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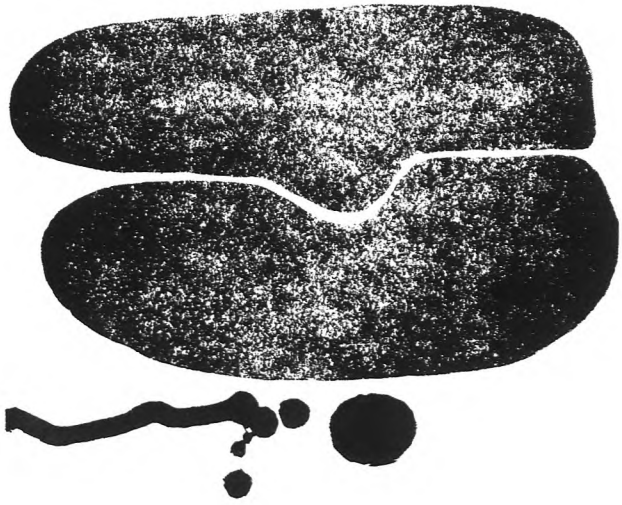

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Dr Heather Suckling - President of the Balint Society

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 is an annual residential weekend at Oxford, and there are occasional weekends and study days for elsewehere in the country.

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

Is Balint good for patients?

If you go to the 13th International Balint Congress in Berlin, this October you will hear a good deal about research and evaluation projects. Balint enthusiasts in many countries are eager to prove to the world that 'Balint works'. We feel that is important if we are going to persuade sceptical, time-pressured doctors and other health professionals that time invested in joining a Balint group is time well spent. In some countries 'evidence' is also required to convince the medical education establishment that Balint groups should be included in the curriculum.

But what does Balint training actually do and how can it be measured? Those of us who have been in a group and felt the benefit are convinced that the experience has greatly enlarged our understanding of our patients and ourselves. We believe that we are more in touch with the emotional content of our patient's lives and the way their feelings interact with ours. We feel sure that we are better doctors than we would have been without the group experience. We may believe we are better doctors than the ones across the street who dismiss Balint as ancient history. We claim, with some support from research findings, that we are happier when dealing with complex psychosocial problems, more tolerant, more satisfied with our professional lives and less likely to become 'burnt out' and seek early retirement.

But what do our patients think? Are they aware that Balint training has made us different from other doctors? Do they live longer, feel better, and have fewer symptoms as a result of Balint mediated care? Can they detect that subtle but significant change in personality? In the 1950s it would have been easier to tell the difference. The Balint trained doctor would be the one who, after listening attentively, told you that your sore throat was a sign of underlying sexual frustration and invited you back for an hour of psychotherapy after the surgery. But nowadays things are different. Balint doctors jump to conclusions less quickly and try to be understanding GPs rather than psychotherapists. Meanwhile, those young doctors in the practice across the road have been trained to improve their consultation skills by studying their performance on videotape. They too know that it is important to listen carefully to the patient's story and to take an interest in his 'ideas, concerns and expectations'. So does having a Balint doctor in your local surgery still make a difference to the patient? Is it possible to develop a research methodology to study the effects of Balint training on patient outcomes?

The first task would be to decide who is a Balint doctor. Should we look at senior members of the Balint Society who have been well marinated in the Balint process for decades? They represent the past, they are approaching a well-deserved retirement but they provide a dose of Balint in its most concentrated form. Then there are doctors who did two years of training at the Tavistock, and come to Oxford weekends when they can, but don't belong to a regular group. Have they undergone the limited-though-considerable, and are they Balint doctors? We hope so. And what about those who were lucky enough to have a Balint group as part of their Vocational Training programme but have not been anywhere near a Balint group since? Will a year's experience in a registrar group be enough to make them Balint doctors? Perhaps we should choose a few from each category and study them all. We will also need a control group of Balint-free doctors (if they exist) matched with our sample for age, sex and other potential confounding factors.

Next we need to decide how to choose the patients and the outcome measures. Balint work always seems to assume a doctor-patient relationship over a period of time, so unlike the MRCGP examiners, we will need to study more than one consultation with each patient. Perhaps we could find a number of patients who had been with our doctors over a ten-year period. During this time, they might have had a number of minor illnesses and perhaps one or two major ones. They might have had help from the doctor through a crisis in their personal lives such as marital breakdown, bereavement or career failure. If they are older, they might have had to come to terms with the attrition of health produced by a chronic disease such as diabetes or arthritis. We shall probably do better to select patients who have had plenty of contact with the doctor for whatever reasons. But what sort of benefits should we look for from ten years with the same family doctor? In what way might we expect a doctor with Balint training to make a difference? Will she be any better at detecting hidden cancer, encouraging a healthy life style, providing good chronic disease management?

Perhaps not. Maybe we should be looking at psychological health, the remission of psychosomatic symptoms, the lessening of anxiety and the lifting of depression. Following Freud, we might look for an improvement in the patient's ability to love and work. But if there are improvements, can we be sure that they are due to the benign influence of the family doctor? Events and relationships outside the surgery may have been much more significant in changing our patients' lives. Quantitative studies of psychotherapy are notoriously difficult even when the course of treatment has a clear end point. Almost certainly, a qualitative approach would be more fruitful. This might include interviews with both patients and doctors with the aim of exploring what goes on, and finding out what doctor and patient think and feel about each

other. Did the patient feel he was supported, helped, understood? Was the doctor there for him in a crisis? Was she sensitive to his feelings, dependable, energetic on his behalf when necessary? Balint work invites us to examine the doctor's feelings, which include those we believe to be projections from the patient. But we don't invite the patient along to ask directly how it was for him. This might be breaking new ground.

Assuming (and it's a big assumption) that we could do some research of this kind, it is intriguing to speculate about the findings. Would we be able to demonstrate that it's better to have a Balint doctor? I suspect that we would emerge with no clear answer to that question; on the other hand, I think we would have gained a good deal of valuable insight into the relationships between all family doctors and their patients. We might also provide some evidence of the value of a long-term relationship with one doctor. Current ideas about health care put the emphasis on rapid access and 'efficient delivery of care' rather than the possibility of seeking help from an individual doctor who is known and trusted. Continuity of care seems to be in danger of disappearing. If we are going to do this work, we should start soon.

JOHN SALINSKY

The Balint Society Website

After a prolonged comatose period the website has now awoken and has been refreshed. Please have another look.

The address is **www.balint.co.uk**

Unlike some addresses, this one is very easy to remember and to find.

When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress.
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on **www.balint.co.uk** you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to **www.balint.co.uk.**

The Watering Eye: weeping without sadness

by Alexis Brook psydioanalytic psychotherapist and Sotiris Zalidis general practitioner

Summary

Although no one questions the emotional origin of tears, it is an issue that is rarely considered in connection with eye disorders. This paper discusses six patients who sought help from their doctor for long-standing watering eyes. Their narratives revealed that they had all experienced painful losses, five being close family bereavements, with which they had not fully come to terms. They were in fact still grieving. The watering eyes seemed to be tears, the bodily expression of the unresolved grieving.

Introduction

Although psychological factors are often considered in the aetiology of many bodily disorders, they are hardly ever referred to in connection with disorders of the eye. W. S. Inman (1876-1968), a highly respected ophthalmic surgeon based in Portsmouth, who was also a psychoanalyst, was a pioneer in the field of psychosomatic ophthalmology and published over 50 papers of which perhaps his best known is on styes.[1] A one-day multi-professional conference organised by the British Psychoanalytical Society and Moorfields Eye Hospital in 1998 discussed some current work in this field.[2]

The observations reported in this paper were made during a study of psychological aspects of eye disorders as they present in general practice.[3] AB is an analytic psychotherapist and SZ is a general practitioner with a particular interest in psychosomatic disorders. AB visited SZ's practice for two half days a month, and as part of our research, we studied 20 consecutive cases of blepharitis seen by SZ or his partners in their surgery.[4] Our findings strongly suggested that, in a significant number of the patients, unresolved grieving contributed to the onset of blepharitis or to its resistance to medical treatment. In the course of the present work, we saw six patients suffering from long-standing watering eyes all of whom had also experienced losses which they had not been fully able to grieve. Although this is a small series, we are reporting it as we have not found any reference in the literature to the emotional background to this condition.

Method

Our method of working was that when the GP suspected that emotional factors might be contributing to an eye disorder he suggested to the patient that stress might be a contributing factor and offered the patient one or more interviews with the psychotherapist to explore this possibility. We have seen three men and three women complaining of watering eyes, with ages ranging from 50 to 81. Five complained of watering of both eyes and one of a watering of one eye only. They had come to their GP complaining that their eyes had been watering either continuously or on-and-off, for from six months to several years. Four were, or had been, mildly depressed.

All agreed to see the psychotherapist. They described their watering eyes in different ways: one said 'I'm not crying, they are watering eyes'; another, 'they are not tears, I don't cry'; another said, 'they are weeping eyes which weep while I sleep'; two said, 'they are watering eyes due to blocked tear ducts'; and the other, 'I never let anything hurt me, I've never shed a tear in my life'. In discussing their lives all revealed varying degrees of preoccupation with feelings of loss: in one it was the death of a daughter; in another the death of a mother; in a third the death of a husband; in two, the death of a close relation; and in one abandonment by her husband. In all six, their narratives indicated a close link between their feelings of loss and the watering eyes. The interviews suggested that, without being aware of it, they were attempting to protect themselves from experiencing the full intensity of their grief. The watering eyes, it seemed, were the expression of the unresolved grieving – tears without emotional crying.

Outcome

One patient was seen once and did not want any further interviews and another did not want to continue after two. The other four patients had between two and eight interviews: in one of these the eye trouble cleared rapidly; in another there was marked gradual improvement; in a third the watering eyes, although still watering, were much less troublesome and in the fourth there was no change: all four expressed considerable relief at having had the opportunity to discuss their feelings of loss.

Discussion

The lachrymal glands produce tears to keep the surface of the eye moist. Watering eyes are the result of overproduction of tears or of obstruction to the outflow of tears through the tear ducts. Excess tears can be produced by external irritants, such as foreign bodies or cold weather, but the commonest cause of overproduction of tears is crying. The normal crying response ranges from quiet weeping to sobbing, grimacing and profuse flowing of tears. In all our patients, the watering eyes seemed to be due to overproduction of tears in the absence of any manifestations of the normal crying response. In fact, in contrast to the normal crying response our patients were responding to grieving by manifesting tears without emotional crying.

The interviews with our six patients revealed a range of feelings connected with their bereavements – sorrow, pining, anger, fear, guilt – which, to a greater or lesser degree, had been blocked from consciousness. The process of mourning involves assimilating the feelings of grief as the individual gradually accepts the loss, re-establishes inner security and comes to face the future with confidence. Our six patients had been unable to cope with their strong feelings of grief, which were, it seemed, expressed in excess tears, interpreted as a purely medical disorder – 'watering eye'. All our patients had experienced significant losses in adult life. The problem was not only the traumatic experience itself but how that particular individual had reacted to that trauma. Two of our patients had also experienced early loss – one had lost her mother when she was very young and the baby brother of another had died when she was a small child. This is in line with our finding that, in some patients, eye disorders, particularly inflammatory ones, may have their roots in emotional difficulties in infancy or childhood.[4]

Three patients said they had been told they had blocked tear ducts: two had been diagnosed, on clinical grounds, as having naso-lachrymal duct obstruction; and in the third, the notes indicated a chronic blocked nose. Our interviews with patients who say that they have blocked ducts suggest that, without realising it, they may also be referring to blocked feelings, 'blocked ducts' being the metaphor for blocked feelings. Discussing this with them helped them to unblock the feelings.

Dart,[5] after reading a draft of this paper, pointed out that as none of the patients had been investigated for lachrymal drainage problems, an absolute block could not be excluded. We agree, and would certainly want to include such investigations in any further studies, but in this paper we are concerned to report our finding that difficulties in coping with painful losses seemed to be contributing to the watering eyes regardless of whether or not there were any organic factors.

We appreciate that this is a small series, that there were no controls, and that our approach is not that of 'evidence based medicine'. Our concern however, is to draw attention to the value of also taking into consideration a different type of evidence, the evidence derived from the patient's narrative. We suggest, therefore that when patients present with watering eyes it may well be helpful to enquire about losses.[2]

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Making sense of the functional symptom: "watering eyes" in terms of emotions

by Sotiris Zalidis

Introduction

The importance of considering emotional difficulties in disorders of the eye was first brought to my attention at the annual Balint dinner in 1992 by Dr Alexis Brook, the guest speaker that year. Dr Brook talked to us of his work at the ophthalmic department of Queen Alexandra Hospital in Portsmouth where he explored the emotional difficulties of eye patients referred to him by eye specialists[1].

I was fascinated by Brook's project and a few days after I had expressed my enthusiasm about his work he contacted me in order to explore the possibility of extending his research to general practice. This was a once in a lifetime opportunity. My partners and I invited him to the Well Street surgery where, once a fortnight, he would see patients with eye disorders who agreed to consult him, and explore the possible contribution of stress to their eye problem[2].

Because the fear of blindness is so powerful that it makes doctors refer their eye patients to eye specialists sooner rather than later, we decided to focus on blepharitis[3], and watering eyes[4], conditions that do not threaten the vision and are therefore more likely to be managed entirely in general practice.

In 1995 Dr Alexis Brook and I were invited by Dr Andrew Elder, a general practitioner and member of the Balint Society who at the time was also a consultant in General Practice at the Tavistock Clinic, to plan a multidisciplinary research seminar that would operate like a Balint group, to study more widely how emotional problems influence the eye[5]. The results of this work were presented in a symposium held at Moorfields Eye Hospital in October 1997[6]. This was so successful that it was followed by a second series of multidisciplinary research seminars the results of which were presented at the Institute of Psychoanalysis in November 2000[7]. The interest generated by this activity led to the inauguration of the Eye and Mind Society in October 2001 in order to bring together all those professionals who have an interest in the emotional difficulties of patients with eye disorders.

The case study that follows illustrates how my experience in the Balint style multidisciplinary group that studied the emotional experience of sufferers of eye problems shaped my response to a patient's symptom of watering eyes.

Multiple functional somatic symptoms

**The patient has given her written consent to have this material published.*

Laura, a Spanish woman in her sixties, is the second youngest of 16 children who arrived in London when she was much younger. She is short and plump, has a permed hairstyle and speaks English fluently with a pleasant Spanish accent. Since I met her 15 years ago, she has requested referral to several specialists for a number of functional somatic symptoms that she has suffered such as: urticaria, angioneurotic oedema, tension headaches, non-ulcer dyspepsia, constipation, abdominal pains, back pain, seborrhoeic dermatitis, hyperventilation syndrome, vertigo, eye pain, blepharitis, watering eyes and fibromyalgia.

Initially, she used to complain of painful sensations all over her body in an agitated way, wincing frequently every time she felt a painful twinge in her body and demanding instant relief. She was coming to the surgery every week as an emergency to see any doctor who might be available. When I realised that my conventional approach was not effective in containing her agitation and none of the remedies I prescribed worked, I decided to try a different approach. I invited her to come regularly with longer appointments to talk about her life, in order to try and understand the emotions behind the physical symptoms. This phase of her treatment lasted four years and I have described it elsewhere[8]. Gradually she realised that a lot of her physical symptoms were related to the physiological reactions of her emotions and started attending less frequently. Since 1992 she has been coming to the surgery once a month with a double appointment. She still complains of functional somatic symptoms, but with a little encouragement she will discuss the life events that activate her emotions so that the physical symptoms stop being the focus of the consultation.

Blocked feelings or blocked tear ducts?

On 12 September 2001 she complained of watering eyes. The symptom annoyed her and she wanted to get rid of it. She had gone to the eye hospital's casualty department a few times and had been given advice about the management of blepharitis, but it had not helped. She thought that her tear ducts were blocked and requested referral to an eye specialist. I agreed to do so.

However, the timing of her presentation made me wonder whether her symptom was caused by crying and so I asked whether anything had happened to upset her[9]. She had seen on the TV the twin towers explode the day before and she had cried at the enormity of the disaster, but assured me that her eyes had been watering for at least three months, and besides, she told me, and I quote: 'I am not one to cry'. Having thus established denial as one of her important defence mechanisms, she mentioned that Sally, her

daughter, was three months pregnant with her second baby and she saw no point in bringing children into the world at present.

This information made me remember a famous paper by William Inman, an English ophthalmic surgeon who was also a psychoanalyst, called 'Styes, Barley and Wedding rings'[10]. In this paper, he makes a link between styes and feelings aroused by pregnancy and childbirth.

I asked her therefore whether it might be possible for a link to exist between her watering eyes and feelings about Sally's pregnancy that she might want to block. She told me that she was afraid in case the new baby suffers the same problem as the first baby that they nearly lost. I decided then to invite her to come back the following week with a half hour appointment to talk about her feelings.

It is interesting that, when she was finally seen by the eye specialist a few months later, he found that her left nasolachrymal duct was blocked by a mucocoele and syringed a lot of pus out of it. He recommended a surgical procedure to unblock it, but she declined. Indeed the finding of the mucocoele raised the possibility that Laura's tears were meaningless, a mechanical overflow, the result of defective plumbing that could be corrected by an operation. However, both eyes continued to water on and off after the unblocking of the tear duct until several weeks after Sally's delivery, when she stopped complaining of watering eyes.

Frey was the first researcher to demonstrate that the chemical composition of emotional tears differs from that of irritant tears[11]. It may be interesting to research the possibility that the chemical consistency of tears associated with denied feelings may have a toxic effect on the mucosa of the lacrimal ducts leading to mucocoeles or other obstructions.

Her feelings about Sally's pregnancy

On her next visit she told me that when Sally was pregnant with her first baby, she went into labour prematurely. When Manuela was born she needed to be resuscitated. In the meantime Sally was bleeding and bleeding, and she saw her becoming paler and paler, fading away in front of her very eyes. The obstetricians had left the room and the paediatrician was concentrating on the baby and there was nobody paying any attention to her daughter. So she ran out of the room in a panic to look for the doctors and she found them in a little room drinking coffee. Suddenly she went mad with anger and started screaming at them at the top of her voice, 'My daughter is dying and you are sitting here drinking coffee!' She was beside herself and knocked a cup of coffee out of the doctor's hand and she had to be restrained from becoming even more violent. The doctors ran to Sally and put a couple of drips up and gave her a transfusion and saved her. She felt that after her outburst they became more attentive towards her daughter. However, she lost her voice for a few days after this shouting bout and she was mortified that she had it in her to explode so violently.

She knew her daughter was pregnant again before Sally knew herself. She noticed that she was more beautiful than usual and she told her so. However, she could not rejoice in Sally's pregnancy because she remembered the fear she experienced when Sally bled after her first labour and this put her off.

'This is the thing I have to block out', she said.

'What do you have to block out Laura?' I asked.

'If Sally dies I will die. Sally means everything to me. Without her my life has no value, even though I love my granddaughter, more than I do her!'

She was hoping that Sally would give birth to a baby boy so that she would not be tempted to have any more children in the future. She found the apprehension about the possibility that something might go wrong too much to bear.

Because I wanted to give her the opportunity to talk about her feelings, I offered to see her regularly at the surgery for emotion coaching. Emotion coaching is a technique I use to educate patients about their emotions as they arise here and now and it is based on Henry Krystal's theory of affect development[12]. It consists in:

- Identifying and acknowledging the negative emotion.
- Helping the patient to name it so that she can discriminate between negative emotions.
- Linking the emotion with the somatic sensations of its physiological arousal.
- Helping the patient to express the emotion in words by telling the story connected with it and by using metaphor. This activity contributes to the cognitive and symbolic processing of emotions and helps diminish the intensity of their somatic components.

