 1964, Reprinted 1995 (Churchill Livinstone).
2. Balint, M. *Treatment or Diagnosis: A Study of Repeat Prescriptions in General Practice,* Mind and Medicine Monograpsh. Philadelphia, Lippincott, 1970.
3. Illich, I. *Limits to Medicine* (originally printed as *Medical Nemesis: The Expropriation of Health in Ideas in Progress,* 1975. First published in Great Britain by Martin Bryars 1976. Harmondsworth, Penguin, 1977, p.79 ff.
4. Michael Balint: *Object Relations Pure and Applied.* London, Routledge, 1996, p.11-12, p.35-36.
5. Gosling, R. 'The general practitioner training scheme' and 'GP training and psychoanalysis' In: H. Steart 1996 (4) pp.99-100; 101-110.
6. Balint, M. (with Enid Balint) *Psychotherapeutic Techniques in Medicine.* London, Tavistock Publs., 1961.
7. Casement, P. *On Learning from the Patient.* London, Tavistock Publs., 1985. Reprinted 1995 (London, Routledge).
8. Reik, T. *Surprise and the Psychoanalyst.* New York, EP Dutton and Co., 1937.
9. Money-Kyrle, R. Normal Counter-Transference and some of its Deviations, *International Journal of Psycho-Analysis,* 1956: 360-66.
10. Winnicott, D. W. *Collected Papers: Through Paediatrics to Psycho-Analysis.* London, Tavistock Publs., 1958. Revised edition 1975 (Hogarth Press). Reprinted 1992 (London, Karnac Books) p.4.
11. Egan, G. The Skilled Helper: *A Systematic Approach to Effective Helping.* Pacific Grove, California: Brooks /cde Publishing 1990 (4th Edn.) p.123-141.
12. Eisenberg, N. & Straker, J. (eds.) *Empathy and its Development.* New York, Cambridge University Press 1987.
13. Kohut, H. The psychoanalyst in the community of scholars. In: PH Ornstein (ed.) *The search for the Self.* New York: IUP, 1978.
14. Rogers, C. R. *A Way of Being.* Boston, Houghton Miffing 1980, p.137, 142.
15. Rogers, C. R. Rogers, Kohut and Erikson. *Person-Centred Review.* 1986, 2, 125-140.
16. Huxley, A. *The Doors of Perception.* NY, Harpers Reh 1963.
17. Kleinman, A. *Rethinking psychiatry.* NT: Free Press 1988.
18. Courtenay, M. Bodily Empathy. *Journal of the Balint Society*, 1994, 22, 51.
19. Zalidis, S. The Human Face of General Practice. *Journal of the Balint Society*, 1996, 24, 25-32.
20. Zalidis, S. "So if there is Nothing Wrong with Me, why does it still hurt?" *Journal of the Balint Society*, 1997, 25, 7-14.
21. Brock, C. D. et al. The Erosion of Empathy in Medical Education: A comparison of Freshmen and Junior Medical Student Response to the Barret-Lennard Ralationship Inventory. *Journal of the Balint Society,* 1992, 20, 8-9.
22. Hogan, R. T. Development of an Empathy Scale. *J. Consult Clin. Psychol,* 1969, 33, 307-316.
23. Balint, M. Training Medical Students in Psychotherapy. *The Lancet,* 1957 (i) 1015-1018.
24. Wolf, F. M. et al. A Controlled Experiment in Teaching Students to Respond to Patients' Emotional Concerns. *J. Med. Educ.,* 1987, 62: 25-34.
25. Balint, M. Training General Practitioners in Psychotherapy. *British Medical Journal,* 1954, Jan. 16 vol. i p.115.
26. Norell, J. What Balint means to me. *Journal of the Balint Society,* 1989, 17: 20-23.
27. Hopkins, P. (ed.) *The Human Face of Medicine.* London, Pitman, 1979 (Based on 4th International Balint Conference, Imperial College, London, 1978).
28. Balint, John. The Doctor, his Patient and the Illness – Revisited: Forging a New Model of the Patient/Physician Relationship. *Journal of the Balint Society,* 1996, 8-13.

"Empathy-based Medicine"

by Boyd Ghosh, Medical Student

Joint prizewinner of the 1999 Balint Society Essay Competition

This essay will begin with a case history of a patient that I have been lucky enough to follow through several consultations. I will then use this case to illustrate a discussion on empathy based medicine. I will go on to show that while empathy does decrease the distance between the doctor and their patient, bringing with it certain difficulties, empathy is none the less a crucial part of the interview process.

Jenny Bishop (not her real name) is a 25-year-old woman who, for the last 6 years, has suffered pain in her lower abdomen. In the last year the pain has been reaching a crescendo and she is reaching the limit of her endurance. The pain is situated in the left lower half of her abdomen and at times when the pain is at its worst she finds that it radiates across her abdomen in a belt and then travels to her back and down her left thigh. She may feel flushed and giddy and nauseous and at these times she is often to be found on the toilet hunched over, shaking her legs and in tears. She experiences diarrhoea and in her more solid phases she has what is called "rabbit stools". Characteristically she finds that the pains get steadily worse as her period approaches and then disappear for the length of her bleeding. The pain may typically wake her from sleep three or four times a night and will last for around 45 minutes. When the pain is at its worst, her only relief is to not eat, so that for around two weeks of a month she may not be eating a set meal at all to try to avoid the pain. She will usually find that she has to stay home from work for around two days a month and she is often unable to see her friends or interact with her family normally. The pains started six years ago whe she was at university and continued throughout that time, while she was working for a large accountancy firm as a trainee and currently while she is working for a national charity.