The aim of the emotion coaching is to help the patient recognise that some of her symptoms are the physiological reactions of her emotions and therefore her own creations that can be controlled and modulated.

More blocked feelings

Somewhat naively, I expected that once the baby was born Laura's health would improve.

So when she told me, two months after the normal birth of her grandson that the rheumatologist consultant had diagnosed fibromyalgia, I felt disappointed. She was in a lot of pain all over her body and the low dose amitriptyline he had prescribed made no difference.

As she talked she startled, and winced with every painful twinge and rubbed the painful spot with her hands. She said that she could not push the buggy any more because the pressure of the bar on the palms of her hands caused pain. She found it difficult doing her housework. Sally

was about to send her on holiday to Spain where the climate is warmer. She talked about her pains non-stop. She said that they were getting her down and as she said that she sighed and I noticed that both her eyes had started watering again. When I inquired whether she was sad, she denied it and said that she was the happiest person in the world. Only the pains got her down. Her boy friend was not around any more to upset her.

Her inability to contemplate an emotional explanation for her distress left no room for dialogue and I began to experience a sense of helplessness. I did not know what to do to make her feel better. Because she was sighing often, I made a hypothesis that she might be hyperventilating, and that she might benefit from being reminded to breathe with the diaphragm as I had done so many times in the past.

I asked her therefore to lie on the couch in order to observe her breathing pattern. For a few minutes we were both silent and felt calm. I was pleasantly surprised to observe that her breathing was diaphragmatic, and I told her so. I put my hand on her tummy and saw it lifting gently with every breath. We continued the consultation in this position, she lying on the couch, while I sat on my chair by her side. This intervention helped her to relax and start talking about the new baby that was eating all the time and cried a lot. She cannot hold him because he is too big for her. He has a dimple on his chin and he is gorgeous. He understands already a lot of things at eight weeks of age and laughs. Then she talked about Manuela. When Sally was pregnant, she pretended to be pregnant too and complained about belly aches. When Sally went into labour, Manuela gave birth too. In fact she had two babies! When Laura told her that they look too big, she said that mummy's baby is big too!

At this point I intuitively felt that Laura might be identifying with her granddaughter and I asked whether she too would have wished to have had two babies. She thought for a few moments and said hesitantly 'well... if I had not lost that one....' She left her sentence unfinished. Her answer confused me because as far as I was aware she had had two terminations in the past and never a miscarriage. However, I felt that this was not the right time to take up this issue as we had ran out of time. When she left I looked in her notes and found a hospital letter about a termination she had had a few years after she arrived in London from Spain. Interestingly one year later, when she became pregnant with Sally and booked in the antenatal clinic of her local hospital, she claimed that she was a primipara! Eight years after the termination, when her GP told her that a pregnancy test was positive, she became extremely tearful and agitated and produced a hysterical attack. He referred her to the pregnancy advisory service where she presumably had another termination.

I realised then that there was much more than meets the eye, and that the feelings she had had about the possible disaster that might befall Sally's pregnancy were not so radically blocked from her consciousness as her feelings regarding the two terminations.

Discussion

Alexis Brook, in his paper, 'The watering eye: weeping without sadness', reported a link between the complaint of watering eyes and the inability to accept significant losses that occurred in the past. The patients he interviewed denied any feelings of grief and attributed their watering eyes to blocked tear ducts[4].

Ever since I had summarised Laura's medical history 15 years ago I had known the fact that she had had two terminations. However, I had never understood its significance before, nor had I been able to make any use of it in treating her. The documented account of Laura's attitude to her first termination and to the news of her third pregnancy leads me to the hypothesis that she had blocked the feelings about the two terminations from her consciousness.

What might these emotions be? A young catholic woman from rural Spain who became pregnant in London would have to face a choice between the disgrace of having a baby out of wedlock or the guilt of terminating a life. An impossible dilemma. Much easier to disavow the emotional meaning of the terminations and pretend that they did not happen. The exploding twin towers might have been symbolic of the two terminations, but also of her emotional explosiveness, the result of the poor control of her emotions.

It is well known that we cannot process cognitively and symbolically emotions that are blocked from our awareness. The emotions will remain primitive and undifferentiated and, when life events activate them, will be experienced at a somatosensory level as physical symptoms and their raw primitive power will threaten to get out of control, explode and disorganise us[13]. Under these circumstances the mourning process cannot be effective and we will find it difficult to come to terms with our losses.

Follow up

It is interesting that after the last consultation, Laura stopped coming to see me once a month as she had done since 1992. I have seen her only twice in eight months. Despite some stressful events that aroused a lot of anger and precipitated a number of physical symptoms she did not rush to make an urgent appointment to see me. Although I was worried that she might have been frightened by coming too close to becoming aware of the long denied feelings, I was hoping that she had become more confident in handling the explosiveness of her emotions.

In the latest appointment she told me that she had followed the advice of the physiotherapist and had a joined an exercise class. She found practising the slow, ritualistic movements regularly very useful in controlling the impulse to express her emotions in automatic action. I

thought that this was a very positive development towards increasing her affect tolerance and encouraged her to continue.

Conclusion

In this paper I have described a number of consultations with a typical somatising patient who has a tendency to consult many specialists. Her latest complaint was watering eyes since the onset of her daughter's second pregnancy. She attributed this wrongly to blocked tear ducts and denied that she had been crying. Participation in a Balint style multidisciplinary group of eye professionals encouraged me to explore the possible emotional meaning of her symptom. In the sessions that followed, she talked of strong emotions aroused by her daughter's pregnancy that she had been trying to block from her consciousness. I also had a glimpse of possible blocked negative feelings related to denied losses in the past. The symptom disappeared a few weeks after the birth of her grandson but other symptoms took its place.

Making sense of her functional somatic symptoms in terms of emotions has enhanced my understanding of her suffering and has encouraged her to consider me her personal doctor. The continuity of our relationship over fifteen years has counteracted the fragmentation of her care inherent in multiple specialist referrals and has helped contain her anxiety.

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Making the strange familiar and the familiar strange: an ethnographer at work with the Balint Society

Ruth Pinder Ph D

(Ruth Pinder has been engaged in a qualitative research project on Balint work in Vocational Training for general practice.)

Clifford Geertz, to my mind one of the finest interpretive anthropologists of our day, wrote of qualitative – more particularly, ethnographic research:

It is a strange science whose most telling assertions are its most tremulously based, in which to get somewhere with the matter in hand is to intensify the suspicion, both your own and that of others, that you are not quite getting it right.[1]

That process of trying to get it right – or at least not badly wrong – draws on a well known theme in anthropological research: that of making the strange familiar, of learning to think with insider concepts and categories, only to distance them again for the purpose of analysis. Navigating just such a push and pull between strangeness and familiarity animated the research project undertaken with the Balint Society which was exploring different ways of evaluating small group work and the place of Balint within it.[2]

For me the process evoked the giddy feeling of seeing plainly and being all at sea – getting twenty things wrong before managing to get one right, only to get it wrong again as I struggled with the research task of making meaning from other people's meaning.

For members of the Balint Steering Committee, the emphasis was reversed. Initially caught in a positivist methodology, the research took another turn when the educational advisor to the project encouraged them to do some qualitative work of their own in the groups selected for analysis. It meant shifting the focus from the familiar 'is it working?' question of Random Controlled Trials to understanding 'how is it working?' – a matter of opening up things to think about rather than proving unequivocally whether the learning experience was good or bad.

Yet the two processes were complementary.[3] If Balint is a reflexive, dialogical approach to the world that sleuths after complexity rather than shunning it, ethnography is similarly one which pieces things together from a gesture here, a turn of phrase there, to build a picture one didn't suspect existed.[4] Both speak to the open-endedness of life, not to its tidying up. Both thrive on an eye for detail, an ear for human folly. Both demand a confrontation with self-awareness which science

might regard as potentially contaminating. A venture such as this was likely to be a disturbing as well as an exhilarating experience.

Of the many points of convergence and divergence which arose during the study, I must settle for two:

'It's not about thinking in boxes'

was a familiar refrain in the Balint VTS group I visited. It spoke both to a receptivity to new ideas, and to the difficulties of thinking outside our own idioms. Translating ideas across often obdurate domains is a refractory business. Whilst in theory there's no idea which cannot contribute in some way to the stock of human understanding, people operating under different paradigms grasp one another's ideas partially at best.

Paradoxically we're constituted both to explore and expand our store of meanings and to resist doing so. Mostly we avoid those different cosmologies which seem to call the meanings we live by in question, those we sum up under the rubric of 'change'. Constance Perin[5] puts it beautifully: 'The fear is not fear of such challenges for their content alone but for their import: they are signs that embedded meanings could become unreliable guides to conduct'.

In conducting the research, our earlier exchanges were dominated by my keen awareness of the Committee's understandable anxieties about a researcher who was neither analyst nor educationalist – would she really understand? But perforce we were each others' eyes and ears. I needed them to help me figure out what was going on: *'This was what Balint was about, no not that'*. In turn, they drew on my awkward questioning, my apparent talent in making a problem of meaning that had not been a problem. Mentally I kept breaking the rules, straying across boundaries that were supposed to be distinct, and, wayward-like, seeing distinctions where none were intended. Looking at 'take-up', for example, also meant having an eye out for the nature of what was being taught, how it was conceived and transmitted. At times, it seemed, I was the archetypal buzzing fly: more irritant than stimulus.

Imperceptibly almost, stray thoughts became embedded, and we began adopting phrases and ideas from each other. I found myself borrowing one Committee member's phrase: the *'anxiety about Balint wandering'* (evocative metaphor), and calling it my own. The conceptual framework for the research was eventually settled upon after another Committee member had remarked *'I love stories'*. I like stories too. The research material I had been gathering was stories, and the turn to narrative was topical in medicine, so narrative (with a bit of narrative theory)

it became. The quiet comments that began to surface, such as, *'Thanks, Ruth, you make me think'*, or, *'I wish I'd thought of that'*, were music to my ears. Pleasure, too, came from watching Committee members' qualitative research endeavours unstiffen, the percentages disappear. Perhaps the uninspirational nature of much educational and health services research could be given an airing too? It was a lovely – if tentative – blossoming

After all some ideas could travel across domains: the strange could be made familiar. As a microcosm of what was happening in Balint groups elsewhere perhaps, this was where the fieldwork was taking place as much as in the VTS group I was studying.

Identity and difference

'It wasn't pure Balint, but ...' the course organisers said of the VTS group I researched. Hearing this echoed in other Balint contexts, I became attuned to the frisson of anxiety which the acknowledgement set in train. I wondered what was this elusive quality? I was caught, too, by the way Balint seemed to be couched in a discourse of nostalgia and loss, fuelled by anxiety lest the threads of continuity which defined its approach were being whittled away. Half a lifetime of structural re-organisation had also changed the contours of the doctor-patient relationship which gives the Balint approach its anchorage. It wasn't simply a nostalgia for the past: it was a yearning for home.

'What Balint is' calls for definition. To define is to draw a real or imaginary line around an entity so as to bound it, and hence prevent it from blending into some other entity. Meanings need to be homogeneous, stabilised, ironing out the subtle differences of interpretation, which are the stuff of improvisation.

Yet, the capacity to blend into the educational scene in which the Balint approach has played such a key role is necessary for its survival. The 'new' cannot be so new that it is rejected. But hasn't this always been the case? A tradition is continually on the move in the sense that every new contribution to it revises it in the minds of those who come after. The dilemma seemed to lie in deciding what the approach cannot afford to keep and what it cannot afford to throw away. Fixing on a heading for the project, the Committee and I came up with getting *'Just the 'right' amount of difference'*.

I found myself see-sawing between wanting to celebrate the approach's special qualities, and pointing to the many common threads with other humanistic teaching in medicine. The rules of procedure[6] which had been drawn up by the Balint Council were a magnet. How did they fit with what was taking place before my eyes in the VTS group? Whilst Balint certainly had customary and distinguishing features, the 'essence' seemed to elude me. It was tempting to conclude that either I was being perverse or wasn't seeing straight. Or perhaps, like ethnography, the knowing only came with the doing.

Gradually I discovered that the approach was dependent on no single ingredient – even the obvious features, such as facilitation, had exceptions. (And facilitation, it emerged, was less obvious than I'd originally surmised too.) Whilst I only saw one Balint VTS group, the Leaders' groups I also attended suggested that not every Balint group would show exactly all of those features in the same mix. More likely, its unique shape and form lay in the hands of those crafting it, as perhaps they have always done. For me it was more a question of what was done with the features than the features in themselves[7] – one of complexions and shades rather than a precise diagnosis, allowing one to play with it in one's mind, as I have done over the course of the project. [8]If difference is an idea, a concept which automatically implies sameness, as Bateson has it, [9]maybe my intuitive see-sawing which had been so destabilising hadn't been far off the mark after all.

Symbols work because they are imprecise. Recipes can be changed, and as the research has shown, were continuously on the move in subtle ways. Trying to pin things down too tightly in the desire to present a coherent picture of what Balint is to other medical educators is one thing. But to concretise it as a set of behaviours or things that Balint doctors do somehow misses the mark for me. *'You can't attach a thought process to a protocol'* as one registrar interviewed commented as we pondered things together.

For me the difference emerged most clearly in the writing: I have tried to write imaginatively and provocatively. To borrow Michael Balint's words, 'I have only the courage of my own stupidity' in tilting at the boundaries a little.

Has making the strange more familiar for me, and the familiar strange for the Balint Steering Committee in order to see ourselves better, 'changed' us at all? I should like to think so. Perhaps, though, as the Chinese Communist leader Chou-En-Lai noted when assessing the impact of the French Revolution: 'it's too early to say'.

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Editor's note: The background to this Balint Society Research Project was described by Paul Sackin in last year's journal: 'GP Registrar Balint Groups: research in progress'. J. Balint Society (2002) 30: 13-14

15th Michael Balint Memorial Lecture

From Budapest with Love: Meetings with ochnophils and philobats and the use of verbal and non-verbal shibboleths

by Henry Jablonski, MD, MSc, psychoanalyst, Stockholm

Given on 14 April 2003 at the Royal College of General Practitioners

Ladies and Gentlemen,

Let's drop in at the fun fair in the company of Michael Balint. On our stroll I first wish to make a detour through some psychoanalytical entertainment. I will end in some amusements which I hope will be more fitting to the taste of a GP.

Now, we can see that some of the visitors to the fun fair, especially the youngest, like the gently moving merry-go-round, to sit on a horse, or if they are even younger in the lap of one of the parents licking a lollipop, watching the scenery and the other parent blurring by. There is a pleasant excitement in this kind of amusement. But to older children, to youngsters and adults this is a sheer waste of time. 'That's for babies and old people!' So we will take leave of the merry-go-round and the bliss of its passengers. Instead, we will join the more daring visitors. We may divide their fun fair activities into two categories.

There are some machines in which you are violently tossed around, such as a roller coaster with a full loop, or The Flying Carpet. For such trips safety devices are required if you are to survive. You get dizzy, thrilled, anxious, nauseous and other symptoms and changes in bodily orientation. After a trip like this (or several) you stumble out on safe ground exhausted, possibly with some residual bodily symptoms, but relieved and happy. You share the scary and exciting details with friends or parents. Now is the time for an ice cream! Before the next round of wild events....Then there are those entertainments where you yourself are in active command, trying your skills: i.e. at smashing china, knocking down grotesque faces with balls, driving the electric cars, finding out if you are a marksman at the shooting track etc.

How come people have different tastes, including distastes, for attractions? What does it signify in terms of the psychological development of the child (the shift from the gentle merry-go-round on to the roller coaster and the shooting track)? Is the excitement for a certain attraction the same in people or is the excitement diversified? Do these issues mean anything for the pursuit of everyday adult life? Does it have any clinical significance for a psychoanalyst to dwell on these matters? And last but not least: what has a GP got to do with it?

Ladies and Gentlemen, before we continue you may be interested in case you did not know before that on our tour we have run into a lot of ochnophils and a philobats. The words do have a foreign ring. Indeed, pronounced with the proper accent, if you were not better informed, you might well take them for Hungarian...

Two concepts linked to thrills and regression

In short, ochnophilia (a love for solid earth) refers to the wish to cling when you are exposing yourself to a known danger. Philobatism (a love for motility, compare with the word 'acrobat') refers to the wish actively, with the help of your own movements and devices, to expose yourself to challenges and uncertainties. You put faith in yourself; your skills, your equipment and you use other persons as objects/auxiliaries to achieve your goal. Balint saw ochnophilia and philobatism as psychic formations deriving from 'normal' child development, and as modes of coping with psychic trauma.

One has no difficulty visualising, on the one hand, a child clinging to his mother (the ochnophil) and, on the other, the philobat in the toddler going in search on his own. The ochnophil needs the safety of his mother, a firm physical attachment to cope with the anxieties of reality. But in the traumatic aspect of the thrill, the ochnophil in a roller coaster seems to playfully re-enact his traumata of early childhood – the insensitive rocking and the fears of expulsion. The safety-devices are a part of his own anxious clinging to a parental body that wishes to throw him off. (Balint M. (1959): *Thrills and Regression* Hogarth Press London. p 138.)

With the philobat things are different. The philobat child needs his mother as the soldier at the front needs supplies and the MASH in the rear, i.e. when he is exhausted, hungry, wounded or things get too scary.*

The safety devices of the roller coaster are his friends in this great adventure. He tests to see how much he can lean out. And when he is upside down in the loop, he lets his hands go off the bar and stretches them right down: 'I can fly, I can fly – upside down!'

Are there differences between the ochnophil and the philobat with regard to basic trust and distrust? Yes, but it is not as clear-cut as it may appear at first glance. Freud in his essay on narcissism distinguished between the anaclitic (leaning onto) and the narcissistic character types. Though Balint vehemently opposed the extrapolations of Freud's concept of primary

* You may visualise the one-year-old child who runs off in frenzy and determination and would be lost if the mother were not fast to catch him. Here Margaret Mahler made the very interesting observation that the language and the emotional and intellectual development in children were slower in those children who very early developed their motor activity. It is fascinating to speculate that these children use motility as a counterphobic, hypomanic defence against perceptions that other children would try to integrate rather than running away from.

narcissism in its more restricted sense, it is not incompatible with Balint's theory of Primary Love. There are constitutional – not only environmental – differences, precursors that affect child development into a more ochnophilic or philobatic pathway, and also the individual child needs more or less time to move from his ochnophilic positions to the philobatic ones.

The motivating forces fuelling the activities of the philobat also have a dark/defensive aspect that in extreme cases paradoxically merges with ochnophilia. The extreme philobat seems to be obsessed by constantly undoing any clinging tendency in himself. He seems to fear the safe comfortable environment. He feels it is boring, it makes him nervous, indeed there is no comfort to be found in rest. It is as if there were no reminiscences of an unconditional harmonious mix-up, of the area of creation. And this basic distrust in an unconditional mixed-up togetherness fuels an anxiety, a denied phobia against the 'active creative passivity' of life and its merry-go-round-like pleasures. The activities of such a philobat are counterphobic but his unconscious tends to catch up with him in the most devilish way, like in nightmares when we try to escape but cannot move fast enough away from the danger. Whether the extreme philobat will be able to survive his adventurous way of life and calm down, or the unconscious meaning of his actions – i.e. his Nemesis or fate – will catch up with him as he is dying in an accident, is an issue held wide open. So it is a matter of perspective if we are witnessing an expression of ochnophilia or philobatism or both when we see a mountain climber clinging for his life to the treacherous mountainsides of K2.

The life and death of the Swedish adventurer and mountain climber Göran Kropp is illustrative. This man took his gear on a bike from Sweden to the Himalayas (passing through a lot of bandit territory) and finally climbed Mount Everest. Saved from a deep rift in the Arctic ice into which he had fallen when he tried skiing to the North Pole, he later met his death in the US as he tried to climb a dangerous soft rock mountainside which would not hold his pitons and threw him into his last abyss.

Central European roots

Sandor Ferenczi, the closest associate of Freud in his inner circle, the founder of the Budapest school of psychoanalysis and the spiritual father of Michael Balint, emphasised from early on the significance of non-verbal communication, bodily expressions and symptoms, and the motherly aspects of the role of the psychoanalyst. Now Ferenczi made and documented the shortcomings and mistakes of an overly active/interactive approach, but he still maintained the importance of pursuing this track in clinical psychoanalysis. The Balints, and before them Imre Hermann, continued to develop ideas and clinical work along these lines. Clinging and Going-in-Search were concepts formulated by Hermann* in the 1930s illuminating similar issues, as later did Balint.+

The contributions of Hermann and Balint were also the forerunners of the pioneering work of Margaret S. Mahler on early child development. What she called the rapprochement sub-phase, corresponds to ochnophilia and philobatism, the clinger and the explorer, ambivalent psychic features of the growing child.

Now from where would you think Mahler got it? This brilliant teenager moved to Budapest for high school studies and made a best friend, Alice Szekely-Kovacs. The beautiful home of her parents at Sun Hill was the meeting place for a culturally and intellectually avant-garde very creative group of people. Young Margaret was accepted into this generous and stimulating circle where she met with Ferenczi, Hermann and also young Balint. And as many of you know, Miss Alice Szekely-Kovacs became the first wife of Michael Balint.

My impression that I would like to put to the test of this audience far better acquainted with Michael Balint than myself, is that Balint did this bridging between cultures both for didactic purposes and for his own assimilation process into his new homeland. That seems to be the double reason why he devoted so much space in his writings comparing the flavours, the qualities of words and concepts between different tongues, particularly between English and German, but also many other languages, in which he found expressions representing important aspects of the human condition. He rightly pointed out – as later also did Bruno Bettelheim – that the process of translating psychoanalytical ideas from German into English had led to a diminishing connotation of words (i.e. Seele – soul, into mind, Trieb – drive, into instinct) which made psychoanalytic thinking sound more circumvented, kind of conventional academic logico-empiricistic.

It seems crucial to the understanding of the psychoanalytical world of Balint to take this

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* Hermann managed to survive the German Nazi and the local fascist efforts to extinguish the Hungarian Jews and also to find a way through the communist mental oppression. Thanks to him, the psychoanalytical tradition and body of knowledge survived unbroken in Hungary into the post-Communist era. In 1989, an Imre Hermann Memorial Conference was held in Budapest.

\+ Freud for several reasons came to oppose this development. Firstly he lagged behind. Although he stated that motherly love was the primary force to keep the world going, motherliness in the consulting room was certainly not his cup of tea. It is tempting to assume this inflexibility was part of his own basic fault. There seems to have been something deeply unresolved in the early mother-child relation in a man who sticks, or rather clings, to heavy cigar- smoking in spite of his mouth cancer. Still it is amazing, awesome with these personal restrictions and without any other personal psychoanalysis but his self-analysis, and the intimate talks he had with some imaginative persons, principally the Berlin oto-rhino-laryngologist Wilhelm Fliess, that Freud had the sensitivity to see so many important issues in the human soul, though he himself could not personally relate to them. Indeed, he was like a Moses viewing The Promised Land at a distance. And still he wished to remain the primus inter pares as the land was conquered. On the other hand, Freud saw the risk of confusion and seduction by a less "strict" analytical conduct. Again this "strictness" did not stop his own eroticised acting /teasing the adolescent Dora in a critical moment of her treatment, or analysing his own daughter Anna. Still again, Freud's writings do not show the psychoanalyst Freud at work. For instance when you read the verbatim of the Rat-man in contradistinction to the famous essay on him, you get the picture of a lively and deeply committed psychoanalyst, who creates a friendly atmosphere, who is spontaneous, who is afraid of having his family secrets revealed, who is even feeding his patient etc.

cultural factor into consideration. 'The harmonious mix-up' of language, culture and psychoanalysis was lost to him when emigrating from Hungary to England. Many psychoanalysts in exile worked very hard at replanting their psychoanalytical experience into a new soil. Some, like Balint, truly tried to create a bridge between cultures. Others, i.e. quite a few of the American exiles, in order to fit into mainstream America, tried to extinguish their 'alien' central European heritage. (From all the Hollywood movies of the 50s portraying shrinks speaking with a heavy German accent you can see how well they succeeded.)

The position of Balint as a 'British Independent' and his view on the contemporary mainstream

Balint was troubled by a rigid withdrawn, so-called Freudian orthodox psychoanalytical attitude, which was partly inherent in Freud's later papers but which also reinforced its legitimacy by the mechanistic bias of the translation of his writings into English. But he was also concerned with the teachings and practice of Melanie Klein and her followers. He made his criticism in the voice of a good experienced psychoanalyst against the stressing of hatred as a primal drive and the gospel of very early established distinct object relations which would justify early verbal interpretations in a very particular vernacular. He stated that the outcome of such an analysis might be an improvement for the patient insofar as the impact of the original traumatic object relationship was substituted by a hopefully less traumatic one to the analyst, but still false with regard to the oppressed inner self of the patient.*

The dream of genuine love will remain unconscious, locked up at the level of the basic fault, in a sealed room of the heart, inaccessible in such an analysis.

He also says in *The Basic Fault,* that because of lack of courage, he did not want to address this issue further. It seems to me that Balint was too self-critical in this respect. One has rather to consider the good sense of a hard-working man not to launch a quixotic attack on the Kleinian windmills of those days, the results of which would have hardly promoted his message and cause.

The main purpose of the theoretical thinking of Michael Balint, as I see it, is an attempt to visualise and pursue what he saw as the main road of psychoanalysis: treating people in an informed interactive and non-intrusive (he used the German expression *arglos)* way which if successful would allow for the development of the patient's true self. Psychoanalysis is a cure through love, Freud had stated. In consequence, love must be there in the patient – a love that has suffered severe impairment. But the analyst must also amalgamate his intuition and analytical skills with love – a restrained passion, compassion and self-assertion.

A few personal reflections on Balint's theory

Balint stated explicitly that every psychoanalytical theory contains a basic fault bias. To my mind, the emphasis on Primary Love is the great strength of Balint's thinking but also his bias as a theoretician.

The concepts of Primary Love, the harmoniously mixed-up mother-and-child-relation and its connection to the creative area of the baby, all offer an essentially different perspective on child development, early psychic life and psychoanalytical clinical approach compared to the views of the Kleinian and the Ego Psychology schools. Harold Stewart has already pointed out in his overview essay, that Balint did little to link his ideas to other contemporary psychoanalytical formations. In comparison to Kleinian theory it seems to me that the conceptual world of Balint is the difference between a warm, nebulous, steamy, young universe, the Gellert bath of Budapest, a river full of life and love with structures gradually shaping and reshaping – in contradistinction to an Arctic river, where ice-flakes of distinct primitive objects and schizoid-paranoid and later hopefully depressive phantasies are drifting down the icy streams. Balint would rather see the iciness or violence as external traumata affecting the Primary Love state and damaging the development of the budding loving capacities of the child. Certainly in his clinical work, he pulled out analysands from icy waters and helped them discover that their buds were still alive.

Those analysts who are not aware of how their own basic faults affect the analysis, and refuse (for narcissistic reasons) to address this problem, use patients and the psychoanalytical body of knowledge to reinforce their narcissism and to avoid a real life. Both Ferenczi and Winnicott recognised the wish and the need of the patient to cure the analyst – in order to have a useful analyst for his own needs. If this wish of the patient is part of his basic fault, patients risk being stuck forever with a defective psychoanalyst. It will be the love of the patient only that keeps the relation going – most likely a sad repetition of the childhood of the patient (since any person with access to his senses would break away from such a relationship). It is likely that such processes in similar unfortunate circumstances can take place in medical practice generally in some long-term relations as well.

In the world of primary love, a fairly stable and fertile landscape of shores and islands through which the stream flows, will gradually emerge. If the current is too violent or too poor, or running over granite hard rock that adds no particles to the stream, no permanent land formation will take place. If the current is icy cold the inner forms of the child will develop

* Balint describes this process as one where the analyst would actively 'educate' the patient as to what goes on in his psyche in a Kleinian terminology. The patient would have to adopt these forms and expressions to maintain the attention and interest of the analyst – the new parent-object.

prematurely, quickly shaping (and quickly moving) split-off ice-flakes (which seems to be the Kleinian theoretical bias at the basic fault level).

Regrettably for psychoanalytical thinking and clinical practice, Balint did not integrate either the Kleinian or much of Ego Psychological ideas into his theory of Primary Love and Basic Fault. In consequence with the idea of a pre-object state of the child, both a harmonious and a disharmonious mix-up will affect the development. It is inevitable since the baby will not be able by definition to locate the disharmonious influences to the outside of his psychic surface. Such phenomena have by Balint's own definition not yet emerged. Freud expressed in his essay *The Unconscious,* that it might happen that a pain – a disharmonious mix-up – becomes internalised, incorporated (before boundaries between self and the object world are established). Whether there will be enough love and strength in the individual for later gradually sorting out these disharmonious elements (these traumata from within) as alien or partially alien to his true self is the whole issue of a successful analysis. This is also a human predicament that the general practitioner will have to relate to every single working day, in his patients and also in himself. I will illustrate and discuss it in the end of my paper. Still, even with good enough developing conditions, the landscape of primary love will be hit by natural disasters, shaping wastelands and abysses, inaccessible and yet affecting the entire inner world. In some the area of creation will be barred, in others it was never well established since some babies have little capacity for dwelling in this area.

Balint's vision of general practice in society – a comparison with the critique of Ivan Illich

Balint stated that in a utopian future, a citizen for his ailments would rely on his general practitioner, who would help him to assess the situation and, when needed, advise him to contact the appropriate specialist. In the centre there will be a good doctor-patient relationship. This utopia should be within reach in Western societies provided there are good enough criteria for entering medical studies, and a good enough Balint-oriented clinical training complementary to the studies of medical technological skills. The more the technological means at the doctor's disposal, the greater will be the pressure on the doctor from the medical industry, from the institutional dynamics, from the anxious patient eager not to be left with last year's medical fashion. Then to safeguard the medical humanistic heritage, the greater will be the need to foster and promote a friendly *(arglos)* critical attitude in the doctor towards his own profession as an integrated part of his professional identity.

This will help him in his daily work

- not to over-treat
- not to under-treat
- to make a decent adaptation to the psychological potential of the patient (i.e. with regard to ochnophilia and philobatism)
- not to let the relation to the patient cloud the diagnostic thinking, his intuition and professional integrity.

Rereading *Medical Nemesis* after 30 years, I found that the criticism of Ivan Illich stands the test of time. Illich says (retranslated from the Swedish translation p110): 'Before the illness came to be regarded as an organic or behavioural abnormality, the patients could still hope to find their anxieties reflected in the eyes of the doctor.' After having criticised the industrialisation of the medical practice, Illich continues: 'The doctors make themselves the lords of the medical language; the sick person is bereaved of those words that would give a meaning to his anxieties and concerns, which instead are increased by the linguistic mystification of the doctors.'*

The Balint approach is an answer from both within the profession and from an allied outsider.

But both Illich and Balint to my mind neglect 'The Patient as Nemesis' – an important but dark side of medical practice. Some patients seem to be able to take command of a gigantic amount of medical resources with the obvious but of course unspoken aim to achieve a majestic gradual self-destruction. For this purpose, they engage several highly qualified doctors (often at several clinics and hospitals) who reluctantly are led by the patient as The Master Puppeteer to carry out extensive, bizarre, health- and even life-threatening medical procedures with no justification whatsoever diagnostically, nor in sound clinical practice. Competent and experienced doctors are taken hostage by patients using the benevolence of the doctor as a sharp blade against the doctor's own throat, so as to make the doctor co-dependent in their own, sometimes severe, destructiveness and abuse of medical resources. The efforts to cope with some of these cases are enormous. No wonder many doctors and many clinics resort to a 'strategy of sedimentation'. You just let these patients decide to act out, and comply with their acting out. But when you have an opportunity to examine the extent of involvement with such patients you realise Kirkegaard was right. The ship is heading towards a reef. The captain cannot decide – shall he steer to the left or to the right of the reef? And Kirkegaard comments: 'Not to decide is also to decide.'

This minor group of patients still shows something in a magnified way that we may also find in other patients with a less prominent personality disorder. An important part of Balint work consists of discussing clashes and breakdowns. It is needed both to understand the demands of those particular patients, the way the individual doctor is trying to handle the situation,

* In the 19th century drama Woyczek by Bluechner the doctor-patient scenes illustrate this dehumanising change in a horrifying way, and Molière made the pre-industrial mystifying medical subculture the target of his drama satires.

and the consequences for the doctor afterwards. It helps the doctor to see which are the emotional reactions in him that prevent communication. But again, it might be that there is something working more or less consciously in the patient not striving towards a meeting. It wants something else – i.e. to usurp the powers and mandate of the doctor, to make the doctor the alien of his own practice. The same pattern will repeat at the next clinic, with the next doctor – again 'The Patient as Nemesis'.

Adapting to medical fashions (i.e. prescribing drugs *en vogue,* putting people on the sick list for months and years because of burnout) can be seen as milder expressions of the doctor being the victim of this Nemesis. Many billions of Swedish crowns are wasted on useless and potentially harmful procedures in this modern form of the medieval dance with death. They have taken such dimensions that they are acutely undermining the entire health system and the economic welfare of our country. It would be more beneficial to public health (though not to an enlightened society), and more true to the veiled magic of these encounters, to prescribe ground reindeer horns, amulets of Nordic gods and the like. And this is partially what our competitors at the health stores and the gurus of New Age are already doing.

The patients in the borderland between somatic medicine and psychotherapy/psychoanalysis. A comparison between psychoanalytical and general practice

Illich and Balint both pleaded for the personal and interpersonal reflection, verbally and non-verbally. This is in line with the thoughts of Ferenczi. In his articles *Child analysis in the analysis of adults* (1931) and *Confusion of tongues between adults and the child* (1933), Ferenczi pointed out an important gap between a hidden inner language, inner expressions, inner gestalts which are inconsistent with the conscious manifest language. One patient in the beginning of her analysis said in despair: 'I know exactly what is going on inside of me, but it seems impossible to phrase it in spoken words'.

Balint work by tradition is a meeting place between GPs/somatic doctors and psychoanalysts. But it is focusing exclusively on the working conditions of the GP. It is about time to make a comparison between our working conditions.

Generally, those people who constitute the main part of our patients both with the GP as with the psychoanalyst have a strong ochnophil/clinging bias. But in part it is due to the setting. They have a demand on us which artificially can be divided into a more realistic and a more imaginary part. In real clinical life it is like a harmonious or disharmonious mix-up.

In my psychoanalytical practice many patients described and presented somatic symptoms of fluctuating severity, which prior to the analysis frequently made them rush to the emergency room, and which also in critical periods of the analysis made their violent reappearance. To exemplify, these patients describe and present vegetative sensations, magma-like movements and pressures, severe pains or cramps in the stomach or chest, epileptic or epileptic-like fits, pains mimicking severe otitis, nausea and vomiting, chronic diarrhoea, true migraine and other forms of severe headache, muscular weakness. Mind you, I still talk about neurotic patients here.*

My belief is that with very few exceptions only neurotic patients can be helped by psychoanalysis. Yet I believe that the psychoanalytically informed doctor or therapist can do a lot for the psychotic and pre-psychotic patients mitigating their sufferings and helping them to find widened contents and some benign structure in their lives. I also think in psychoanalytical circles the use of the diagnoses of schizophrenia and autism is highly inflated. They are used to describe states where schizoid and autistic/mutistic defences in persons with the inner structures of a neurotic are wordings that give a better idea of the situation – though it makes the successful contribution of the psychoanalyst less heroic and spectacular. Nevertheless, general psychiatry has destroyed many such pseudo-psychotic or borderline patients by declaring a full-scale war on their symptoms with extensive collateral damage of their personalities and capabilities. Also, the grand-scale biomedical experiment without any control by the conventionalised prescription of SSRI drugs for the more neurotic citizens of our societies in the last decade has extended this warfare to include a terrifyingly large part of the Swedish population. Far too many GPs here are letting themselves be used as too obedient mercenaries in this campaign.

Reading Bunyan's *Pilgrim's Progress,* I found in Christian a tormented and demanding person, resembling many of the patients whom we meet in the consulting room who are possessed by anxiety, burdens and bodily symptoms for which we cannot give a proper diagnosis, and even less a lasting remedy. To gain the confidence of a patient like Christian, the doctor would have to find a position combining the qualities of the two allegorical gentlemen Worldly Wisdom and Evangelist who are merged in Balint's expression 'the apostolic function of the doctor'.

To realise the connection between a symptom and its corresponding emotions and cognitive states is usually a long process. Symptoms are alien to the self of the patient, out of touch with the inner language (compare to the footnote about 'the psychotic homunculus

* As a rule, patients fluctuate between words, thoughts and symptoms. We have illuminating reports from psychotic patients on an intestine-like tube containing thoughts/words in its upper part and symptoms/diffuse anxiety/faeces in its lower.

intestine' above). And it is in this state that the patient will present himself to the general practitioner.

As I said many of my patients consulted GPs and other somatic specialists before they started their analyses. For longer or shorter periods of the analyses these somatic doctors continued to play an important part in the lives of my patients. Gradually this dependency was diminished, the calls became less frequent and the use of the services of the GP more adequate. The experienced and Balint trained doctor will be better equipped to meet such patients. Referring to Dr Salinsky's conceptualisation, the landlords or landladies of the Balint enlightened medical inn will be prepared to improvise a welcome to the visitor, and not make him feel more awkward than he already does.

The affective burden of the strong clinger on the doctor may prevent him from relating in an autonomous and friendly way. Then again the philobatic (or counterphobic) patient presents a different problem. Such a patient tries to carry his symptoms seemingly light-heartedly. To him, leaning on another person is an alien phenomenon it itself. With such patients there is the risk that serious medical problems are denied. On other occasions the doctor will meet a philobat cracking up, and the clinging child inside him will show an extreme anxiety in response to some trifle dysfunction. The follow-up appointment will be cancelled, or if the patient shows up, he will not be in touch with what he felt on the previous call.

Whereas psychoanalytical treatment is aiming at gradually, little by little or in leaps, working through the psychic conflicts, including the psychosomatic symptoms of the patient, in comparison as a whole one is justified saying the function of the GP – and any concerned somatic specialist – is ego-supportive. Many a patient will have a sense that the doctor is carrying part of the burden, will continue to do so and that it will always be possible to come back, whether this refers to the doctor as a person, or to the outpatient clinic as a composite persona. We could use the ego psychological concept of permanent auxiliary ego to describe this function. In between the meetings self-healing may occur, initiated and supported by the meetings with the sensible and understanding GP. We do not know much about these processes, these turning points. The Flash is one aspect of it, clash and reconciliation another. They deserve continuous reflection. Since patients come to the GP in more or less anxious states, more or less in crisis, they are more vulnerable than usual to good and bad experiences. Therefore they might also be more susceptible to change. Thus the GP with some patients does such dependency-unlinking work over the many years of contact, similar to psychoanalysis but less systematically, sometimes knowingly, but mostly not. To be self-conscious is not a necessary prerequisite for caring and listening with good judgement....*

I wrote a few years ago in Allmänmedicin, the Swedish Journal of Medical Practice, that the GP is rowing his boat (and doing his fishing) in an ocean, whereas the specialists of various kinds including the psychoanalyst are practising in lakes. Patients burden us not only with the specificity of their demands, and the unwished for professionally restricting reactions that they may trigger in us, but also because these triggering demands are hidden in an ocean of other demands at the surgery. It is not so easy to know even afterwards if there was a particular patient, or if it was the mass of patients, that knocked you that day. It can be a confusing situation depending on the intensity, but it is not always the intensity in itself, I believe, that exhausts the doctor. A knockout punch can be very inconspicuous if you do not have the time and the awareness to look for it. And very few GPs have or give themselves that time. That is to my mind the most urgent reason for a GP of today to be in a good Balint group. In this respect the working condition of the psychoanalyst compared to that of the GP – both with regard to the time devoted to each patient and the deeply rooted psychoanalytical tradition of individual and group supervision – provides a better platform for sorting out these matters and making use of them therapeutically.