Her boyfriend, who she has been with since her time at university, is very understanding and will often talk her through the pain at night. He lives in Bristol as a computer programmer and she lives near London and so their relationship is conducted by phone mostly. Her family is rather strained. Her father and mother do not really get on that well and their methods of coping with Jenny's distress are varied. Her father finds it difficult to cope with Jenny. In his eyes, her giving up accountancy was tantamount to failure in life. When Jenny argues with him that she felt compelled to give up her job because of her pain, she feels it makes little difference with him. Her mother is very caring and tries her best to look after her daughter, but the constant nature of Jenny's symptoms and her inability to help, wear her down. Jenny's brother is not living at home with the rest of the family. While he is supportive he is too far away to be involved on a day to day basis.

Jenny went to see her GP soon after she started to get the pains. He diagnosed irritable bowel syndrome. She was referred to a gastro-enterologist to exclude more serious pathology. The consultant performed a sigmoidoscopy and when he blew up the balloon inside her it reproduced exactly the pain that she had been experiencing. This was used as evidence to convince her that she had irritable bowel syndrome, but the ineffective treatments and the poor chance of recovery from irritable bowel led her to seek other diagnoses.

For the first year or so she tended to rely on her GP for guidance. He prescribed buscopan, normacol and mebeverine and told her to take the medication for a month or so to assess their affect on her pain before coming back. However he did not, to Jenny's satisfaction, provide proof for his diagnosis or talk to her about her prognosis. She felt reluctant to take a long term medication if she wasn't sure that she had the condition. She went back to the GP on a number of occasions to complain of her pain but when questioned she admitted to not taking the tablets. The GP complained to her about her non-compliance, giving her the impression that she had the choice of either taking the medication or not complaining to him. Jenny did not or could not get over to the GP her doubts about the diagnosis and her disquiet about taking the medication.

In the last year the pain has been getting progressively worse and while she has never quite accepted the diagnosis of irritable bowel syndrome she has recently started to question the diagnosis more actively. The consultations that I want to concentrate on are with a gastro-enterologist at a hospital in North London. He was first seen by Jenny privately, a year ago, having been recommended by a friend of her boyfriend's family as someone who specialised in irritable bowel. At that consultation he intimated to Jenny that her pain seemed to be quite severe for irritable bowel and that he was hopeful that there were a few diagnoses that had not been considered, that would be likely to cause this pain. The consultation in question is taking place as she starts to see him as a NHS patient.

Up to this point Jenny has been in almost daily pain, her social and family life has been almost totally disrupted, her career has been changed and her relationship with her boyfriend has been put under considerable strain. She is very keen to find an alternative diagnosis. A different diagnosis brings with it the hope that there will be some active treatment that will bring her relief. She has, for the last few years, been taking the buscopan that her GP prescribed,

although with little impact on the pain.

At the first NHS consultation with Jenny, the consultant asks how the use of the GTN spray, prescribed by him at their last meeting, worked for her pain. She said that it had not eased her pain and that it had made her dizzy and describes to him how she hadn't felt herself. She says that her mother described her as talking very strangely. He looks at the barium enema result which he requested last time and says that it is all normal. He says that her blood tests are all normal. Jenny describes again to him how her pain has got worse, how she cannot eat for days at a time and how it is affecting her work. She also expresses surprise about how her pain eases so much when she has her period. He then says that he would like to try her on amitriptyline. He describes it as a tranquilliser but in a very low dose and describes its action as being to blunt the pain that she feels. He asks her to make an appointment for three months time and to see how the tablets work. He gives her the number of the nurse who is sitting in the room and tells her that she can ring to adjust the dose at her convenience. The consultation is then over and Jenny leaves.

Over the next few weeks she takes the tablets with decreasing enthusiasm. The tablets make her feel very tired and her family are alarmed by how groggy she seems on them. Her pain is blunted but it doesn't clear enough for her to go on to lead a near normal life, which is what she wants. Nine months then elapse until she sees the consultant again. In the meantime Jenny tries ringing the nurse but she finds her unhelpful. Her repeat appointments are with the consultant's junior staff who are unable to consider questioning the consultant's diagnosis.

At the subsequent visit with the consultant, he asks Jenny how the amitriptyline is for the pain. Jenny replies that it is helping but she still finds the pain difficult to deal with. She still finds that she has to stop eating for weeks at a time and her social, work and family life are disrupted. She says that she has started going to a nutritionist who is looking at her diet in order to help her to alleviate her symptoms. The consultant says that a problem like hers involves many different areas and if she finds relief with the nutritionist then she should pursue it. He looks rather taken aback when Jenny asks him whether he thinks she has irritable bowel. He says yes and she then brings up again the fact that she has no pain when she has her period. She asks whether this is normal, to which he replies that the symptoms do seem to be affected by the period, some people finding that the pain is worse and some people better. She then asks him if he has considered a disease called systemic mastocytosis, which her boyfriend found on the Internet. She described the symptoms that seem to be in common. At this point the consultant says that she has to look at one thing at a time and that she should pursue the nutritionist. Systemic mastocytosis is very rare he says, although he admits to not knowing all that much about it, and adds that if she has brought it up then he would feel duty bound to exclude it. He thought though, that it would be unfair to consider a diagnosis for which further tests are involved for something that is vanishingly rare. His attitude to her questioning his diagnosis has been one of irritation and annoyance. Jenny then backs down and asks the consultant for some more amitriptyline to take with her. The consultation finishes with an open appointment leaving it open for Jenny to book when she feels it to be appropriate. The consultant suggests she should make it after she has finished with the nutritionist and has decided about further tests for systemic mastocytosis.

When she leaves she bursts into tears and says that she hates going to see doctors because they don't tell her anything. She wants to know why she has this pain and why her pain stops when she has her period.

This history is useful to analyse with reference to empathy based consultation. At this point it may be fruitful to talk about the definition of empathy and how it can be used in medicine. Stedman's medical dictionary[1] defines empathy as "The ability to intellectually and emotionally sense the emotions, feelings and reactions that another person is experiencing and to effectively communicate that understanding to the individual."

In other words, empathy is the ability to recognise the emotions and feelings that a patient is going through and to be able to explain to or show that person, in a sensitive way, that you do understand the state they are in. Gianakos[2] has neatly summarised the aim of medicine as "...the essential goal of medicine is to cure or comfort the sick patient in the context of a relationship."

Empathy based medicine then, would involve sensing the patient's emotions and feelings either intellectually or emotionally and reflecting that understanding back to the patient through words and non verbal communication, to aid in the diagnosis, cure, comfort and management of the patient.

Squeir[3] has suggested in his paper that this empathic interviewing style is important in establishing the conditions for information to be shared more openly with the practitioner. The more emotions are shared, effectively understood and reflected back to the patient, the more able the patient is to disclose increasingly sensitive areas to the practitioner. Neuwirth[4] describes a model devised by Suchman to explain the beginning of the empathic process. He asserts that the patient gives the practitioner "empathic clues" to their emotional distress, which the practitioner can then follow up by asking the patient to elaborate. The practitioner can then acknowledge the emotion with a suitable empathic response, to enable the patient to feel understood. Suchman found that those patients, who did not receive either the initial "empathic opportunity continuer" or an empathic response, escalated the intensity of their empathic clues.

Jenny's unhappiness with her consultant

stems from her feeling of not being understood. The consultant has managed to elicit many empathic clues[4], but he has not followed these up to enable him to fully understand Jenny's situation. In the first NHS consultation, the consultant does not recognise that Jenny is questioning the diagnosis. This loses him respect in her eyes due to her needs failing to be met in that consultation. Her clues[4] in her first consultation e.g. the fact that she is surprised about her pain being non-existent during her period, turn into frank statements in the second consultation when she openly questions his diagnosis. Instead of dealing with her underlying worry, he answers her on a rational basis, talking about the unlikelihood of a rare disease instead of comforting her fear for the diagnosis of irritable bowel syndrome.

Squier[3] also cites evidence, that an empathic interviewing style by the practitioner increases the patient's compliance with the medication. He asserts that using empathy helps the patient to come more quickly to an understanding of their condition. The subsequent shared understanding between the practitioner and the patient on the nature and treatment of the disease promotes a common aim between them. This enables the practitioner to respond more effectively to the patient's needs and improves patient compliance with the treatment.

In the case above, at the point where Jenny and the GP fell out, the GP was not concentrating on being empathic and had instead isolated the success of the consultation to whether the patient was compliant with the medication. Pelligrino as cited in Gianakos[2] states that "A morally valid clinical decision must be technically correct and also good for *this* patient, ie. in keeping with his values and beliefs about the purpose and meaning of his life and the kind of life he wants to live."

Jenny was uncertain about the diagnosis and therefore also uncertain about the treatment offered. Without a common aim, Jenny would never be compliant with the GP's prescription to take, in her view, unnecessary and pharmacologically active substances.

In addition to the effect of empathy on compliance rates as outlined above, there is some evidence to show that empathy has a direct effect on cure and comfort rates in patients. White[6], and Hart and Dieppe[7] used the range of placebo cure rates in various controlled trials as evidence for the effectiveness of empathy in the medical setting. They found the average to be around 35% but they varied between 20% and 70%. They assert that the placebo cure rate is really indicative of the cure rate due to caring.

Satisfaction is easier to assess in relation to empathy. Squier[3] cited above, asserted that satisfaction was positively correlated with empathic interview technique by practitioners. Additionally, Redelmeier[8] et al conducted a study in which 65 homeless adults attending an emergency department, were allotted a trained volunteer to give them compassionate care while 68 controls received the care that they would have received anyway. Compassionate care in this context involved talking to the patient about a range of issues including previous hospital care and living situation etc. together with bringing them some food. They found that the patients who received compassionate care were twice as likely as controls to rate their overall quality of care as excellent or good. Their total number of visits to the department was reduced compared to the controls by 28% with a 95% confidence interval of 14-40%.

Kutner[5] has stated that empathy is not what is needed in clinical medicine. He asserts that communication rather then empathy is important. The crucial difference between effective communication and the empathic process, however, is the reflection of the patient's emotions back to them by the practitioner, enabling them to know that they have been understood. If this is not done, the patient will be unable to feel secure in the relationship and sensitive areas of emotional concern will lie undiscovered[3]. In the case of Jenny above, the consultant has heard that she is dissatisfied but has been unable to elicit why and has instead concentrated on assumed areas of dissatisfaction.

Many doctors use the argument that to become more empathic with their patient they must become more involved and to do so would reduce their objectivity[2]. However, while objectivity is necessary in certain areas of high strain such as an emergency resuscitation, it is a handicap in dealing with a chronic and debilitating illness. Without closing the gap between patient and doctor, the patient will never be able to effectively communicate to the doctor what they feel about thier illness. Gianakos[2] supports this statement in his article saying that "Physicians must be able to shift back and forth between objective and imaginative (empathic) frames of mind to truly help their patients."