The shibboleth in GP and psychoanalytical practice

You will recall from the Bible that the Israelites used the word shibboleth to differentiate between friend and foe. In contrast to Hebrew, the 'sh' sound was not a natural part of Philistine phonetics.

Now, where the procedure ends for the Israelite, it begins for the GP and his patient. There will be a shorter or longer exchange of shibboleths between them before any reasonable course of action can be taken.

To repeat, in general practice body and mind problems are often interwoven, and the sorting out requires a broad and simultaneous awareness and knowledge on the part the GP. The patients themselves generally have very little awareness of the psychological problems expressed by their bodies to the consulting doctor. They are alien phenomena to the self. Let's assume that there is a place midway between our reality and our imagination where the patient says: 'Good morning doctor. I have something in my stomach. It hurts, it makes me weak, nauseous, and at times it is absolutely disabling. It is like an alien.'

We really do not know much from this opening about the self-perception and the intention of the patient calling on the doctor. The GP will have to start from oceanic scratch. Answering, 'Tell me more about it', is just the

*Insight and dependency unlinking is not the main conscious aim of treatment. However, since the good enough GP over the years will find himself (alongside with the prescriptions and routine check-ups) the mediator of such divine mercy to his patients to a higher degree than statistical probability would reasonably grant him, the researcher in him is justified in asking what is his own part in it.

spelling out of the shibboleth. It has to be pronounced to show to the accessible parts of the patient that the doctor is reasonably accessible too. If the GP cannot do that, he had better not ask, and tackle the situation differently. The body examination offers many such opportunities.

As a psychoanalyst I could answer, 'How do you think I could be of help to you? I assume you gave it a lot of thought before you decided to contact me, and probably you consulted other doctors before coming here. Tell me.' From the start there are boundaries for our meeting. I can, gradually interacting with the patient, define the shorelines of the psychoanalytical lake and investigate if the patient is interested in exploring himself in depth there. Other specialists will delimit the consultation in a similar way idiosyncratic to their fields.

What a difference it makes to the GP and to the psychoanalyst if the patient continues by saying, 'Can you help me to do something about it?' rather than, 'I don't want it to be there, I can't stand it. You are the doctor, the expert – you should know how to fix it.' Yet we know this is the expectation of many patients. And the doctor with his medical knowledge and technique is only able to manage a fairly narrow range of aliens in the way that would satisfy this second wish.*

The GP will make extensive efforts to say his passwords, to stay friends, and keep contact with the drifting boat of the patient. It may happen that the shoreline will disappear behind the horizon as he follows the meandering route of his patient. And he will have to listen for further shibboleths from the patient, ...or is it sibboleth? And is the doctor himself answering in the friendly Israelite way, or does he appear as a Philistine to his patient – and to himself? And to complicate it further: who is speaking through the mouth of the patient – the help-seeking patient or the alien, each of them negligent of the other? It is indeed not easy to know out there in the open sea with no landmarks in sight. Again, a Balint group is an excellent landmark.

As an analyst, I do not need to try to keep myself available as a prospective helper over such a vast ocean as the GP. I would pronounce my shibboleth to make it possible for the patient to define my nationality and his own as soon as possible. I would not rule out that the patient is in the wrong place and try to meet him accordingly. 'I am not sure, but there might be some confusion and misunderstanding about your coming here. Let's try to sort things out and see what we can make out of it.' The patient might answer: 'Well, I don't know, Dr A said it is psychosomatic, and that I needed psychotherapy, so he told me to contact you. To me it makes no sense, but since he said so...I thought I'd give it a try. I really must have some help to get rid of this!'

I would answer (allegorically) by saying: 'How odd it may sound, I co-operate with patients to help them get to know their aliens better. Not until then can a person really know whether he wants to get rid of the alien, or if he can come to terms with it. But since it seems that you see your symptoms as bad and meaningless only, I doubt I can be of any help now. A psychoanalyst can only be of use to his patient by helping him to come to terms with his alien, and also other parts less alien but still confusing to him. This is hard work and usually takes a long time, and during its course you may come to re-evaluate matters and relations that you now see as safe and sound. I have no doubt you suffer as the victim of the alien who seemingly without purpose is tormenting you. But a lot of people live like that. Believe it or not, you are not alone. There are drugs that can make things easier for a while; but then again they cut both ways. They might calm the alien but they may also in the long run restrict and alienate you from yourself. You'll risk becoming a "zombie light" without noticing. Adequate medication really requires co-operation with a sensible doctor. Also, when you have an active alien, it occupies your mind so much that you become numb to other matters. For this reason you also need the help of a good GP not to overlook serious medical diseases that may appear alongside or interwoven with the alien disturbances. Also, you may adapt and learn how to live with your pain and misery. You will also have to fight the alien by thinking and behaving differently when you are under attack (autogenous training), working, socialising, encouraging yourself, having hobbies, taking a double Scotch after dinner or at bedtime. And there are periods when you will feel better, so don't loose hope!

In view of this, I am not sure you came to the right doctor. But in any case, you do need a good general practitioner, don't you? Think about this, discuss with your GP, and you are also welcome back here to discuss these matters further.'

The patient might have found this 'sermon' more or less relevant to him. He might return to his doctor with more realistic demands and expectations. Maybe he will think of that shrink as some kind of remote harmless alien or at worst as a devilish spectator of the patient on his road of suffering. But maybe a seed started growing.

The GP will have to tackle the situation differently. There are so many ways in which he may say sibboleth instead of shibboleth. He is the person to say in due time some of those things that the psychoanalyst said during that misdirected referral consultation. But the GP will try to be available to the patient regardless of the patient's attitude toward his alien. Shall he suggest the psychosomatic link and therapy for treatment and risk the patient will feel offended? Shall he suggest a low dosage of Melleril and have the patient at the follow-up accusing him of

* Some doctors might be tempted to promise a cure that will bring relief for a shorter or longer period. Such a promise contains a strong suggestive, and more or less conscious element of seduction. This captivating relationship is fragile, and will either change into an unprofessional relation (true, con or folie a deux) or end in disappointment, and the patient looking for a better doctor.

poisoning him? Shall he calm the patient after a physical examination and ask him to come back in a week and risk the patient will feel he is not taken seriously? Shall he start a medical investigation at a slow pace, non-intrusive, and risk the patient will feel neglected, not given the tests that modern science can provide? Shall he order a very comprehensive invasive set of examinations straight away and/or try out the latest drugs recommended for combat against this kind of alien, and risk being drawn into an escalating warfare against multiplying aliens – like the fight of Hercules against the Hydra?

Without good judgement, clinical and psychological intuition, he will be a Philistine to his patient. Certainly it takes derivatives of Primary Love in both the doctor and the patient to establish some kind of trust and hope to keep the contact going in a mutually constructive and basically non-abusive way. What remains so hopeful with good GP work is that there are many situations which seem hopeless and lost, but still can be repaired and turned into something good. Clashes and subsequent reconciliation between doctor and patient tend to improve the treatment situation and the handling of the (medical and psychological) problems of the patient. In the end both the doctor and the patient will know how to pronounce their shibboleths to each other. These issues, so frequent in daily work, have been illuminated in the best of Balint tradition in What are you feeling doctor? by Drs Salinsky and Sackin.

Concluding words

The Balint group setting will continue to play an important part in the professional development of physicians, not only for GPs, but also for mature hospital doctors who sense the complexity of the disorders of their patients. Modifications of the Balint group will be important for medical training. The contributions of Michael Balint in the intertwined traditions of the Budapest school and that of the British independent psychoanalytical tradition will hopefully play a role vitalising the psychoanalytical practice. In both these aspects we have an important heritage to benefit from and to develop.

So I raise my glass to the memory of Michael Balint: 'Egésségedre, Balint Mihaly, and thank you for the music!'

On making a decision

by Mike Brearly, psychoanalyst and former England cricket captain

A talk given to the Balint Society on 25 March 2003

This piece has grown out of a talk I gave in Cape Town last year to the 'elite' panel of cricket umpires on the subject of making decisions. Tonight, I'm going to try to give you a rather more analytic version of this.

In that context the question mainly was: what are the kinds of psychological obstacles that stand in the way of accurate decision-making in situations where authority has been given to be the judge, referee, or umpire within a system of laws or rules? Making a decision in ordinary life includes much more, of course – not just a judgement about conditions being met according to rules, but also the whole field of intentionality.

Tonight, however, I don't have time or ability to widen the discussion to cover all this. I will instead (1) offer you a condensed and modified version of what I said in Cape Town. And (2) try to consider more fully some of the processes that impair truthfulness, integrity and open thinking in the analyst when working with certain patients. I hope thus to link the kinds of pressure on the umpires with the kinds of pressure on the analyst, and specify more accurately what this pressure consists in. I will also be saying something about the inner struggles to maintain or recover a state of mind from which to think clearly and come to a decision that expresses our honest conviction.

So, I'll start with some of the points I made with the umpires. One of the crucial things for an umpire (or judge), as, indeed, often for the psychotherapist, is gaining the respect of the participants. Respect doesn't come with the office, or because of past pre-eminence. Deference is a dead duck. We live in a more questioning, challenging, envious, litigious society. So how is respect earned?

For the umpire, it comes first and foremost from good decisions. Players trust someone who gets things mostly right. But it is also earned by an attitude lived out by the umpire, an attitude that communicates such qualities as honesty, impartiality, fair-mindedness, integrity, directness, and openness. It is important to cultivate in oneself a love of truth and justice. When Dickie Bird gave me run out in a Test match at Birmingham in 1978, he came closer and closer in towards the stumps from square leg as the ball was thrown in from the boundary. When he actually gave me out, he must have been no more than seven or eight yards away. What I noticed was the grin on his face. But I did not feel that it was a sadistic grin, or a grin of triumph; rather it was the expression of joy at having seen clearly and truly the truth. When players get a sense of this kind of attitude, then they will give the umpire the benefit of doubt in marginal decisions. They complain less at his mistakes. They know that he will be consistent. There will be fewer shenanigans from them, less acting up, deviousness, and pressure. A benign cycle will occur, rather than a malign cycle. The umpire's integrity will lead to respect, will lead to less pressure, will lead to better decisions, will lead again to a deeper respect. (In parenthesis, all this applies too to the doctor or therapist).

Integrity, then, leads to respect. But I want to go further. I want to argue that integrity is part of making good decisions too. But here I am referring less to fair-mindedness and impartiality, more to a range of qualities, which include the capacity not to split or deny difficult realities, and the ability to tolerate anxiety. These are qualities that function at a deeper level than simply being unbiased. There are many unbiased umpires who are nevertheless bad umpires. Bias includes corruption and dishonesty of which the umpire is aware. But there can also be a deeper dishonesty or lack of integrity (sometimes even corruption), of which the practitioner is unconscious. This latter failing might well result in mistakes that are equally distributed between the two sides.

I want to go on to speak about situations where umpires may succumb to pressures (from players, crowds, media exposure, even from the game's administrators; or indeed from within the umpire himself). Such a succumbing leads to impulsiveness or panic – both of which are parodies of decision-making.

Here is a personal account from one of the umpires in the seminar. In the first over of a big match, there was a huge appeal from the fielders to him. Like the players, he had had no time to acclimatise, to get used to the behaviour of the ball, its bounce, its degrees of movement. In the face of this sudden demand on him for a decision, he panicked, and in his panic, his spontaneous sense of his own perception was scrambled. He had no clear picture of the event that had just then unfolded before his eyes and ears. He felt totally paralysed; in effect unable to make a decision. There is a fail-safe way of dealing with 'don't know' cases, as in the law; the batsman, like the defendant, is presumed 'innocent', or given the benefit of the doubt. But here the umpire was not in a state to be able to decide that there was doubt, he was unable to come to a proper conclusion at all.

Here is another example from my own experience. Many years ago, I was batting in a representative match abroad in front of a large crowd. There was a loud appeal from about 40,000 people, as well as from the home side, and the umpire gave me out, caught at the wicket down the leg side. The ball had in fact hit my pad, not my bat. Later that evening, the umpire was honest enough to send me a message, in which he

said that he was very sorry about the decision, but he felt his arm going up and couldn't stop it.

We may laugh, but I think that all of us, in everyday life as on cricket fields, know on occasion something of the feelings that led in one case to paralysis, in the other to purely reactive, impulsive behaviour. However much we have generally mastered these tendencies, we all know them in ourselves. Afterwards we are – if we think about it at all - nonplussed at what we did, or failed to do; at the states of mind which led to such desperate confusion. We feel that the way we acted didn't really come from us, in a personal way; we don't recognise it as fully ours, we acted out of character. We react, rather than respond. We 'lose it' in the same sense that we 'lose' our tempers. In the phrase of the philosopher Ilham Dilman, author of several books on psychoanalysis, we 'are not behind our actions'.

In both cases – impulsive reaction and paralysis – what we temporarily lose might be said to be our minds, our own selves. We lose our 'presence of mind'. The umpire who felt his arm going up became a puppet, dangled by the crowd and his own excitement, an automaton. He lost his capacity to make a proper decision. And the panicked umpire, also shocked by this demand for which he felt unprepared, was in a panic, and unable to perceive. On another occasion, each man would have seen clearly, reflected on his impression, and if necessary replayed the action in his mind. Each could have seen properly for himself, and based his decision on that. Instead, a passive emotion took over, either a drop into a frozen, paralysed state, or a rush to a compulsive act.

Pressure on umpires comes from players, crowd, media, and above all from inside themselves. Pressure also arises from the media, who as ever prioritise stories or narratives featuring goodies and baddies – and when it comes to umpires there is more mileage to be made from a story about an incompetent or 'bent' umpire than a story about a good one. And of course there is also technology, which has led to situations where the whole world knows a mistake has been made except the umpire himself, or where he along with the crowd immediately learns of his mistake from the large screen on the ground. The impact of technology is bound to create anxiety among umpires. The umpire fears being exposed as second-rate by replays, especially by those shown instantly on large screens on the ground. Mistakes, which are inevitable, now become immediately verified and public. And there must be apprehension about being made redundant, or a mere cipher, by the relentless march of technology.

Imagine this scenario: There are several appeals over a short period of play. They are respectable appeals, but all are turned down by the same umpire. Bowler and fielders get more and more frustrated, incredulous, angry and scornful. Such behaviour is partly the natural expression of emotions. But we all know that it is also meant to make the umpire feel bad, both as punishment and to soften him up for the next appeal. When I say 'meant', I include situations where the fielders aren't aware of this intention. But as observers we would recognise that it is there. Such behaviour is not only emotional expression, but also emotional action, and as such, it has a tendency, when directed at umpires, to affect them.

How is it likely to affect them? One possibility is that the umpire reacts angrily, either with a hostile look, or with a longer-term stubbornness. He may then refuse even valid appeals from then on. Such behaviour by the umpire tends to elicit further bad feeling and bad behaviour from the players. A second possibility is that the umpire becomes upset, offended, taking on the view of himself that is being expressed: he feels incompetent and worthless. He may then appease the fielding team, by giving the next appeal out, or becoming falsely nice. Or again he may become wooden and unable to function properly. This too elicits more acting up from the players, who are astute at sniffing out weakness or vulnerability and ruthless at exploiting it. He may too continue to be his own man, and decide things for himself without being influenced in any of these directions.

There are of course other modes of applying pressure. Players sometimes use the opposite tack. They flatter, congratulate, playing a longer game. The aim is to get the umpire to feel that he and the bowler are much of a mind. 'I am not the kind of bowler to insult your intelligence by appealing unless I'm pretty sure it's out, and then, Mr Umpire, *mon cher confrère*, you will of course agree.' This is a less crude pressure, but nevertheless real - a kind of seduction. We are all vulnerable to such flattery if it's subtle enough. In one series, I was surprised to hear my opening batsman colleague Geoffrey Boycott address the umpires as 'Sir' when asking for guard; I was even more struck by the number of times he was given not out.

Another kind of pressure (which I have alluded to) enters because of the stage of the game. Another concerns the status of certain players. Umpires are as aware as anyone of the crucial nature of some decisions. It is harder to give a key batsman out than a nondescript or incompetent one, for such a decision makes more of a difference, and is more liable to rankle with players and crowds. Depending on their characters, umpires may opt for safety first, and give the key batsman not out, or refuse all appeals until later in a match or lower in the batting order. Others, priding themselves on their independence, do the reverse, tending to draw attention to themselves by giving the prime batsmen out.

Umpires like judges have to realise that their task however hard is bounded by rules. They need to limit their focus; the umpires' task is not to even out bad luck, to balance out earlier mistakes or even to forestall riots. Nor is it to

curry favour with anyone.

As we have seen, pressure comes from outside, and increases along with technological advancement. But in the end, potential pressure becomes realised only if it receives some echo from inside the umpire's mind. For it to become a factor, it must, as with trauma, have some impact on the individual. As human beings we are all liable to be affected more or less by the kinds of pressures I have been alluding to. But the important thing is the 'more or less'. For it is possible to become more sincere and honest, to thicken one's skin (without becoming impervious) and to focus on the job in hand.

There are people for whom felt pressure comes more obviously from inside themselves. For instance, some of us have an attitude to ourselves that converts a minor mistake into a wholesale character defect. We are in effect reduced or destroyed by our own severe self-judgement, which must actually also come into play also when the obvious pressure is from outside. There is also the opposite situation, when an inner voice tells us that we are perfect, infallible. In relation to umpires, I suppose this might lead him to decline to call for the assistance of the third umpire and the camera, to adjudicate on a split-second run-out call. The elite panel of Test match umpires have been chosen because such tendencies are less thorough in them than in lesser umpires. But we are all liable to such reactions at times, even if in short-lived ways. Is there a recipe for keeping one's presence of mind when under pressure of one sort or another? Can we free ourselves reliably to focus on the world without distortion, without a drop into mindlessness?

I doubt if there is a recipe. It seems to me that there is a life-long struggle to maintain one's integrity and independence of mind when threatened, seduced, appealed to, and distracted. Each person may find his own helpful image or talisman. Fellow umpires may help at times. Training and experience are invaluable, though nothing guarantees that even the best umpires won't find that certain situations or people shake them to the foundations. Personally, I find it helpful to recognise and give intuitive shape to the pressures, meant, often, to fluster and disconcert. The fact that we can, with part of our minds, recognise this and our own tendency to react in one way or another creates an area of freedom in our selves, rather than falling into an automatic (or even automaton) response.

In the end, it's a matter of integrity and an unclouded mind that count. No one can make decisions except we ourselves. We rely on who we have become, or the better part of who we are. The analogy for the therapist is clear. The job is to keep to one's role, but be open to all the conscious and unconscious projective identification from the patient without panic, compliance, or loss of mindfulness. We have to struggle to retain our inner capacities when there is psychotic pressure on us not to think. Or, since no one is exempt from such impact, we have to develop the capacity both to recover from shock by re-finding the space to think, and come to understand the patient better in the light of such projections.

I will now turn to my second topic. Here there are several routes I might take. What I've decided to do for this paper (and making this decision was not easy, and arose after several false starts) is to give some more analytic account of some of the processes that interfere with the mindfulness required for thinking with authentic feeling, and hence to making decisions. I shall make use of material that I have combined under the heading of the treatment of 'special' patients. I shall leave aside the issue of what, if anything, makes this a coherent group, in order to have the time to attend to some of the inter- and intra-personal processes that so disrupt our capacity for making up our minds.