Squier[3] also agrees that empathy is more important in long term or debilitating illness. He argues that long term illnesses "carry a significant amount of stress that must be contained within the treatment system."

A decrease in the distance between the doctor and the patient may bring other problems however. It may be said that more familiarity makes it difficult for the doctor to refuse requests for help from patients at times when they are not acting in their professional capacity. They may also find that their ability to control the consultation effectively becomes hampered by the reduction in the professional distance that they have created. As with so much in life, balance is important and with very emotionally or physically demanding patients, more distance may be required. There is evidence to suggest however, that empathy may actually help to decrease the emotional and physical demands made by patients on their doctors[4,8].

It took me 24 years to decide to study medicine. When I did finally gain a place at

medical school, my friends, almost without exception, insisted on telling me of their dissatisfaction with their doctors. A classic complaint would involve them recalling their shock as discovering how little time they had with their GP and they would describe how the GP would face the computer while he typed, only actually looking at them when he handed them their prescription. I have now seen the GP surgery from the other side and I can vouch for the stresses that may make the GP more task oriented, but what my friends were describing was a doctor without empathy. In the pressured environment of today's NHS, it is easy to see how a doctor becomes disillusioned and emotionally blunted, but what my time with Jenny Bishop has taught me is the devastating and time consuming result of not listening to and feeling with the patient. Without the courage to decrease the distance between patients and ourselves, all doctors risk becoming just another typist with a prescription pad.

References:

1. Stedman. *Stedman's Medical dictionary:* Baltimore, Williams and Wilkins 1995.
2. Gianakos D. Empathy revisited. *Archives of Internal Medicine.* 1996, **156(2)**: 135-6.
3. Squier RW. A model of empathic understanding and adherrence to treatment regimens in practitioner-patient relationships. *Social Science & Medicine.* 1990, **30(3)**: 325-39.
4. Neuwirth ZE. Physician empathy – should we care? *Lancet.* 1997, **350**:606.
5. Kutner JS. Understanding patient values requires communication, not empathy. *Archives of Internal Medicine.* 1996, **156**: 1582, 1586.
6. White K L. The measurement of caring. *Lancet.* 1996, **348**:338.
7. Tudor Hart J. Dieppe P., Caring effects. *Lancet.* 1996, **347**:1606-8.
8. Redelmeier DA. Molin JP. Tibshirani RJ. A randomised trial of compassionate care for the homeless in an emergency department. Lancet. 1995, **345**:1131-4.

The International Balint Federation 1999

Those of you who came to the International Congress in Oxford (September 1998) will have made all sorts of new friendships with Balint colleagues from many countries. It does our hearts good to realise that we are not alone on this island in our enthusiasm for interpersonal medicine. The Oxford Congress is now receding into memory – but the International Federation is still alive and well and busy thinking about the next International Congress (No 12) which will be held in 2001 in the charming city of Ljubljana, the capital of Slovenia. If you do not have an up-to-date atlas, you will find Slovenia in your old school one as the area which used to be the northernmost province of Yugoslavia. You may even have visited the famous lakeside resort of Bled on your holidays. Slovenia nestles in the Julian Alps, and has borders with Italy and Austria as well as Hungary and Croatia. So it is very accessible from both East and West Europe. We are particularly hoping that there will be some Italian delegates; there is a very active Balint Society in Italy but we hardly ever see them at International meetings because they don't speak much English. The Slovenians are planning to offer translation into Italian as well as English and Slovenian. If you come, you will have a chance to practice your Italian and make some Italian friends too.

The Congress will be in 2001 which is quite a long time to wait; so what does the International Federation do in between Congresses? Well, our council meets twice a year in a different country. Each member Society is allowed four delegates and additional observers are always welcome. At these meetings we discuss the plans for the next congress and we hear reports about Balint activities in all the member countries. We particularly wish to support and encourage the development of Balint groups in countries which do not yet have an established Balint Society. But it's not all business and committee meetings. Each time we meet, the host country arranges a little programme of talks and discussions and we nearly always have a session in which we all sit round and someone says: 'who has a case?'. I think you know what happens next. Add a nice dinner, some sight seeing and some shopping in the country concerned and you can see why we look forward eagerly to our council meetings. The last one was in Brussels in March of this year and the next will be in Budapest in October 1999. After that, maybe Paris in the Spring? If you would like to come to any of these meetings, please contact me on 0181 904 2844 or e-mail: jsalinsky@compuserve.com.

JOHN SALINSKY
General Secretary
International Balint Federation

Obituary

Aaron Lask died July 1999., b. 1918., q. 1941 (Cambridge, Leeds)

Aaron was a member of 'the old guard', the nickname of the first Balint group which led to the appearance of that seminal book: *The Doctor, His Patient and The Illness*. He did not let on to Michael Balint that he had a diploma in psychiatry when he applied to join, and I remember M.B. saying he would never have let him join if he had known! Several of the original group, including Aaron, went on to work in seminars undertaking specific research projects, leading to the books: *Night Calls*, by Max Clyne and *Asthma* written by Aaron himself. He was in practice with his two brothers (referred to by him as Dr M. and Dr S.). Their indefatigable (sic) receptionist, Mrs Marson, appeared to keep them in order! I cannot help thinking that the style of the partnership echoed Aaron's, that is to say, unusual. At one case presentation of his in the group which produced *Six Minutes for the Patient* he reported that a bus driver parked his (full) bus outside the surgery while he came to consult Aaron. He had a habit of teasing (consciously or unconsciously) the group by producing new material when the group had got itself tangled in knots over a case of his; to such an extent that the phenomenon entered the jargon of the group as "doing a Lask". He had a wicked sense of fun, but the group could never quite accuse him of doing it on purpose! He had ruffled a few feathers when he contributed the final chapter of *Night Calls*, entitled 'Doctor and Patient'. Although the personal issues perceived in the individual doctors' work was set in the context of the doctor being snatched from sleep to exercise his professional skill, the lessons learnt are readily applicable to ordinary consultations. Aaron did not spare his colleagues praise or criticism in his analysis. He especially took them to task for not using knowledge of the patient that was at their finger tips, but when they seemed to have used their knowledge his praise was unstinting. It was this clarity of vision, even-handedness and wit that endeared Aaron to us all. But I can never think of Aaron without thinking of his wife Rita, who appeared as a bird of paradise, flitting across the Balint landscape in a charming and personable manner; they made an unforgettable couple. Sadly, Aaron's health over the last decade had not been good. Ironically, the last vivid memory I have of him was giving an after-dinner speech at the annual Oxford Balint meeting, which included a joke that proved to be all too prophetic for his own future. He is survived by his son, Brian, of whom he was immensely proud.

MICHAEL COURTENAY

The 1999 Oxford Balint Weekend

A Medical Student's view

by Rebecca Gledhill, Sheffield University School of Medicine

I cannot clearly recall what it was about the tatty notice pinnned precariously to the edge of the Medical Society notice board which grasped my attention. It was certainly the most uninspiring scrap of paper, posted amidst a colourful array of conference advertisements, cheap excursions for students, tantalising scholarships for medics and some local Indian take-away flyers (which, as an essential part of any medical students' education, had hijacked their place, on top of seemingly less important things like timetables). Neither can I remember what it was on the notice itself which prompted me to actually call the number given for further information, but on reflection it was probably something to do with the word "subsidised" which my narrow, money-grabbing student mind equated with "freebie".

Some days later I received an invitation to the Balint Society Group Weekend. My presence was requested on Friday 10th September and for a small fee I was to be accommodated in Exeter College, Oxford. At this stage I felt reluctant to comply. I had minimal knowledge of the Balint Society; I knew it was something to do with GPs and there was some mention of group discussion but further investigation into the precise nature of this "cult" was clearly in order.

After scouring the library and performing a number of internet searches all my efforts could produce was a grossly unappealing dusty red hardback copy of a book entitled *The Doctor, His Patient and the Illness* by a certain Michael Balint MD. It was the type of book you may look at and instantly disregard, as obviously many library explorers had done for some years. The book was in an unhealthy condition, riddled in dust and exuding that mildewy, stale aroma that is often associated with thrift shops and nursing homes. It was indeed best described as a geriatric of the publishing world and had been banished to end its days in a dark, dank zone of the library where it was to harbour paper rot and fungal infestation before recycling became its ultimate destiny.

Again it was probably the sheer lack of appeal which provoked my interest. I would even go as far to say that, like the Balint Society notice, I felt sorry for the unfortunate article. Its chances of being noticed were slight – let's face it, most medical students having undertaken the unfamiliar step of entering the library, will overlook even the most jazzy, modern textbooks on display, let alone a despairing volume like this. It lacked all the credentials: no fancy pictures of cells magnified at high power, no partially dissected arty interpretation of the human body in full sprint, certainly no graphic picture of a classic clinical sign designed to shock you into delving deeper beyond the front cover, and most significant of all, it certainly was not on the recommended reading list.

So I dusted the book on my white coat and took it on its first outing outside the library since 1975. I had little intention of reading it but for some reason found myself venturing further on the bus on the way home that night. The text contained the findings of a research project carried out by a team of 14 GPs and a psychiatrist in 1957. Each chapter dealt with a few cases picked out by Michael Balint to illustrate a particular triumph or failure in the dynamic relationship between the doctor and patient. The cases are presented to the Balint Group in a style which I was to find still persists in meetings today, i.e. a factual account of the patient's background is given, including a full social history and any details the presenting doctor deems relevant to the discussion. Following this there is an interval in which the other physicians are invited to express their own thoughts and beliefs about the situation. The emphasis is on the interaction which takes place in the consultation. It seeks to explore issues beyond the presenting complaint; what can be discerned from the manner in which the patient approaches the doctor? What are the patient's underlying fears? What does the patient expect the doctor to do about the problem? Balint proceeds to address these questions, including as he does so, a personal psychiatric assessment of the consultation.

I was inspired – though I hasten to add not immediately so. The book cannot be described as easy reading and it takes some time for the tired mind to adjust to the language and terminology very much rooted in 1950s English. However, it is quite possible to pick up a chapter in isolation and get a feel for what is going on. In short stints it makes for more digestible subject matter and there are some fascinating revelations in Balint's own interpretation of the material.

The Balint Society was founded in 1969 "... to promote learning and continue research in the understanding of the doctor-patient relationship"[1]. These were the sentiments echoed throughout the weekend meetings, where unsurprisingly (on account of the dismal PR campaign on medical schools) I was one of a grand total of two medical students who actually made it to the event. I was welcomed warmly and invited to be a member of a group of seven GPs, one GP registrar and a psychiatrist, all previously unacquainted and from different parts of the UK.