We all share the wish, and sometimes the demand, to be 'special' whether as patients or in everyday life. We would like the world to fit in with our views of ourselves, bolster our self-regard, and make exceptions in our own case. When anxious or panicky these tendencies increase. The pressure created by these desires (which often amount to demands) on the analyst will be to get him to join in with the patient in one of a range of interactions which reflect the state of the inner world of the patient. We are to be omnipotent or all caring to our child-like patient; or perhaps to become erotic, intellectual, sadistic or masochistic. In analysis, such wishes and demands are the stuff of the process; the analyst's job is to interpret resistances. Towards the end of the spectrum of narcissism, however, the demands are much more insistent; far from leading to reflection and working through, interpretation intensifies them. The analyst's stance is attacked, including his proper neutrality. Special patients come in various forms. The type I wish to speak briefly about fits in with Main's and Freud's examples.

One ordinary scenario in a Monday session is that the patient seems cut off from any needs, especially in relation to the analyst. In the material, it is others who are uncomfortable or have feelings of being left or abandoned. We hear about others, possibly representing the therapist, who have been abandoned. Someone else has sexual feelings, perhaps towards the patient.

The special patient is likely to annihilate need more absolutely. There may be an almost anorexic lightness, as if she has fed herself and is totally self-sufficient. There might be reference to others being admiring of and grateful to her, and/or behaving cruelly. The best possible light is put on the patient's own state and behaviour in her various activities and thoughts. She speaks with authority and conviction; there is no question of her being wrong. Her thoughts are insights. She tell many intricate stories, each populated by numerous people known to her, whom the analyst feels he's assumed or supposed

to remember by name and by biography.

This psychic situation is in place on her arrival at the consulting room. It has served a defensive function over the weekend. By means of projective identification, the special patient has been enabled to move up into a position of immunity from need or discomfort, even to a sublime superiority. She thus rids herself of any sense of lurking or incipient anxiety (for which the analyst may have evidence from previous knowledge of her). If we consider where in her inner world the anxiety has been put, the answer may be, in part, into her internal analyst. She has become the teacher, parent, therapist; the analyst is experienced as the child, adorer, personal assistant, or cleaner. The relationship for the session has been prefigured, and the projective identification has already served an important purpose. She feels of course complacent in this inner arrangement. In the session itself, it would feel appropriate to her if she can bring the phantasy to actuality. How exactly does she do this?

In the session, if she simply has to live out the part she has already in phantasy occupied, her analyst is bound to be treated patronisingly as prescribed by the inner screenplay. Whether she has to do no more to actualise it or 'make it congruent with' her phantasy, depends partly on how he responds. The patient may feel nothing more is needed.

If for instance he signs up to one or more of the roles assigned to him, it may be that the patient can go sublimely on without insight. On top of the initial success of the projective defence in removing anxiety, she will also have enlisted him (as shown by his compliance) to support it. He may be secretly infatuated by patient; or envious and admiring of her conviction (in contrast with his own uncertainties). In this case, he is liable to think that any unease that does arise in him is due to his own inadequacies, and that the patient is strong and doing well (is in fact better off than he is). He fits in with the scenario in a self-effacing, masochistic way. The patient is delighted and may feel no need to do more to actualise the situation. Nevertheless, having established a bridgehead, she is likely in future sessions to increase her demands for special attention and adoration. The analysis will, of course, remain stuck. One reason the patient may need to intensify the situation is that if one aim is sexual, this initial success will only whet her appetite. Another (more healthy) reason may be that she needs her analyst to be much more uncomfortable if he is to get any sense of the scale of her anxieties over the week-end, as well as her early experience as a child of being and feeling rejected or abused.

The analyst may also fit in with the patient's scenario if he becomes overtaken by irritation with her for taking up the whole space, and for her contempt, and unable to keep himself open to thought. He may push back the bad feelings into the patient, or become stiff and unable to think from the effort to repress his sadism. Either way he is now fitted into the scenario in another, more sadistic way.

If he is impervious to the force and logic of the text which informs her being, she may again feel everything is fine, that she is not being in any way challenged about her apparent state. (Though again this may not satisfy her for long, as she may need unconsciously to create palpable discomfort in him.)

Let us return to the more promising possibility, Let's say the analyst registers the impact of this drama (feeling uncomfortable, perhaps in some way resentful and put upon) but has the psychic space to think about it, and to begin to formulate thoughts about the origins of it. Furthermore, he then registers the emotional, intra- and inter-personal situation, and frees himself enough from the discomfort. By reflection and self-analysis, he finds over time some way of addressing it straightforwardly to himself and to the patient. He ceases to be the patient's puppet, whether servile and adoring or retaliatory, or paralysed, and becomes again her analyst. What happens now?

Again, there are different possible kinds of response to this threat to her defensive configuration. The patient may be able and willing to see that there may be some truth in what has been said. This part of her may be able to bear more of her own anxiety, and want the analyst to help her understand more of what goes on in her mind. In that case, it will be her turn to reflect, to countenance her emotional moves, and to further the process of self-awareness.

But with the patients I am concerned with, any momentary or short-term realisation will often quickly be repudiated, and they will feel the need to apply further pressure, by words and attitude, in order to force home the projection. Here I will condense for the purposes of presentation what may take many sessions, weeks, months, or even years to build up.

The special patient cannot allow the analyst to keep an independent mind. She feels she has to shake him out of his neutrality. All may be well, she claims, if he will only show that he really loves her. How else can she trust him unless he goes beyond the bounds of his interpretative stance? Why must he stick to this rigid technique? How can he be so heartless? The ball is in his court. Why will he not help her? She requests a 'timeout' from the analysis, in which the analyst could tell her exactly how he feels towards her; then the analysis proper can resume. She complains that he is two-faced, and despite his apparent thoughtfulness, he is the one to be envious or vengeful. She may, accurately or not, accuse him of paying too much attention to her defensive activity, and not enough to her emotional pain and dependence (which have in fact been so quickly disowned).

In fact she may well be envious of the analyst's composure, and wish to disrupt it, as well as reject any truth in what he says. She will

be unable either to tolerate the (mounting) guilt involved in knowing about her wishes, and about her tendency to compulsively force her bad, i.e. humiliated and angry, feelings into him. And she may refuse to give up her sadistic excitement. She may fear incestuous elements in her expectations of intimacy. She will also be anxious that the 'bad' analyst, filled up with her projections and therefore, no doubt (she feels), himself sadistic, will rub her nose in it if she offers a hint of repentance. All this leads to the need to further intensify processes that are already predominant in order to achieve the congruence that Feldman refers to.

To make her position cast-iron, the patient makes use of rhetoric and propaganda, in the most extreme cases stopping at nothing in discrediting and sneering at the therapist's attempts. Language can be used in Machiavellian ways, to control, strip of self-regard, and make abject. By this point the patient has become the rampant phallus, in the grip of an internal gang (Rosenfeld). Excess and cruelty increase unconscious guilt (cf Macbeth), and hence call forth increasingly systematic ways of keeping it at bay. All access to her vulnerability is closed off by fear and by her own propaganda, and she becomes more superior and self-righteous. In such moments, the patient works herself up to a near-delusionary state, identified with a murderous superego whose verdict is that the analyst has no right to exist. (Again there may well be a more hidden message which can only be conveyed in this primitive, split-off way – that it's only by these means can she communicate her earlier utter helplessness as a small child with no one to turn to from abusive parents.)

By now we are no longer simply in the world of defence against uncomfortable experience. There is also the mounting excitement and pay-off in sadistic superiority. A drama has been created in which the roles have become fixed. She is compelled to perpetuate the delusion of superiority and the humiliation of the object (in this case, the analyst). At the limit, the latter is now needed (and retained) only in order to be tortured (and/or to torture her). She is in the grip of perversion, both in the old sense of corruption of the truth, and in the newer one of the excitement of cruelty or suffering. She somewhere knows that her position is not true, that a truer account has been replaced by a cruel version in which she is nothing but the victim of cruelty at the hands of her analyst, but she would utterly disavow such knowledge.

Along this painful route there have been many forks, for analyst as well as for patient. How has the analyst reacted? How should he react under this kind of pressure?

Again, I will condense. He may become mesmerised by her rhetoric, and feel he is simply inadequate. Such an outcome is more likely if because of envy and admiration for her paranoid-schizoid licence, her intellectual range, and her rhetoric he denigrates his own capacities. When this happens he becomes neutered rather than neutral. An important part of the struggle will have to be with his superego. If the projected qualities chime in with this internal harsh view of himself, he really will feel that nothing he does in the world is of any value. Perhaps we all have to suffer mini-breakdowns as recipients of such psychotic and perverse processes.

Certainly when faced with this kind of massive and cunning projective activity, we are bound to enact some or other of the pathological reactions, according to our personalities, whether masochistic compliance, or sadistic retaliation. If however the analyst can analyse himself as well as the patient, he may be able to recover himself sufficiently – and repeatedly enough – not to reject the poisonous food, but to digest it without becoming reduced to a self-less conglomeration of retaliatory, or adoring reactions. Thus we regain our neutrality and capacity to think. We will also need to work to find other routes to engage with the patient without provoking her too far. We may come to recognise the kinds of situation that set off her fuse most. The recovery of empathy with the patient, not only with her suffering, but also with her compulsion to deal with it in her specific way, is vital. The analysis may be rescued even now, or the patient may be helped to make the best possible ending in the circumstances.

Different but similar dramas may be created. One patient oscillates between the dramatic intensity of the sadistic position with that of the masochistic. She prefers the simplicity of humiliation or outrage to the more complex reality, which however includes painful elements like loss, jealousy, hatred, and guilt. Fearing she will be left with nothing if she gives up the old dramas she clings to, she invites her analyst to be prosecutor and judge, to beat her, and thus by exciting her keep things as they are. Again the task is to fight for one's neutrality and independence.

Being someone for someone

The Balint Society Essay prize 2003, joint winner, by Oliver Samuel

Getting it right is hard. Tom Main once described GPs as being "in the front line"[1] and at times that warlike metaphor seems just right although usually practice is much more benign. Family doctors have to learn technical skills and how to be able to respond flexibly with all sorts of problems. So much happens in the consulting room that is unexpected, and sometimes it is hard to know what to do. When first I worked in general practice, I was often out of my depth with patients. Their troubles did not fit what I had been taught. So, in groping around for some help in finding out what I was supposed to be doing, I joined a Balint group. Even there, I found very few answers but the members were very supportive and, more than that, we found ourselves empowered to try out ways of working with patients that would not have seemed possible before. Here is one case that I presented (almost thrust on) the group after I had been a member for a couple of years. I remember every detail like yesterday.

On being (almost) a husband:

She was aged 30 and had been married happily for five years. Her gentle and conscientious husband was an office worker. They had been patients since they moved into a flat nearby shortly after their wedding. She had come initially about painful periods but sexual anxieties and non-consummation emerged all too easily as the real problem. At first I felt at a loss to know how to deal with this but, with the group's encouragement, suggested to the patient that I should examine her and show her how to palpate her own vaginal introitus and so learn more about her own body. While doing so we talked about some of the fears she had about sex. The sessions were uncomfortable for both of us but therapeutically successful, for after our third session she told me that they had achieved normal sex and subsequently she became pregnant.

I had recently read *Virgin Wives*[2] and it had alerted me to the problem of unconsummated marriage, a topic I had never heard discussed before. So I had started to notice previously undiagnosed sexual problems, but without having too clear a notion of how to deal with them. I had great reservations, as a man, about following the author's suggestion of trying to combine vaginal examination with verbal exploration of feelings and fantasies. It seemed fraught with difficulty. I was a male doctor acting out penetrating my female patient on the surgery couch. But the patient was desperate about her situation and it seemed worth a go. At the time I felt extremely uncomfortable, almost a usurper – as if, rather like a medically qualified Count Almaviva in Mozart's *The Marriage of Figaro*, I was exercising the '*droit de medecin*' perhaps. After this initial foray into sexual medicine, there followed many other patients with such problems and helping them was never quite so difficult. The group had helped me to tackle an area of which initially I was virtually unaware and for which I then sought some further training.

My later cases in the group may have been more mundane but no less stressful. I believe that a Balint group can serve each member in different ways, enabling every one to learn whatever skills and attitudes are personally relevant at the time. As Enid Balint wrote[3] "....they can get in touch with feelings in themselves about which they have been unaware and which may enable them in due course to understand something about their patients which they would not have been able to do, had they been out of touch with their own feelings and the seriousness of them."

I went on taking a particular interest in people who seemed in some way out of the ordinary after I had stopped attending the group. I noticed my kind of 'special' cases were often ones in which I found myself playing a role in relation to the patient that was in many respects different from normal day by day doctoring. So when a case grabbed my notice, or if I found myself making some kind of unusual or different relationship with a patient, I made it my regular practice to start thinking about what kind of person that patient needed me to be. Not all 'special' cases were difficult. Doctoring is often both rewarding and good fun and often my required persona was simple and obvious. The children who consulted with their mothers seemed to regard me as a kind of extra uncle, who gave them sweets and tickled them with a stethoscope or whatever. And often enough they gave me a sticky cuddle in return. But it was not only with children that I found that I was taking on a family role.

On being a big sister:

She was in her late twenties. She worked up in town and lived locally in digs. She came in for smear test and to discuss contraception. But having dealt with the technical aspect, she was obviously flustered about all the shopping she had brought in with her. So she started showing me what she had bought and discussing what clothes she would wear with what. I must have demurred a bit as we then moved back to the original reason for the appointment and she told me about her boyfriend and her mixed feelings about the relationship. She told me that she was an only child and was away from home and in a new job and had no one to talk to about such things. She dried up a few tears, blew me a kiss and was off.

One cannot think of a more intimate physical examination than that provided here. But I hardly knew the patient as a person. We started with the doctoring, but then moved on to more

loaded issues. Her opening gambit seemed, at the time, to be more woman to woman than patient to doctor. Or maybe, having allowed me, literally, to look at her inside, she wanted to let me see her more personable interior, so we looked in her shopping bags as she flirted with all her new clothes. This led to her feeling able to open up about interpersonal problems and to talk about her sexual feelings. But it was the farewell kiss that said it all. It seemed to characterise how we had been together – technical but sexy, and dealing with shopping– a feminine interpersonal agenda. I felt like a sort of older sister, intimate and allowed to know, close, concerned but not too deeply involved. But was that in part my reservation against allowing a more intimate response? I never felt quite certain. My relationship with her stayed friendly and very personal until she and her boyfriend married and moved away.

On being a nephew:

She was a lovely lady, aged 82, living alone in a small house with rather steep stairs. She had been widowed for 20 years. Her daughter lived about half an hour's drive away and was concerned and attentive, albeit in full-time work and not always available. My patient was rather overweight and had severe arthritis. So she was housebound and neighbours did her shopping. She was charming, always grateful and much loved.

I have never undertaken regular social visits to the elderly, but happily accepted the slightest reason to come and visit here. We would deal quickly with the medical matters and then chat about her family and about my family. After a time I realised that I always reported my own family events to her and she took a real interest. So she had become a kind of extra grandma to my kids and I seemed, if not quite a spare son, then at least an honorary nephew.

I know that being unable to go out of the house had severely restricted her life, but somehow I never felt sorry for her while visiting; more privileged to know someone who is able to stay happy and apparently contented despite considerable disabilities. But was this really true? Perhaps the cosy relationship that had grown up was stopping me from asking about other discomforts in her life. I knew nothing much about her past, or about her husband or background. None of this seemed to matter, for her present problems were being housebound and socially rather isolated and suffering from painful arthritis. I was able to help her with just these problems so for the time being the dose of doctoring would seem to do. I remember this patient particularly because my role as a doctor, though never interrupted, was complemented by my unexpected personal familiarity with a lovely old lady — easy to sustain and comfortable to live with – and it seems to have served the patient well. Thinking about it now, I wonder how much at the time, I may have wanted her approbation and interest to serve my own needs. Perhaps at that time I may have needed an extra someone to be my auntie and to be interested in my family. We certainly 'clicked' and were both happy with the extra social dimension.

We all make many relationships starting, for sure, in infancy and this background of experience provides the structure on which new relationships are formed. As a family doctor, I try to offer patients an open-minded and neutral face for them to react towards and I take my cues from them about how they need me to behave. Sometimes the patients' expectations are unacceptable; collusion must nearly always be avoided and dealt with by offering an alternative but hopefully helpful response. But quite often it feels alright to be the kind of person that the patient wants to relate to. Such thinking may be like the psychoanalytic notion of analysing the counter-transference, but I think that I am describing something that is mostly more superficial and social. A psychoanalyst will try to be apart from the patient's world, so as to be able to reflect entirely on all the material that the patient offers. For a GP such remoteness is entirely inappropriate, for a family doctor works within the community and may be part of the patient's social and cultural life too. My kind of reflections about how I perceive the role I am to play with my patient often incorporates ideas about their social setting as part of trying to understand the emotional aspects.

Are such perceptions valid? Unlike the 'flash'[4] – in which the doctor and patient are supposed to have a magic moment of mutual understanding that changes their relationship – I have no expectation that the patient will be aware of my way of thinking about them. The normal role of the family doctor is to provide technical competence, medicine and sympathy in appropriate doses. My personal aim goes further and is to enhance my own perception of the patient's needs so that I can react in a more meaningful way and with greater tolerance. If this approach allows some patients a better deal, then that is a sufficient justification. But although it is true that being sensitive and empathic can lead to new kinds of understanding, you can also get it wrong.

On being a dog:

She was a brusque Northerner, far more professionally successful than her husband who always seemed to be the more feminine of the pair. She consulted me about a lump in the breast that turned out to be highly malignant and had already metastasised widely. I had referred her for rapid full investigation and was now meeting to discuss the findings.

I believe strongly in being open and honest with patients and in sharing important medical decisions with them. So I was surprised when she opened the consultation by telling me that she didn't want me to tell her anything. She told me about the tests she had had and said that that was the end of the matter and please would I

not refer to it again. I must have got it wrong because she left the room, made an appointment to see another partner in the practice and asked him to take over her care.

About six months later she asked me to come and see her at home. She looked ill, but was still as sparky as ever. She just said she wanted no discussion but would I now take over her care again. So I did. And without explanation did all that I could to keep her comfortable until the end. Her husband later told me that she hated me but had confidence in my technical skill.

My preferred mode would have been to talk it though and try to understand, but she had a different agenda. She needed to split off what she couldn't allow herself to know and then she left me holding it. I felt that I was being blamed for giving her cancer and was certainly someone to hate for her having it. Yet curiously enough, when at some level she knew that she and her dreaded secret could no longer avoid being put together, I was allowed back. I was clearly no part of this family circle and had to be muzzled before being let in again. I felt as if I was the family Alsatian – to be kept in the kennel and only turned loose around the grounds after dark.

I have been describing my private way of thinking about my special patients; those with problems that still hold a place in my memory. Initially these were the sort of cases that I presented in my Balint group – an experience that played such a useful place in helping me to climb the steep learning curve out of hospital medicine and into general practice. But the trick has stayed with me, of puzzling about what kind of a person particular patients want me to be. Not all patients are lovely or even pleasant to care for and sometimes the kind of relationship that develops can be both close and uncomfortable. The final case shows how this worked to help me cope with a really difficult pair of patients.

On being mother:

They were an elderly couple who had moved into a small bungalow as arthritis had made the stairs in their house intolerable. She was a couple of years older than her husband and had been somewhat demented for a while. But for years he had looked after her, cosseting and fussing round to make sure that she had everything she wanted.

Their daughter brought their medical cards in to book them in as patients and our very bright registrar went out to visit them. At first all seemed well, but then came a never ending stream of requests for urgent home visits, often several times in the same day. The doctor went in repeatedly but to no avail and, most unusually, she asked to be taken off having to see them. She couldn't cope with the incessant demands.

So I took over their care and became a regular visitor. What had happened was tragic. The old lady had been highly dependent and totally demanding for years and her husband had lovingly responded to her every whim. But now he too was losing his short-term memory. Every time his wife said she was ill, he phoned for the doctor, unaware that she had been visited only a few hours earlier.

They were always very polite and very grateful, but the phone never stopped. We tried everything we could think of: immediate telephone advice, a regular doctor's visit twice a week, sharing visits with social workers and a psychiatric nurse. The receptionists starting dreading the phone calls and, like everyone else in the practice, I too starting hating them. But that was unfair for they were pathetic and in real difficulties. So I made time for a more leisurely visit to try to get to know them as people. She was really unknowable, but her husband was charming. He had been a bank manager and was a stamp collector and only too happy to show me his collection. But he also showed me how pathetic and inadequate he felt in trying to care for his wife. I found myself comforting him and promising to try to make him better.

The phone calls continued as ever before, but now I had a way of seeing the problem that was different. I would speak to him as often as I could and still had to make frequent visits, but now the focus was on giving him comfort and trying to make him feel less lonely. I came to admire him for the way he was trying to manage. I saw my role as putting verbal sticking plaster on his poorly, bruised knees as he struggled in the mess of his mad wife's making. In time, they moved to more supervised care, arranged for them by their daughter who had received at least twice as many demands for help as we had.

As his dementia made him regress from kindness and competent coping to childish demands for immediate succour, his phone calls sounded more and more like crying for 'mummy'. His wife may have been a motherly sort of person in times gone by, but by time I knew them both, she was far past it. So it was by taking on a sort of mothering role for this poor man that I was able to respond to at least some of his cries for help. And understanding myself as trying to play this role increased my forbearance of this totally demanding impossible couple to the level of being able to sustain their care. I even grew to rather like them.

I have used these case histories to illustrate how introspection made it possible to risk working in new ways with my patients. Thinking about what kind of family role I was playing served as a short cut to understanding and shouldering their problems. It formed a matrix for structuring ideas about relationships with patients. But it also served as protective procedure that has allowed me to take on patients without being overwhelmed by their difficulties. This was not an unconscious negative reaction to avoid engagement, but a considered attempt to differentiate between my private emotions and an empathic professional engagement. It became my internal language for focusing on the patient and rethinking what was going on; it became my new and personal way of coping.

All family doctors must develop survival skills if they are to manage the incessant accelerating demands. We all need some defences against being overwhelmed, but they have to be proportionate and not get in the way. Doctors all too often deal with their own anxieties or other distress to the detriment of their patients. Defensive behaviour can obscure the patient's needs and doctors need to know about their own reactions. As Salinsky, Sackin and their colleagues have recently shown[5], it is unrealistic to expect a doctor to be able to maintain a professional *sang froid* at all times. So I hope that the approach that I have outlined here might fit some aspects of the "elastic bespoke medical defences tailored for each case and each doctor" that Tom Main challenged us to experiment with a quarter of a century ago[1].

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The Balint Group and the Doctor-Patient Relationship

The Balint Society Prize Joint Winner, 2003
by Pat Tate

The Balint group, for those fortunate enough to experience it, is a potentially potent force in the development of a doctor. Michael Balint wrote (1966), of the kind of doctor successful in the early groups, "It is highly probable that he will derive from this professional work enough 'deep' satisfaction to compensate him for the strains caused by the training. In this way he will be able to give up without too much pain some of his accustomed ways of behaving towards his patients and to achieve the often mentioned 'considerable though limited change of his personality'." And if the doctor's personality changes, we can be sure the doctor-patient relationship changes as well.

Those who present cases to a group sometimes comment, "I will go back to this patient a different doctor." Sometimes that amounts to a new approach, sometimes to increased patience, sometimes to less self-doubt. The knowledge that at the next meeting, or the next, the group will be there to hear the followup, to comment or reflect, is enormously important, and allows the doctor to think and to venture.

But most groups (and sooner, rather than later) come to an end. Does the influence on the doctor and on the doctor-patient relationship, end as well? From experience, it seems that answer is, "No." The group continues to exist in the doctor's mind, both in the conscious and in the unconscious, a 'virtual group' which is transportable, transferable and ready for use when needed. It merely requires the doctor to remain open to the awareness originally developed within the group, and to continue to examine his work in the language of the group.

This doctor had the benefit of a long-term Balint group, but that finished years ago. Because the working environment did not change, it did not feel too difficult to continue thinking in the style of, and referring to, the former group. But recently, this general practitioner made some substantial changes to her working life, moving from full- to part-time, from city to rural practice, from Principal to Assistant. These big changes made the doctor wonder what resulting differences would be found in consultations. In the old practice, the doctor was known as a 'psychological' doctor, interested in the unhappiness/happiness of patients, and of course, people understood, and brought that kind of problem. But what would it be like in a patient population of strangers? And would the virtual group survive the move?

First morning, first surgery, first patient. A working class man in his 40s, looking worried. We are mutually unknown entities. The computer says he has not attended for years. "It's those headaches, doctor, and I can't sleep." Some physical examination, some questions, a lot of listening. He and his wife of twenty years have split up, he is living in digs, aware that he is losing a great deal of what his life's hard work has earned. No other parties involved, just a realisation that they married young, and it no longer works. No details are given about the joint pain that must have led to this decision, but the pain is acknowledged between the two of us.

The doctor reassures, "I don't think there is anything physically worrying here," the headaches are likely to be related to tension, the poor sleep to a strange, lonely room. The doctor adds, "Generally, I don't like sleeping tablets, but try these few for a week, to break the present pattern. I won't be here again for a fortnight, but please come back and see me then, to tell me how you are getting on." And during that time of wanting, what will the group think, what will the doctor think of herself, with regard to the bending of a fairly strict 'No Sleeping Pills' policy.

The man seems relieved that serious disease is unlikely. He has spent 15 minutes with the doctor, who has accepted the fear and unhappiness, and now shares them. He departs. The doctor is aware of two emotions: firstly, amusement, that random change has brought a first patient of the kind she likes, and feels capable of helping, and secondly, self satisfaction in a good piece of work. This could be reported to the group as an interesting short case!

A fortnight later, but the man does not reappear. Disappointed, the doctor checks the computer, – no, at least he has not been back to see someone else. But the doctor's self-esteem is shaken – maybe that was NOT a good piece of work. Maybe the man was disappointed in what he received, maybe the doctor was too intrusive into the personal story. Did the doctor do too much or too little? These are issues the doctor imagines the group tactfully exploring.

Another week passes, the man reappears, three weeks after the initial meeting. He is dressed up – jacket, shirt and tie, all a bit on the flamboyant side. The doctor is pleased and excited, but plays it cool. "How are things going?" He is relaxed. "Headaches nearly gone, and what's left I can live with. Sleep nearly back to normal, I only took 4 of the sleeping tables, but they helped." There is a shared smile, and a pause. The practical side is being amicably arranged, he has a better place to live, the family will spend Christmas together. This feels like a cue (both doctor and group want to know more) so the doctor inquires what Christmas was like for the man in the past. The resulting story is dreadful – a mother who died when he was 7, a father who

put him into care, abuse by foster parents, independent living from age 16. This man has had more than his share of unhappiness.

Another shared pause, solemn this time. Both doctor and patient reflect on the sad history, the sad present. Then the doctor feels it is time to acknowledge the man's outward presentation. "You're looking very smart today, what is that about?" "Oh, I'm off to London on business today." The doctor wants to give him a present. "I expect you are good at your job?" Quick as a flash, the man replies, "Yes, I am – and so are you." A gift in return. They part, friends after two brief meetings. "Please come and see me in the New Year, let me know how it's going."

That night, the doctor dreams of the man – but it is her father, wearing the flamboyant jacket. The two men are completely mixed up together in the dream; the emotion of the dream is sad but bearable. And does the man thank about the doctor afterwards? Is she mixed up with the lost mother (the doctor is the right age) and have these two brief encounters met a need to tell mother about the unhappiness? Probably the doctor will never know, but, conscious of the internalised group, she can wait and see, bear the uncertainty, hold on to the unhappy story. Maybe they will never meet again, but the man has made quite an impression on the doctor. And what will the group make of bringing a dream into the case.

The whole episode reminds the doctor that, no matter how often she does this, she remains unsure of her abilities, anxious not to do harm, wanting to feel good about herself. She thinks of the old maxim, 'only the wounded physician heals', interpreting the 'wound' as an awareness that can flow from a powerful experience. It seems that the doctor contains an element which is 'patient' and the patient an element which is 'doctor'. In addition to expertise and experience, the doctor also possesses the weakness and helplessness inherent in the patient role. For the practising doctor, the 'doctor' pole is dominant, while the 'patient' pole is latent. But the latent helplessness is there and, if it can be consciously accepted, it is the wound.

The doctor in this account is relieved – it seems that general practice is not different in this different setting. It seems that the virtual group is transportable, along with the BNF and the stethoscope. That random first patient had a common problem, for which the doctor, supported by the virtual Balint group, felt skilled enough to offer help. Doctor and patient have formed a relationship and then parted, satisfied with each other. Unhappiness remains, but two people have met and examined it together. Beyond those meetings in the 'real' world, the doctor, as if in the group, has reflected on the relationship. It's all right for now.

Reference

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A Case for an Impotent Apostle

The Balint Society Essay Prize, joint winner 2003

by Ryan Hutchison MD, Department of Family Medicine, Medical University of South Carolina, USA

In the second year of my residency training, I acquired a patient that presented himself as a unique case for which none of my therapeutic efforts succeeded. Despite this failure and the apparent frustration of both parties, he continued to return to my clinic. I brought this case to a Balint session, and we discussed the nature of our patient-physician relationship and the roles that each was playing. With suggestions from the group and a review of pertinent concepts from Michael Balint's *The Doctor, his Patient, and the Illness,* I have been more equipped to take an empathetic approach and create a more therapeutic compromise in our work together.

GR came on strong from the moment that I met him. "We're gonna get along great…they say you and I have the same twisted sense of humor". He is a 32 year-old man with a ventriculo-peritoneal shunt, placed at age 16 as a result of hydrocephalus. His concern at his initial visit to my office was recent headache and unsteadiness, the same symptoms he had when his shunt was originally placed. Because of his insurance, he needed a referral from a primary care physician to visit his neurosurgeon. His neurologic exam was normal. I gave him the referral that he requested, and he indeed did have a shunt revision (based on clinical suspicion, since the shunt series and CT scans were negative).

Shortly after his surgery, GR returned to my office complaining of pain at his incision site and, soon thereafter, for insomnia. I initially prescribed amitriptyline and later gabapentin in response to phone calls and visits reporting poor effect.

In the months that followed, GR returned for several visits and left several phone messages regarding multiple complaints such as various pains, fatigue, and blackout. During these encounters he was dramatic and sometimes childish. He was convinced that he was a 'medical mystery' with unique physiology and responses to medicines. For example, he reported having enhanced senses. He could smell antifreeze in the car behind him at an intersection. He could hear conversations in the house next door. The sound of screaming children pierced his senses and he thus needed to avoid such situations. Medicines, as he claimed, affected him differently than other people. He would require double doses of all antibiotics or pain medicines. Amitriptyline caused insomnia. Gabapentin worked 'as needed' for panic attacks. (Of note, I found him to be neither psychotic nor manic.)

I also learned in these encounters more about his background. GR is an only child, raised by a single mother. He is married with two young sons (two and four years old). He used to be a professional fisherman, but he no longer works due to a back injury that resulted from a car accident in 1999 (although he was not hospitalized at the time and never met legal criteria for disability). His wife works and is the sole provider of income for the family. Despite his being home, he does not participate in childcare, as his children are sent to day care and his wife attends to them on the weekend. Although he is 'disabled', he has a rather active life, enjoying computers and fishing with friends.

After several visits, a pattern to our encounters emerged. I realized that all of my efforts were failing. My medical evaluations of complaints were fruitless, and a multitude of medications and dose adjustments were ineffective or caused idiosyncratic or 'reverse' effects. He expressed frustration, and I certainly shared this sentiment. However, he continued to return.

It was clear as time went on that he was a 'problem patient', so I brought his case to our weekly Balint group. Why does this man continue to return if nothing I do for him helps any of his problems? In the session, the group challenged my assessment of the arrangement as a failure. They proposed instead that it must be a success on some level if GR continued to return. Perhaps, they suggested, the relationship reinforced his identity in some manner. Finally, the group underscored my irritation with GR and asked me to explore what this might mean about personal bias and the dynamics of our relationship.

This case was an opportunity for me to review some of that which Balint presents in *The Doctor, his Patient, and the Illness.* Specific to this case are concepts of the 'apostolic function', 'mutual investment company', and the role of the 'impotent doctor'.

The 'apostolic function' is Balint's idea that we have biases regarding how one should behave when one is ill and what one should expect from a physician in this setting. Importantly, one's apostolic function has no roots in medical training, but rather is a collection of personal beliefs and experiences. Balint refers to it as 'personality', 'zeal', or 'common sense'. We expect our patients, who have their own beliefs and experiences, to comply with our constructs. In Balint's words, it is 'as if every doctor has revealed knowledge of what is right and what is wrong…and a sacred duty to convert to his/[her] faith all the ignorant and unbelieving among his/[her] patients'. If too rigid, the apostolic function can be an obstacle to proper clinical assessment.

Every patient-physician dynamic

involves offers and responses. If an acceptable compromise is found, a patient might return and become a continuity patient. The terms of a compromise are functions of that which the parties allow or accept to be part of the negotiation within the relationship. Balint calls this the 'mutual investment company'. It is 'on the basis of mutual satisfaction and mutual frustration that a unique relationship establishes itself between a GP and those of his/[her] patients who stay with him/[her]'. The nature of the compromise cannot be overestimated, as it is on these grounds that therapy is attempted.

The more I saw GR the more aggravated I became and the more I dreaded his visits. His presentation clashed with my apostolic function and our relationship was a compromise on his terms. My personal beliefs and 'personality' disapproved of his behavior as a father, husband, citizen, and patient. I felt that he wasted my time and clinic space and insulted my education and work ethic. I quickly became disinterested and 'invested' less in our relationship. I resorted to any means necessary to please or pacify him enough to end each encounter. This meant endless referrals, laboratory investigations, and medications for less-than-convincing indications. All of these measures, of course, failed.

GR dictated the nature of our negotiations. I unknowingly accepted a role that served to reinforce his pathologic identity and therapeutic inaccessibility. Failure of his doctor ensured his incurability and secured his status as unique. GR needed me to be impotent, and when I was he stayed with me. This way he could remain ill and disabled, which may well define his identity

The impotent doctor is a difficult role to accept. As Balint writes, '[the] majority of us, driven by our apostolic zeal, have to do everything possible to impress our patients – and ourselves – that we are good, helpful doctors.' The compulsive tendency of doctors to take action and give makes the impotent doctor a role that is easy to assume and thus compounds the inaccessibility of those patients for whom failure serves (misguided) needs.

My experience with GR shows how personal judgment can impede clinical impression and how a patient-physician compromise on pathologic terms can lead to therapeutic failure. The apostolic function can obstruct empathy. A more flexible, empathetic approach to GR recognizes that he is riddled with guilt. He knows he is not upholding his duties in his system(s). To relieve his guilt and to excuse him of his responsibilities, he seeks an impotent doctor that can prove his illness. It may take a slow titration of myself as the 'drug doctor', but in the future I will try to resist the compulsion to act, changing what is expected of me and thus changing the terms of our compromise. I can understand his need for an impotent doctor if he understands that we will acknowledge his underlying guilt as we approach his somatic complaints. This would not likely happen overnight, but if he returns, it could one day be therapeutic.

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Balint Groups from the perspective of a teacher

Laurel C Milberg PhD

(Keynote paper given at the Oxford Balint Weekend in Exeter College on Friday 13 September 2002)

Good Evening. A strange thing happened to me on my way here from the States. I and some of my colleagues from the American Balint Society decided to come and see how you do these weekends, because we are trying to start something similar in the U.S. When I inquired by email as to whether my registration had been received, John Salinsky wrote back suggesting that it had been received if I agreed to give a keynote address. Very persuasive fellow! I agreed, however, because it allows me to tell you what Balint work means to me as a teacher. I'm hoping as the weekend progresses you will stop and tell me what it means to you, as well.

Quite simply, Balint groups were an inauguration, 25 years ago, into my new role as a psychologist teaching family medicine in a brand new residency program in Pittsburgh, PA, USA. I was full of enthusiasm in 1977 to begin applying my knowledge and skills as a psychologist to the doctor's job. Unfortunately, other than my own trips to the doctor, I had little real understanding of the doctor's job and not the foggiest idea of what or how to teach them. I was given one hint: I was to conduct Balint Groups. It was a very good hint, indeed. Balint work remains today the single most potent tool I have for creating a safe but challenging environment where trainees can learn and grow to be competent personal physicians. It is how I do my job.

I was fortunate to have been introduced to Balint seminars and taught to lead them by a man who worked and mingled ideas directly with Michael and Enid Balint. His name was Dr. Rex Pittenger. He gave the seminars we co-led (he led while I learned) his own style, yet helped me to see the sometimes hidden essential themes that constitute the Balint group process. Best of all, he encouraged me to use my judgement and experiment with the group, much the same way he encouraged the resident participants in our Balint seminars.

A personal/professional identity was formed from this initiation by Balint group. It created for me a place where what I know and what young doctors could benefit from learning came together and made sense. Things like:

1. Widening and deepening one's perception of the patient, learning more about their circumstances, context, family and how that might relate to their complaint.
2. Actively listening to the patient – being able to empathize and understand what is gong on with them and what that might have to do with their symptoms.
3. Valuing listening and the doctor-patient relationship as diagnostic and therapeutic tools.
4. Understanding how the illness impacts the patient and the patient impacts the doctor.
5. Self-reflecting on the doctor's own responses to the patient or the illness, having insight into the roles the doctor is habitually drawn to play with patients as well as his or her allergies to certain illnesses or patient behaviours.
6. Responding with more tolerance to a wider range of patients – developing a larger, more varied repertoire of interventions.
7. Having the patience to work with patients over time despite lack of a cure or even sometimes a common ground.

These are all lessons relevant to the doctor's job which could be embraced by trainees in my program. I learned them in Balint group. Best of all, Balint work showed me a way to transform at least an hour and a half a week into something more positive, affirming, divergent, creative, supportive, verbal, thoughtful, emotional, intuitive and humanistic than medical education in general appeared to me to be. This was good stuff.

And then, a couple of years ago, I received a gift of confirmation. We surveyed our second and third year residents as part of a research project. We asked them, 'What have you gained from participation in Balint groups during your residency?' 'What, in general, is the value of having Balint groups in residency? And what are the drawbacks?' I was thrilled with their answers. May I read you a few?

In answer to 'What have you personally gained from participation in a Balint group during residency?' they said:

Catharsis: getting rid of frustrations built up over time from dealing with patients.

Normalizing even negative feelings toward patients: builds confidence when I make a mistake or have heinous feelings about patients; makes me feel more like that is human and less like it is a fault; feeling like it's OK to admit I have emotional responses to patients; I am not the only one who feels a certain way about a situation with a patient.

Empathy: empathy for my reactions from fellow physicians. I can connect to people who may be too scary for me to empathize with all by myself.

Insight: new things brought up I couldn't see from being too close to the situation; a forum to work through what is difficult about the relationship; insight on where to go, questions to ask, practical ideas so I don't flounder with patients who have me stuck; better insight into the doctor-patient relationship especially from the patient's point of view.