Initially I wondered to what extent my own thoughts regarding the cases were worth hearing – with my grand total of six weeks' clinical experience in a hospital environment, having just emerged from the blur of lectures and dissection (and extracurricular activities) that is years 1 and 2. However, after my humble introduction to the group in which I over-

modestly described myself as "only a medical student", I was firmly told to abandon all feelings of inferiority and be free to say what I thought. This was not an easy task at first – I felt a little uncomfortable being frank with my fellows, who had a total of centuries of experience between them. However, I sensed that my views would be taken seriously, so became increasingly confident in saying what I thought, in no uncertain terms (one aspect of my character my friends know only to well). Many of the cases presented involved younger people in their twenties and if I was unable to see the consultation from the doctor's perspective, I often found it easier to relate to the patients' and so tried to present their point of view.

It was not an exercise in looking for solutions to dealing with the patients presented; it was more an opportunity for the GP to reflect on their own approach and consider the immense impact they have on the lives of people under their care. Balint's book cleverly uses the analogy of the doctor as a drug:

"... by far the most frequently used drug in general practice is the doctor himself ... no pharmacology of this drug exists yet ... no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his maintenance doses should be ... the possible hazards of this kind of medication ... or the undesirable side-effects"[2].

It would be fair to say that the Balint Society Weekend was not a venture tailor-made for student involvement, and, save for the prospect of subsidised accommodation and 3 course meals for an entire weekend, I can appreciate there may seem little attraction to the project. The Balint Society on the other hand seems very keen to recruit the younger generations of medical professionals. They are planning to encourage student interest in the future by offering reduced membership. There is also a movement towards the inclusion of practice nurses in the projects. Throughout the weekend cases studies (of which there were only 5 per group taking up total of 8 hours), I really did get a feel for the way general practitioners work. I was able to glimpse beyond what you witness in a standard teaching session sitting in on a consultation because there was time to reflect on matters beyond the clinical diagnosis. Often the GPs spoke of patients they had known for many years so you could appreciate how the nature of the relationship with the patient develops over time, and as a consquence, how the doctor's sense of responsibility for them intensifies.

As medical students we are aware that the curriculum puts a great emphasis on communication skills. A Balint Group meeting may seem like an old-fashioned way of learning to talk and relate to patients, but it is worth noting that it is a movement that is established all over the world and its success must be attributed to the fact that it actually helps those involved.

References:

1. Hopkins P. (Editor) *Journal of the Balint Society* 1998; vol.26:2
2. Balint M. *The Doctor, His Patient and the Illness*. London: Pitman Medical Publishing Co. Ltd., 1964:chapter 1:1. Reprinted 1995, Edinburgh, Churchill Livingstone.

Secretary's Report: 1998-99

This year began with the very successful 11th International Balint Congress, held at Exeter College, Oxford from September 9th to 13th. The Congress was attended by over 148 people from 22 countries. A full report appears in the Conference Proceedings. The conference was immediately followed by the Society's AGM at 2 p.m. on Sunday, September 13th at which officers, council members and ordinary members of the Society were elected.

The lecture series at the RCGP began on the 10th of November when Mrs Juliet Hopkins addressed the Society on "Attachment Theory". I was unable to be present but gather that the discussion was very interesting and look forward to reading the paper in this journal. Next was an unconventional presentation on February 15th, 1999 by Professor Nigel Oswald of the University of Teesside entitled "How do Medical Students begin to understand Ill People?" We discussed a list of questions presented to us as relevant to student understanding of ill people. They are published here in the journal and as you might expect produced a very stimulating evening. On March 16th Dr John Salinsky, Secretary of the International Federation and past president of the Balint Society spoke about the history of the Society in Britain. The last talk was the 12th Balint Memorial Lecture, given by Dr Jon Sklar on April 20th. His title was "General Practitioners' Freedom and Balint's Tradition". The Society was very pleased to welcome Dr Sklar, one of the very few psychoanalysts in Great Britain with an interest in Balint work with GPs.

In the end there was no Nurses' Study Day in May 1999 but there may be one before the end of the year. The Annual Dinner took place at the RSM as it has for the last few years on June 29th. The members and guests had an excellent meal and were addressed by Dr Chris Donovan on "Adolescents and Balint: can they connect?"

During the year the Council of the Society met to arrange the ordinary functioning of the Society but was particularly focused on leadership accreditation. A list of accredited leaders of Balint groups in Britain now exists and most recently the name of Dr Shake Seigel was added to it by submission of his accreditation forms and their review by Council. We hope to revivify the Balint group leaders' workshop, which met twice last year to discuss transcripts of Balint group meetings presented by the group leaders. This coming autumn we hope to join with those doing Balint work at the Tavistock Clinic in another group leaders' workshop. Anyone interested in coming to these meetings should send their name to the organiser, Dr Peter Graham, at 149 Altmore Ave, London E6.

I am now looking forward to the ordinary Oxford Weekend from 10th to 12th September at Exeter College and also to attending the Annual Meeting of the Société Medicale Balint, our French sister organisation, in Pau, at the foot of the Pyrenees on October 23rd and 24th.

DAVID WATT

Adolescents and Balint: Can they connect?

by Dr. Chris Donovan

From the annual dinner held on Tuesday, 29th June, 1999.

I am honoured to be invited to speak at this the last Balint Society annual dinner of the 20th century.

It has been said: "It is sad to grow old but nice to ripen."

As you can see, I have ripened. So I am in a position to tell you that the process has one advantage. It enables you to differentiate between events that come into your life that eventually develop into significant influences as opposed to those which wither and die. This is a thing that is impossible to predict when the events first occur.