Better knowledge of patient: know the

patient better: motivated to get to know the patient better. I realize there is more than one way to see patients and look for those alternate ways; makes me hate fewer people, more tolerant of difficult patients. I ask more questions of a difficult and regular patient: 'I know you', vs. 'Oh crap, it's you;' I realize that the feeling I have when I leave the room may be the feeling the patient has; insights on particular patients and their relationship with me.

Skills: gaining a small useable amount of 'touchy feely'; I develop a more holistic approach to patients; getting a shared experience and mental skills to deal with difficult cases; not put up barriers which is what I'd be doing otherwise; alternative ways of dealing with patients.

Transformation: ways to use insights about how I am with patients that gets in the way of connecting/dealing with them to transform certain relationships into ones that work better; frequently revealed other avenues to pursue with difficult patients, though not the purpose; new ways to face that situation in the future; hearing different people's approaches in a non-confrontational setting* a fresh perspective on a difficult doctor-patient relationship.

Support: not getting advice on what to do; not feeling alone with frustration; helps cope with stress of practice; decreased isolation as a resident; makes us feel understood and cared for.

In answer to, 'What can be gained in general from participation in a Balint group?' they said:

Increased sense of camaraderie;

Increased ability to be less judgmental toward patients and peers;

Makes you a better doctor;

Helps cope with the stress of practice;

Getting a fresh perspective on difficult doctor-patient relationships from others in a non-confrontational setting.

In answer to, 'What is the value of Balint groups to the residency as a whole?' they wrote:

Cohesion: decreased isolation as a resident; helps establish closer relationships between residents; leads to a closer group; makes us a team, a confident team.

Intimacy: get to know other resident better through what they express in Balint.

Values: reflects emphasis of residency on importance of seeking help from others; helping MDs cope with difficult roles; social aspect of patient's lives has an impact on health; makes our training unique; better training of family physicians in the doctor-patient relationship.

In answer to, 'What are the drawbacks of participation in a Balint group?' they said:

Difficult emotionally: sometimes it is extremely emotional and it is hard to reset oneself to go back to work.

Lack of skill in some members to 'do Balint': new people don't have the feel for how the group can work to explore complicated feelings, issues, etc. and can stop the momentum by side tracking or getting superficial.

Vulnerability: can be uncomfortable to be that revealing.

Hard work: even though I knew it was good for me and understood the benefits, I did not look forward to it; very time consuming which can be hard on tired, busy residents.

I believe these trainee comments reveal much about what is so valuable and hard won about Balint training and Balint groups. I think we all stand to gain this and more through our participation in Balint work.

Finally, Balint work provides me with a group of like-minded, though diverse, colleagues who allow me to feel I am not alone. My mentor, Dr. Pittenger, talked a great deal about acceptance as a key outcome of the Balint group experience. Working in these groups gives one the definite feeling that someone really knows what I am up to and accepts me, even if I'm frustrated, or flawed or impotent. This is not unlike what the patient feels when attended to by a Balint group trained physician. On another level, the collegiality we in the States have experienced with the International Balint community has truly encouraged us. Here, too, were folks who knew what we were up to and cheered us on. The British Balint Society essentially birthed the American Balint Society, with John Salinsky in the role of midwife. Together and from different sides of the Atlantic we continue to challenge each other to grow and learn the art of mindful doctoring.

In December of 1965, Michael Balint wrote:

If it is true that patients can get a better, more understanding service from doctors who have had a training along the lines advocated by us and I have no doubt this is so then patients will have the right to expect this better and more reliable understanding from their doctors. This in turn requires that the methods leading to this sort of understanding must be integrated into the training programs of the teaching hospitals not as an additional frill, but as a basic ingredient.*

Graduate medical education in the States has just begin to require that programs show how their trainees become competent in six major areas including doctor-patient communication and professionalism which includes self-awareness, self-reflection and self-evaluation. After all this time, Balint groups may just be the idea whose time has come in the U.S.

For us here this weekend, the time is now. We have come to experience an Oxford Balint Weekend. A warm welcome to all of you and let's get on with it. Does anyone have a case?

Post script: Two years ago, Balint work lost the man who literally helped bring Balint Seminars to the United States. In 1956, Dr Rex Pittenger invited Michael Balint to Pittsburgh to help initiate Seminars for General Practitioners at the Staunton Clinic. Balint's visits to these ongoing seminars and his collaboration with Rex continued for eleven years. From that time on, Dr.

Pittenger himself started many successful Balint Groups and served as mentor for scores of Balint Seminar leaders in Pittsburgh, West Virginia, New York and across Pennsylvania. No doubt the practicing physicians, residents and leaders he taught are now spread all over the country. He was a wise and patient teacher-guide of Balint work and wrote several articles and books on Balint groups. I honour his contributions by dedicating this talk to his memory.

Laurel C Milberg PhD

Metaphors for meddling

by Marie Campkin, General Practitioner, London.

I believe that the 'short paper' session at the Oxford Conference should not only be for the reporting of 'proper' research and completed projects, but also offers an opportunity to bring along some half-baked ideas in the hope that someone may care to pick them up and pursue the culinary process. Having recently conducted my last ever GP surgery I will not be able to do this myself.

My sub-title is 'The opening of floodgates, cans of worms and Pandora's box', and I am taking another look at how the metaphors we use loosely when talking about patients usually contain a nugget of diagnostic and therapeutic truth – and in particular these three, which all refer to dilemmas about whether to intervene (some might say to interfere) or to leave well alone.

The idea arose out of a case discussion at Oxford a year earlier. I had been telling my group about a 36-year-old woman who was first brought to the surgery by her older sister. The patient was distraught. Their mother had just been diagnosed with advanced cancer, and she was unable to cope, shaking and tearful and clearly unfit for work. Her mother died three weeks later. Subsequently I had seen her several times over about six months, but in presenting the case I realised how little I still really knew about her. Partly perhaps this was because she had repeatedly come with her sister – which itself should have been telling me something. But I was unsure whether our failure to engage came from the patient, her sister or myself, or whether all three of us were contributing.

I want to leave this case aside for the moment, but its presentation to the group had led me on to a more general thought about those patients with whom it seems difficult to get involved. The feeling is often that there is something hidden, which is unpleasant or frightening to the patient, the doctor, or both, so it seems better, avoided. In this context a commonly expressed fear is of 'opening the floodgates'. This seems mainly to do with the doctor's anxiety about being overwhelmed or even swept away by the patient's tears and troubles. This may be a particular worry to younger doctors, whereas greater experience may allow us to appreciate both our own ability to survive and the value to the patient of being allowed to let go. On the other hand time constraints can bedevil us at any stage of our career.

The two other metaphors, 'a can of worms' and 'Pandora's box' are often used almost interchangeably, but I think they have rather different implications. The term 'a can of worms' is of relatively recent usage, originating I believe in the 1950s. I couldn't establish whether it was initially to do with fishing bait or with faulty tinned food, but I suspect it was the latter. Either way it implies opening an innocent-looking container and finding something inside which is totally disgusting (unless you actually happen to be a fisherman who already knows and values what's in there).

Meanwhile we all know that the story of Pandora's box, dating back many centuries, is about the girl who opens the forbidden box and lets loose a flurry of troubles which surround and overwhelm her as they escape into the world. However the story goes on to tell us that afterwards one thing remained in the box, and that was Hope. So perhaps this illustrates a distinction to be made between those for whom exploration of hidden secrets may seem wholly negative and those for whom there could be gain to outweigh the pain.

Years ago I remember hearing Claire Rayner interviewed by Anthony Clare for the radio series 'In the Psychiatrist's Chair'. She undoubtedly had painful early experiences which she was wisely unwilling to disclose on air. But she explained that she had always resisted going into therapy because she reckoned there was now 'six inches of clear water running over the bed of the stream' and she had no intention of stirring up the underlying mud to sully it.

I quoted this in a seminar some time after, and the Jungian analyst leader made the comment, 'Ah, but what gold might also have been hidden there.' But the price for finding the gold is to have to look into the murky depths – to sift through the debris of sad events, difficult relationships and painful failures – to seek the understanding and healing which allows for change and a different future. As with Pandora, letting the troubles fly out is frightening but afterwards Hope remains – whereas what can you do with a can of worms except to get the lid back on it as quickly as possible? (Incidentally, I was informed at Oxford that in fact worms in a tin tend to cling together and are quite difficult to extract and separate. Perhaps this adds another dimension to the metaphor when applied to the patient's situation – that as well as the sense of disgust there is a particular difficulty in disentangling its component parts.)

Now for a follow-up on my original patient. After Oxford I returned – as one does – determined to make better progress – or at least to acquire more information. By this time she had already had some anti-depressants from me and some bereavement counselling through the hospice where her mother died and she had returned to work part-time.

I now learned she had another older sister besides the one I had met. Both had married and left home, aged 17 and 19, by the time she was six. Both lived some distance away. Their mother had had some heart problems, father was around, and my patient had stayed at home, got a clerical

type of job but apparently had no significant relationships. I do not think she had ever been sexually active – smear tests refused and no contraception recorded. But as we know, questions get answers but nothing else. I had discussed with her the possibility of further counselling but she had politely said she would leave it for now. Most of our consultations seemed to have featured tears but little other communication.

Despite, or perhaps because of, my renewed efforts she now stopped her anti-depressants. This was after a day when she had left her handbag on the bus, which she blamed on the tablets (for those who know of my hobbyhorse about accidents and depression this may ring a bell). She stopped coming to see me, took St John's Wort and other herbal remedies and increased her hours at work. One day she left work early with a headache, earning herself a verbal warning, and came back to me asking to re-start her medication. However she then tried to get a repeat prescription without being seen, and having failed, ceased to attend. So far as I know she didn't see another doctor in the practice instead.

So what was happening here? Did I finally drive her to a 'flight into health'? Was there a 'can of worms' that she couldn't bear to look at? Perhaps it was the apparent emptiness of her life, brought into focus by sudden loss of her mother, leaving her to continue indefinitely looking after the father while the others got on with their lives and families. Perhaps there was something more sinister – one could speculate about all sorts of reasons why the two older girls might have got out so quickly but this one couldn't or didn't. Perhaps it was just a simple bereavement and she will 'get over it.'

As is often the case one is left with many unanswered questions. But who says we are entitled to answers, or to the satisfaction of having been able to understand? If there is really a 'can of worms' which can't be faced we need to accept this, but somehow to stay with the patient and not frighten them away. At the same time it would be too easy just to say we should let people get on with it – for some there will indeed be a Pandora's box with hope in the bottom if we are prepared to encourage them to brave the opening of it. The problem is to learn how to recognise which one we are dealing with, and not let our therapeutic enthusiasm, or our curiosity, get in the way of what the patient really needs.

Hazards and puzzles of irony in Balint Groups

by Vladimir Vinokur Ph D

Associate Professor, Department of Medical Psychology,
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It is well known that all Balint work has to be protective, supportive and safe. It relates very much to the understanding of the doctor–patient relationships and the psychological defences of the group member presenting a case. Often these defences are uncertain, ambiguous and contradictory. Among the different factors that interfere with the sharing and analysis of thoughts, feelings and experiences in the Balint group is irony, which, according to experience of our group, happens quite frequently and needs to be studied more.

In irony the comical and funny is usually hidden under a mask of seriousness, but with the predominance of negative attitude and mockery. These points deeply distinguish irony from humour, which is, in opposite, usually serious under the mask of comical with the predominance of the positive. Perhaps Victor Hugo was right when he suggested that *irony* could be derived from *iron.* But we know that originally the Greek *'eiro'* meant 'to speak'. Later it acquired the meaning 'to lie, to pretend', and so nowadays irony is the expression of something uncertain and opposite to what is pronounced. It corresponds with Freud's idea that the nature of Unconscious is always ambivalent. There is another very appropriate remark of Freud's, that laughter and humour are based on understanding of the unconscious, while irony is understanding without application to unconscious. Irony is 'double meaning' so we consider it to be a form of psychological defence aimed at reducing the anxiety and tension of the ironic person.

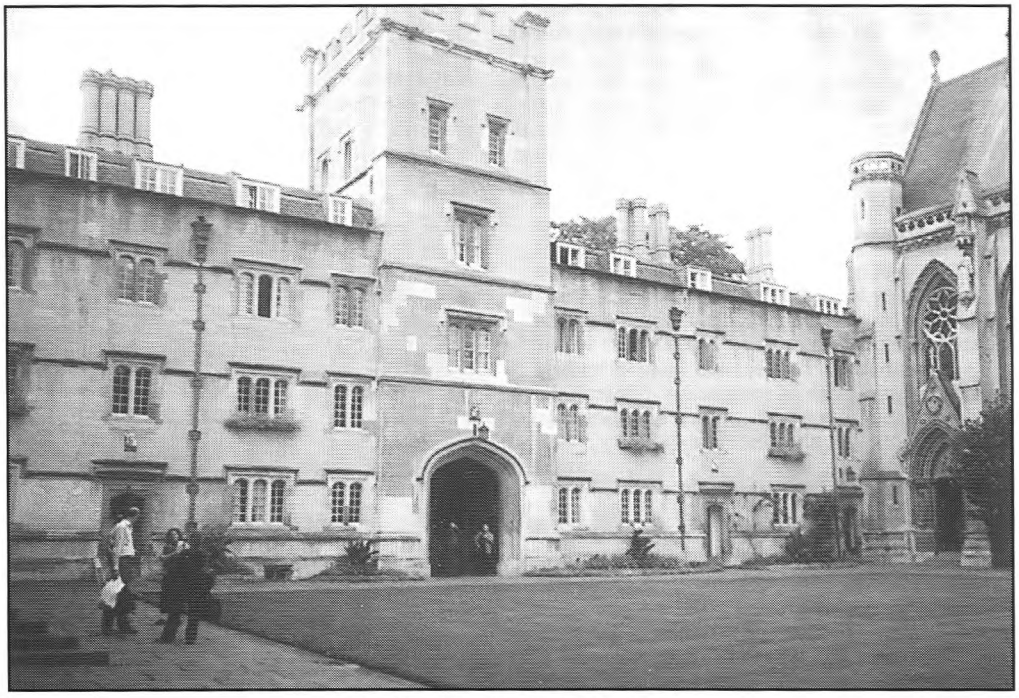
We suggest that irony is often used in the Balint group as a legitimate way to express hidden emotional arousal or even hostility and so to gain self-satisfaction. In the irony there is a contradiction between the manifested, apparent and the concealed, cryptic meaning in the speech, because often the plain understanding of the pronounced sentence could be unacceptable. So irony has the contradictory character of superficial support and agreement which are used for the expression of critical disagreement. We can see this definition in the Oxford Dictionary (1985). It is a way in which to react to another person's behaviour when it is not approved but is out of the control of the ironic speaker. The irony looks to be a suitable shelter where somebody can move to escape something unpleasant, unhappy or even dangerous within the significant communication.

There are some potential advantages of irony, such as avoiding difficulties in plain and direct expression, and thus feeling more protected from uneasy and deep feelings. But the biggest hazard of irony is to be misunderstood. In this case the real feelings of the speaker are repressed with the unconscious attitude to them. Thus it can lead to increasing the anxiety in the group and so stimulate more defences.

On the other hand quite often we saw in our group that irony sometimes was really helpful. Being expressed through overstatements, jokes, and ironic provoking aiming to confirm and even intensify some inappropriate thoughts and behavioral patterns in the relationships with the patients, the irony stimulated group members to become more aware of their feelings, and this was effective for their professional and human growth. Sometimes it was irony that helped people in a group to release the situations of 'pregnancy by difficult sense' as it was named by Carl Jung. In these cases we try to keep the balance between the irony expressed verbally (if any) and the non-verbal positive support as two parts of a whole.

Just as the irony is contradictory itself, the results of it in a Balint group are also ambiguous. We are convinced that irony has to be appropriately disclosed and analysed along with the other mechanisms of psychological resistance and defence in a Balint group. We try to include such analysis as part of a supervision of the internal group process, to make more clear the aims and intentions of irony in the group, how it helps the presenter and the whole group, what the irony is based on – to prove something, to avoid some contradictory feelings, or to reveal somebody's 'silly' way of thinking, or to help him to get more internal freedom. Lastly we suggest the necessity for attention and sensitivity to the feedback in the case of irony in the Balint group.

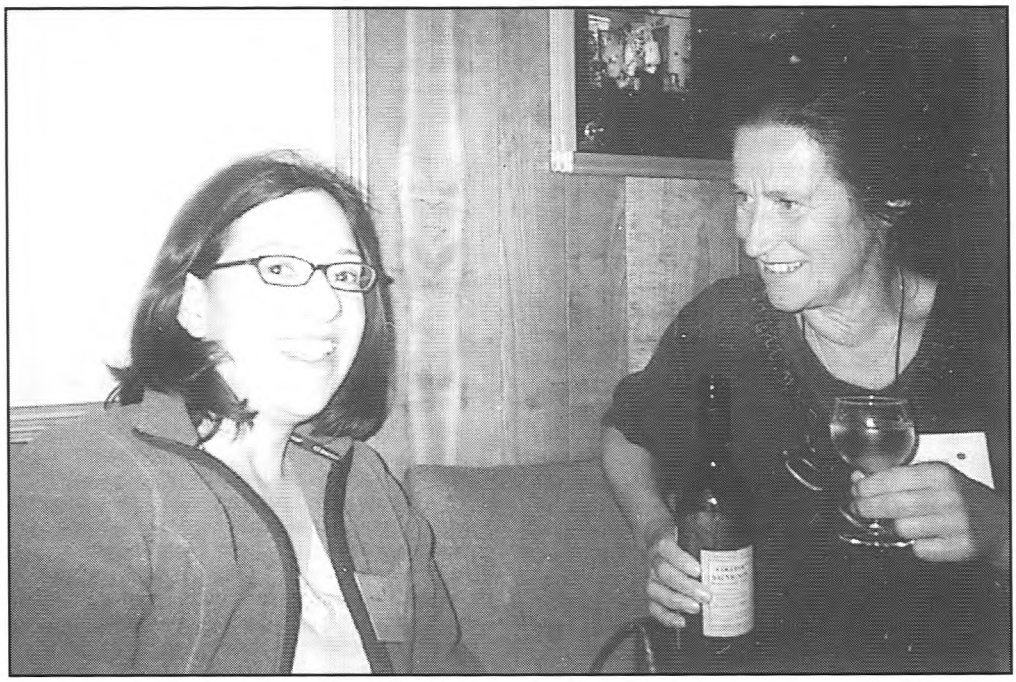
PICTURES FROM OXFORD 2002



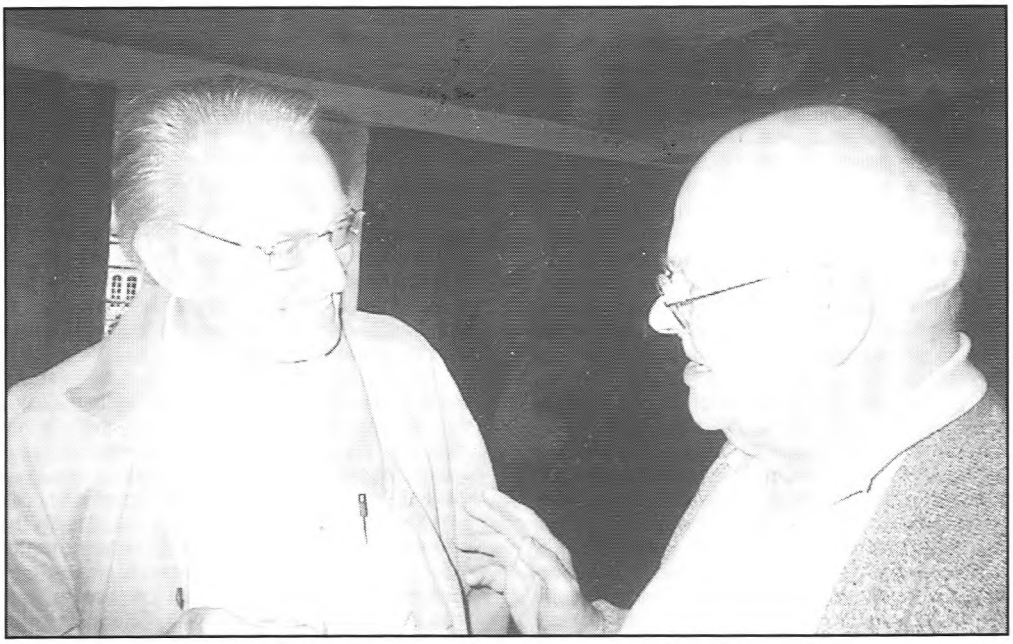
The Quadrangle, Exeter College.