For example, who of you can forecast the future influence of today's initiatives in the Health Service; Primary Care Groups, Health Action Zones, or that new word to cover a very old activity – Governance?

Tonight I would like to share with you two events that slipped into my life – one in the sixties and one in the seventies which, over time, grew into significance for me.

The first you will understand. It was in the sixties that I first drove up to the Tavistock on my half day off from the practice and started my five years of the Balint course. This "reframed" my attitude to the doctor/patient relationship and opened my eyes to the most commonly prescribed drug – "The Doctor". My training at UCH was, I believe, a good one. However it left me with the belief that one should try and keep one's emotions out of clinical contacts.

The Balint course showed me how dangerous this belief can be. Instead it taught me how, in Michael Balint's words, to "accept my emotional reactions to my patients and acknowledge my counter-transference and work with it in the service of my professional endeavour." Indeed I ended up agreeing with Ian McWhiney when he claimed: "If we do not acknowledge and deal with our disturbing emotions they may be acted out in avoidance of our patients and in emotional distancing, and in an exclusive concentration on the technical side of care."

I now feel there is an added danger for GPs who deny their feelings; when things go wrong they are tempted to project blame onto the patient or the medical system. They also are eventually at risk of 'Doctor Burn-Out'.

What was the second event? This occurred in the late seventies, when Dr John Horder was President of the Royal College of General Practitioners. He summoned a meeting of four GPs to consider "Prevention". Each of us was invited to take a subject, convene a working party, and produce a report. Dr Julian Tudor-Hart, for example, got Cardio-Vascular Disease – I got Children and Adolescents.

That is when I went to see that great man, Professor Court. This was a couple of years after his highly acclaimed 'Court Report' had been attacked by the RCGP for proposing the creation of "GP paediatricians".

Professor Court was unable to join our group, but he did convince me that, in his words: "Adolescents have problems sufficiently distinguishable from those, on the one hand, of children and those, on the other hand, of adults, to warrant a consideration as a distinct group for Health Care Provision."

Moreover, he urged me to encourage the RCGP to continue to fight to respond to the unmet needs of adolscents.

This is not easy, for nature seems to have produced an antagonism between the generations. Shakespeare referred to this when he made one of his characters say: "I would there were no age between ten and three and twenty. Or that youth would sleep out the rest – for there is nothing in between but getting wenches with child, wronging the ancientry, stealing, fighting."

Adolescents contribute to this antagonism. I like the way Mark Twain put it: "When I was a boy my father was so ignorant I could hardly stand to have the old man around. When I got to twenty-one I was astonished how much he had learnt in the seven years."

Professor Court suggested Dr Freddy Brimblecombe join our Group which, with a major input from Dr Dennis Periera-Grey, the present RCGP President, produced a report entitled 'Healthier Children – Thinking Prevention'. In this we urged that developmental paediatric development should be streamlined and extended to GPs seeing twelve to thirteen-year-olds and sixteen-year-olds.

No-one took much notice of this recommendation. So, in the early eighties, I began in my practice an Adolescent clinic by sending for all sixteen and seventeen-year-olds on my list, and offering them one appointment. I was amazed to find that 60% of young people responded, and that both I and they enjoyed the occasion. Our relationship greatly improved and many problems were shared and treated.

This led eventually to the setting up of The Adolescent Working Party of the Royal College of General Practitioners, which I now chair.

The aim of this Working Party is to encourage primary care to recognise and respond to the unmet needs of adolescents, and to stimulate more research and better training into adolescent care.

To this end, we encourage publicity of the statistics that I am sure you have all heard. For example, the pregnancy rate in the UK of under-sixteen-year-old continues to be the highest in Europe – seven times that of the Netherlands. There are eight thousand of these a year, and

Parent-line claim that the most common call from the fourteen to fifteen-year age group is that they fear they are pregnant and dare not tell their parents or their GP.

Drug clinics claim that one in twenty heroin addicts are under twenty years of age.

Young men are thirty-five times more likely to die from suicide than from HIV infections. In the fifteen to twenty-five year age group there are two suicides a week, yet this country worries more about 'beef-on-the-bone'!

In the last General Household Survey in the five to fifteen age group, 20% of males and 16% of females claim they had an ongoing chronic condition, and about 10% of each sex said that this affected their mobility. The percentage of adolscents coping with chronic illness has greatly increased in recent years as a result of medical advance. For example, 80%-90% of childhood lymphatic leukaemias now survive, but many with ongoing problems caused by treatment.

Perhaps most worrying of all is the percentage of adolescents suffering from mental health problems, around 10%-15%. The more serious of these are referred and wait for months to see a Child & Adolescent Psychiatrist. In Northern Ireland this waiting time is up to nine months.

Three hundred children are excluded from school each day, and 45% of crime is committed by those under twenty-one.

Why do I tell you of these two events? Because I want to urge that they be brought together in Primary Care. And I see the Balint Society playing a significant role in achieving this.

My wish is that we take on board our tendency to feel irritated by adolescent experimentation, and become aware of our collective distancing from teenage needs. As Professor Court rightly said: "Adolescents need to build a relationship with you as their **personal** GP, and not a **family** doctor." This takes time and continuity of care – things that are increasingly difficult to find in today's primary care.

We also need to commit ourselves to increased training in communication skills with adolescents and ethical issues, and in more research into their needs and how to respond to them.

In this context I would like to end by mentioning a small pilot project that your vice-president, Dr Heather Suckling, helped me to run. This was a Balint-like group which met in the evenings at the College of GPs. The cases presented were of consultations with adolescents, that the professionals labelled as "difficult". This enabled the group to look in detail at areas where problems can arise in adolscent contacts. I hope that more of this exploratory quality research might take place in the future – and that we publicise the results.

It is time for me to sum up. What I am advocating tonight is that the truths discovered through the Balint movement are more widely applied to adolescent consultations. A recent book on interviewing rightly says: "There is a real danger of losing sight of the human side of patient care, as physicians are tempted to respond to time restraints with more focused questions, misguidingly aimed at efficiency at the expenses of establishing a helping relationship."

There are seven million adolescents in the UK. Each is important – many need a helping relationship with at least one adult outside the family. Moreover, every adolescent that falls off the ladder of physical, psychological and educational development, is both a human tragedy and, in our ageing society, our economic loss.

There is a need to convince those reshaping our Health Services that concerns about "structure" and outcomes need to go hand in hand with understanding and improving "process". This means that the truths that Michael and Enid Balint helped us to find – must be given more encouragement to flourish in our contacts with Adolescent patients in trouble.

Adolescents and Balint: Can they connect? They can! But will they?

We all must wait till we have ripened a great deal more before we are able to look back and answer that key question.

Thank you.

The 11th International Balint Congress 1998

The 11th International Balint Congress was held in Exeter College, Oxford, from the 9th to the 13th of September 1998. This highly successful and enjoyable event was attended by 148 people of whom 136 were delegates or guest speakers. There were keynote speeches from Dr Tony Hope, Reader in Medicine at the University of Oxford, Dr Philip Hopkins, founder of the British Balint Society, Professor Ian McWhinney (Canada), Professor Roger Higgs (UK), Dr Carl Edvard Rudebeck (Sweden) and Dr Michelle Moreau-Ricaud (France). These were complemented by two sessions of short papers and a symposium on 'Balint in the 21st Century'. In addition, everyone was able to take part in small groups which met every day throughout the Conference. Exeter College, well known to the British contingent as the venue for Oxford Balint weekends, provided a delightful home for the Congress and we were also able to use the magnificent Sheldonian Theatre for the first day. Entertainment and spiritual refreshment was provided by 'I Fagiolini' who performed a varied programme of songs in the Sheldonian, and by Dr John Horder who gave a brilliant organ recital in the College Chapel. A full account of the Congress and the text of all the papers will appear in the *Proceedings of the 11th International Balint Congress* which will be published shortly. A free copy will be sent to all delegates who were present and to all members of The Balint Society.

The next International Congress will be held in Ljubljana, the capital of Slovenia in October 2001.

JOHN SALINSKY

Ripon Weekend 1999

After two years' hiatus we again held a Balint weekend in the North of England. This was at Ripon, at the short course centre (Highfield House) of the College of Ripon & York St John. It took place from lunchtime on Saturday May 8th till tea on the Sunday, May 9th, allowing five case discussion sessions. Ten people attended, forming one group, led by Doris Blass and John Salinsky. Three group members were new to Balint work. At the plenary session we were able to discuss the whole weekend. The new faces were not "converted" but certainly knew a lot more about what Balint work entailed. None of them felt it was what they wanted at this time.

We hope to do follow-ups by letter at three months and this is now taking place. Perhaps in next year's journal we may be able to give a longer report focused on the cases.

As usual, Highfield House proved a wonderful venue for this type of work – a combination of calm, quiet and luxury. We hope to run another Ripon weekend next year, so keep May in mind.

DAVID WATT

The Balint Society Prize Essay, 2000

The Council of the Balint Society will award a prize of £500 for the best essay entitled
"Time and Patients."

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

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

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2000** and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS

International Balint Award 2000 for Medical Students

For more than 30 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 March, 2000** to the following representative:
Dir. Dr. med M. Tomamichel, Via Simen 10, 6900 Lugano.

The presentation of prizes will take plce at the Monte Verità Centre, in Ascona, Switzerland on the 17th of June 2000.

Information can be obtained from: Prof. Dr. med. Dr. h.c. B. Luban-Plozza,
Foundation of Psychosomatic and Social Medicine,
Via Monescia 2,
6612 Ascona.

Programme of Meetings of the Balint Society for the Thirtieth Session, 1999-2000

"Talking with Patients" –
a Balint Study Day for Nurses — **Friday 3 December 1999**
at Paddington Green Health Centre, 4 Princess Louise Court,
off Church Street, Paddington, London W" 1LQ.
Cost: £40. Applications to the Secretary.

Annual Dinner of the Balint Society — **29 June 2000**
Royal Society of Medicine.

Residential Conference at Exeter College, Oxford — **15-17 September 2000**
"Balint and Emotional Intelligence"

30th Annual General Meeting — **17 September 2000**
Exeter College, Oxford.

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.:

Doreen Clifford, Founder member, Association of Psychosexual Nursing
"Balint training and Psychosexual Nursing Care" — **26 October 1999**

Dr. Martin Stanton, Tavistock Marital Studies Institute
"Linked Innovations-Balint Groups, Focal and Marital Psychotherapy." — **23 November 1999**

Dr. Andrew Elder, GP and Lecturer, Tavistock Clinic
Review of Balint Work — **22 February 2000**

Dr. Gwen Adshead, Department of Psychotherapy, Broadmoor Hospital
"Give sorrow words": language and therapy in a maximum security hospital — **11 April 2000**

All meetings are PGEA approved.
Further information 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.

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 7, 6 or 2. Other acceptable files are WordPerfect versions 5.0, 5.1 for DOS. Authors should supply the name of the file on the disk. Please send three hard copies with your file.

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

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