Erica Jones, Laurel Milberg and Mary Hall (USA).

PICTURES FROM OXFORD 2002



Anne Coppola and Lenka Speight.



Michel Delbrouck (Belgium) and Don Bryant.

Book Reviews

Mental Health in Primary Care – a new approach. *Edited by Andrew Elder & Jeremy Holmes (2002). Oxford University Press 248 pp. Softback. £29.50*

After I finished reading this book I went back to re-read the editors' excellent preliminary essay: 'Introduction: the need for a new approach'. I wish that the whole of this short chapter could be printed here in place of a review since it perfectly encapsulates both the intentions of the editors and the discomforts which the book's reading may engender. I make no apology therefore for quoting freely from what they have written.

'It is paradoxical that family doctors – who conduct more psychiatric consultations than any other group of professionals in the Health Service – are often not considered "mental health" practitioners.' This first sentence summarises the problem. The plea for 'a new approach' is not for completely new or revolutionary thinking. Rather it is the hope that long-held views from within general practice as a whole, and perhaps from Balint-inspired doctors in particular, may, thanks to general practitioner input, figure more prominently in planning for service provision in the future. Such ideas, for example, as that 'the narrative experience as "evidence" is no less important than that provided by biomedical science.' They also hope for 'a new approach to community care for the mentally ill – a 'third way' between the stasis of incarceration and the chaos of community neglect.'

The view persists that mental health and illness are primarily the province of the disciplines of psychiatry, psychology and psychotherapy. Despite some recent policy shifts: 'there is a continuing tendency among policy makers, researchers and writers to adopt the paradigms, perspectives and classifications of the secondary services when considering primary care.' This perpetuates the apparent mind/body split in the consideration of mental health, whereas the editors affirm the need for the GP approach to continue to be 'narrative, generalist, interpersonal and undivided between body and mind', pointing out that having these skills at the core of general practice confers benefits to the mental health of all patients.

Following this introduction, the book is arranged in four parts, though it falls effectively into two. As the editors comment, the divide is apparent, both in writing style and approach, between the three sections originating from primary care and the fourth on 'perspectives from secondary care'. They note that the GP perspective is 'personal, subjective, experience-based…' while that from secondary care is 'cool, objective, structured …evidence-based.' Despite their efforts to get their contributors to think along similar lines the gulf seems more apparent than ever, and perhaps this in itself provides an illustration of the need for the 'new approach' and where it might begin. (It should be noted that the editorial partnership itself represents a model for successful collaboration between representatives of primary and secondary care.)

The first three sections are 'In the consulting room', 'Reflective practice' and 'Mental health thinking in the surgery'. In the first, four GPs reflect on different aspects of mental health and mental illness in their ongoing care of patients over time. In the second, there is consideration of the inter-personal nature of the GP's work, the problems of difficult doctor-patient relationships, issues of stress, morale and burn-out and the need for improved training and ongoing support/supervision to address these issues. This section and the next both emphasise that any consideration of mental health in primary care needs to include the mental well-being of team members as well as patients.

In the third part the practice is considered as an organisation – sub-headings include 'The mentally healthy practice' and 'The practice as mental health team.' This is followed by an account of 'Systemic family practice' and a chapter on 'Therapists and counsellors in primary care.' Throughout all these chapters the authentic voice of general practice emerges albeit in varieties of practice style and through contributions of writers from several different disciplines.

In the second half of the book there are chapters on post-natal depression, eating disorders, serious mental illness, and other conditions where secondary and shared care may be involved. As the editors noted, the whole approach is inevitably different, and the chapters feature statistics, bullet-pointed lists, and protocols. There were some useful bits of information, but too often the writers' comments about how their special interest should be dealt with in general practice suggest a lack of understanding of how general practice actually works. A notable exception is the chapter on 'Trauma and PTSD' by Gwen Adshead, who works closely with GPs and primary care teams in her clinic and whose comments I found to be both informative and realistic.

I am left wondering what the various contributors from secondary care will make of this book, if they read it themselves, and whether they will find the primary care perspective as discomforting as I as a GP find theirs. It really is difficult to envisage how the two approaches can be effectively brought together, but clearly the effort must be made. I consider one very useful role for this book could be to provide a resource for those in administration and decision making who belong to neither camp, to inform them of the background against which their work of providing mental health services must proceed.

I think this book will be of particular interest to Balint doctors and their practice teams, and despite some irritations in the second half it is well written and a worthwhile read.

Marie Campkin

Supervision and Support in General Practice. Edited by Jonathan Burton and John Launer (2003) softback, 160 pp. £24.95 ISBN1 85775 951 6 2003.Radcliffe Medical Press Ltd, Oxford.

This is an introspective book all about different ways which medical professionals have invented to talk about themselves and their work. The editors are experts in this field and they have recruited a number of other experts to provide a series of chapters, which seem comprehensive in their coverage of the subject. The book will be of interest to general practitioners in general, but particularly to GP educators and Appraisers. Two significant messages emerge. First of all, there is almost no objective evidence of the benefits, or effectiveness of clinical supervision, although almost everyone who does it seems to think it is a good idea at an anecdotal level. Second, while there is a great deal of clinical supervision in all sorts of different disciplines, general practitioners themselves are conspicuous as a group by not having an established, structured system of clinical supervision.

The editors start with three chapters about the nature of clinical supervision, the obstacles to its provision and how it might be promoted, particularly among general practitioners. For a book whose readership will mainly be general practitioners, it seems unnecessary to set the scene quite so comprehensively as the content of these chapters is common knowledge to most family doctors, particularly those involved in education. They conclude with a slightly patronising invitation for doctors in general to think harder about the need for clinical supervision.

The following chapters describe the various kinds of clinical supervision which have been developed for mental health workers and nurses, among whose ranks clinical supervision seems to be culturally embedded. They go on to describe Balint work, a narrative approach, mentoring and peer supervision groups. The final section is to do with higher professional education for general practitioners, which will be of interest to newly trained GPs. The last chapter is about educational supervision for general practice registrars. Of these chapters, I found the description of Balint groups by Dr John Salinsky of great interest. The chapter reads like a handbook for aspiring Balint group leaders. The point is well made that Balint work is now an internationally accepted form of clinical supervision, but paradoxically is very much a minority activity in the UK, where it started. Balint work is unique among the various forms of clinical supervision in having a growing international evidence base for its effectiveness. Other sophisticated kinds of supervision in the ensuing chapters are of interest, but clearly have required a great deal of time and effort to establish. Dr John Launer's description of a narrative based approach describes a fascinating way in which doctors can be trained in a new syntax to use in the consultation. Mentoring and Peer Supervision groups have both thrived in various localities around the country and have evidently been of anecdotal benefit to those who have had the opportunity to engage with them, but there is a pervasive lack of evidence about their effectiveness at achieving what they set out to do.

The penultimate chapter by Dr Tariq Abu Hab and Dr Neil Jackson of the London Postgraduate Deanery will be of interest to newly trained general practitioners, but has the unique obstacle of offering a glossary of 16 different terms, which presumably the reader is supposed to learn before embarking upon the rest of the chapter. The final chapter by John Launer on the subject of supervision of general practice registrars should be required reading for all doctors involved in training, whether registrar or trainer.

The publication of this book is obviously meant to coincide with the initiation of the appraisal process for GPs. It is a pity it was not published five years ago, when it might have had a role in encouraging GPs to develop their own means of supervision and avoid having one imposed upon them.

Andrew Dicker

Emotions in Practice: A study of Balint seminar training as experiential learning for qualified nurses by Jan Savage (2003) Royal College of Nursing, softback, RCN Code: 001 933 ISBN:1-904114-03-2

This is an extended research paper running to some 65 double columned A4 pages, that is, the length of a small book. It reports a research project run by the Royal College of Nursing, studying a group run by the Association of Psychosexual Nursing, with whom the Balint Society has had many contacts. The Association trains nurses for psychosexual work in the same way that the Association for Psychosexual Medicine does, that is under the founding light of Dr Tom Main, using Balint Groups to look at practice.

This research was done to look at an advanced, experienced group and see how it functioned, what characterised it and, where possible, what were its outcomes. Also, whether such groups might in the future be more widely used in nursing for professional supervision.

Jan Savage was present in the group as an ethnographic observer and has written a long but clear paper, supported by a great deal of theoretical material, on what the group was like. Balint people will love the case descriptions, the

people in the group, and the rather tiny room in which it took place. I think they may be a little surprised at the energy or directedness of the group leader but also by the degree of pain seemingly always present in the group. Perhaps the repeated discussion by a group of women of couple's sexual problems is a less leavened diet than in an ordinary GP Balint Group. It will be very interesting to read the Balint Society's somewhat similar investigation into a Vocational Training Scheme group when it is published later this year and to compare the work done.

Jan Savage's conclusions are very realistic with recommendations that further investigation into different group leader styles would be interesting. There should be some investigation into the clients' experience of the nurses' work backed up by the group work. Work with people new to Balint work and what changes may occur early on in their practice would be valuable. Finally, there is the endless question for our Society, why do more people not take up this work, and why do people discontinue their group work?

David Watt

Obituary

Boris Luban-Plozza

Prof. Dr. med. Dr. h.c. mult. Boris Luban-Plozza died in the night of 24th of December 2002 in his 80th year after a long and severe illness. He qualified in medicine in Switzerland and worked as both general practitioner and psychiatrist in Locarno in the Italian speaking southern canton of Ticino. He met Michael and Enid Balint in the 1960s and became an enthusiast advocate of their ideas. For many Balint enthusiasts his name will always be associated with the little town of Ascona on the shores of Lake Maggiore where he lived for many years with his wife and family. Perhaps his greatest contribution was his work with medical students in Ascona. He believed that students needed to be given the opportunity to discuss their experiences with patients as early in their career as possible. For many years he invited students from all over Europe to come to Ascona and work in Balint groups in the Monte Verità hotel, perched on top of a hill with a beautiful view of the lake and its surrounding mountains. Many of today's European Balint leaders were introduced to the benefits of the Balint group at Ascona and acquired an enduring enthusiasm from the experience. On the Saturday evening there was always a party with music and dancing, and of course, some Neapolitan songs from Boris who had a fine light baritone voice. The Monte Verità student groups achieved world renown and were recognised and commended as an educational method by the World Health Organisation under the name of 'The Ascona Model'.

Together with the Swiss Foundation for Psychosomatic and Social Medicine and the Swiss Red Cross, Boris also inaugurated the International Balint Award for students. Prizes are awarded each year for the best essays from medical students on the theme of the student patient relationships. The prizes are generous and the competition attracts entries from many countries. Happily, the Awards will continue to be administered by the International Balint Federation.

In the 1980s he and his friend Professor Walter Pöldinger introduced the Monte Verità group, a modification of the Balint group in which the patient and his family were invited to meet with the physicians and other medical staff. These discussions showed that the family were often the real 'experts' in caring for the patient and the medical staff were able to discover many small but important human touches which tended to be overlooked. Boris was the author of many books, most notably his textbook on psychosomatic medicine (with chapters on the Balint method) which is available in English translation.

John Salinsky

Secretary's Report 2002-2003

The Oxford Weekend ran from September 20th to 22nd 2002 at Exeter College.

There were 54 attendees, including two medical students and one practice nurse. A council meeting of the International Balint Federation was held on the Sunday afternoon which led to more foreign delegates than usual, who all participated fully in the weekend. The key-note address was given by Laurel Milberg PhD, former president of the American Balint Society. There were four short papers on the Saturday, some of which appear in the Journal. The speakers were Marie Campkin, Vladimir Vinokur (from St Petersburg), Brian McMullen and Sotiris Zalidis. As last year, we again wished for more time for discussion. The plenary session asked for the short paper session to be moved to Saturday morning and for the chairperson to be more strict. At the AGM on Sunday at noon there were no constitutional changes, and few changes in the officers, except Dr Lenka Speight replaced Dr Marie Campkin as vice-president. Ten new members joined the society.

It was announced that Certificates of Basic Balint Training are available from the Secretary, free to previous Society members, but that there will be a small charge in the future for new members.

The Lecture/Seminar Series 2002-3 began with a joint meeting with the British Association of Psychotherapists (BAP) at their headquarters, 37 Mapesbury Rd, London NW2. The Society provided a demonstration group, based on the membership of the most recent research group. More than 60 people attended from both societies and we hope that this will lead to further cross fertilisation. Indeed two BAP members are trying already to set up a Balint Group in Buckinghamshire and attending our group leaders workshop. On November 26th, back at the RCGP, Dr Shake Seigel discussed his long ongoing Balint Group in Staffordshire and the kind of modifications one has to make to survive in the current climate. Dr Mike Brearly, former England cricket captain, spoke to us on February 25th, 2003 on the difficulties of leading any kind of group, based on work he does with international cricket umpires. Lesley Caldwell from the Squiggle Foundation, an organisation devoted to Donald Winnicott, spoke on March 25th about links between our interests and also about the difficulties of surviving as a small organisation trying to promulgate work that we feel devoted to. The 15th Michael Balint Memorial Lecture took place on April 14th in the Long Room at the RCGP. It was preceded by drinks and canapés and attracted about 50 people (usual lecture attendance is around 15-25). Dr Henry Jablonski, a psychoanalyst and Balint Group Leader from Sweden, addressed us under the title "From Budapest with Love", touching on the Hungarian school's higher interest in love in psychoanalysis. Two of these papers appear in this Journal.

The Group Leaders' Workshop continues at the Tavistock Clinic, organised by Dr Peter Graham and led by the President of the Society. It has attracted new members, particularly those seeking Leadership Accreditation. It tries to meet about four times a year but practical problems make this difficult as does finding volunteers to discuss their groups.

Newham General Hospital in East London, previous host of two Balint mornings, is now trying to set up an ongoing group for hospital medical staff, led by Dr Heather Suckling. It has met three times and the Society is wishing this difficult enterprise good luck and offering our ongoing support.

The 3rd Chester Balint Weekend took place successfully, with one large group, on May 16th-18th. It was led again by Drs Caroline Palmer and Marie Campkin. It feels like this will be able to continue annually.

The Annual Dinner on June 24th 2003, at the Royal Society of Medicine, was attended by 26 members and guests. As in recent years, it was a most convivial occasion with old and new members and guests meeting informally, but capped with a serious after dinner speech. Dr Tim Fox, former GP and now psychotherapist and officer of the BAP spoke "On Roadmaps and Bridges."

I look forward to the 2003 Oxford Weekend from September 12th-14th and after that to the 13th International Balint Congress in Berlin, from 1st to 5th October 2003. Also, of course to the coming year of Balint work with my own group, the lecture/seminar series and continually trying to expand and improve the activities of the Society.

David Watt

Report on the Third Chester Balint Weekend Workshop, May 2003

This year a group of 12 GPs and therapists met in the comfort of the Gladstone short course centre near the heart of Chester to share their experience of difficult patients or troubling consultations. The comfortable surroundings and the safety of a small group allowed both the conscious mind, and the unconscious to emerge and explore the cases, and during the weekend a few themes developed and grew. It was noted that conscious questioning tended to occur when the presenter sits in line with others in the circle, but the invitation to the presenter to sit back a little way from the circle seems to allow the unconscious intuitive powers of the group to come into play. The theme of power within the consultation seemed ever present throughout the weekend, beginning with cases with a striking mismatch of power, leading to frustration, anger or shock in the presenter, and similarly reflected by the group.

The group got off the blocks to a pacey start with a first case brought by an enthusiastic Balint novice high-lighting the issue of control within the doctor-patient relationship, in which the doctor felt disabled and frustrated. The group noticed how this controlling behaviour also shut down our empathy for and curiosity about the patient. It was also sensed that this may have been a projection of the patient's own unconscious frustrations and fears, which also act as an effective barrier to meaningful help, and deeper therapeutic understanding. Over-identification with the patient may have also been crucial in this case. The following case explored these issues again, but with a patient that seemed conversely powerless, and which rendered the presenter shocked and angry, and the group by turns outraged, astonished or deeply sorrowful and silent. They sensed the deep impoverishment of the patient's situation, feeling both anger at the injustice of life, and discomfort tinged with thanks at our own safe insulation from those depths of need. The group admitted to finding it difficult to identify with such a downtrodden client, which may constitute quite a solid psychological defence on the part of the group.

The next few cases seemed to follow a pattern of shared or equal power and control between doctor and patient, but rarely in free therapeutic flow and often leading to irritation in the presenter, which was reflected within the group.

The third case was a more balanced but still dysfunctional situation, in which doctor and patient seemed to mirror each other's insecurities, with a vague patient rendering the doctor vague too, but with dawning dissatisfaction, leading to a determination in the doctor to shift the way of being in the consultation as a thoughtful therapeutic tool. It was interesting to see how physically shifty and restless the group felt during the presentation, reflecting the discomfort of the presenting doctor's feelings. The following case also had the patient and doctor more comfortably balanced, and perhaps too cosily in role at first during the presentation. There was a growing sense of unease about our ability to contain and maintain honestly therapeutic relationships over the longer term, and a growing disquiet at counterbalancing the insidious power of patient demand and expectation, with the doctor's power to give or take away sick-notes, or encourage what may or may not be an ultimately therapeutic return to work.

The next case was again one in which both doctor and patient shared mutual feelings and frustrations, with mirrored roles: both felt unheard, victimised and sabotaged by the family during the consultation. During the case discussion it became clear that both the doctor and patient felt the need of an advocate and interpreter to allow themselves to be heard and their positions and needs understood by the disabling family. The next scenario was one of a patient in chronic patient role, who projected their feelings deftly onto the doctor, and refused to own their own problem even to the extent that they expected the doctor to complete the whole DLA form for them. Permission was given by the group to encourage the presenter to hand back both the responsibility for this, and ownership of the illness itself, to the patient. The patient with chronic pain can very easily become the doctor's pain! This led on to the next case, which featured a fellow doctor as a patient, and the difficulties of doctoring our colleagues. These included overcoming our own insecurity in the consultation, encouraging them to adopt the patient role and to be looked after, while also enabling them to retain some responsibility for their predicament.

The last few cases on the last morning were powerful, intense vignettes, in which the doctors felt under more acute stress, thus building the group tension up to a dramatic crescendo. One of the cases involved bullying of the doctor by the patient and their victimisation for all the faults of the practice and the NHS. Another involved the doctor bearing the double burden of worry and insecurity over a possible threatened suicide or threatened complaint, which led to palpable fear and anxiety within the group, and the sharing of supportive concern by the group for the doctor. Another case involved the nurturing, healing role of the doctor helping to transform an abuse victim into a strong survivor, and the mixed feelings of pleasure and pride at their liberation, tinged with regret that this intense phase of work, and interaction is coming to a natural end. There was recognition that the relationship between doctor

and patient can be meaningful, while still professional, and the feelings at closure can feel like the end of an intense affair. This of course reflected the feelings of the group members at the end of an intense, meaningful weekend of Balint work!

The group worked well, cohesively and politely, no doubt because in a weekend affair there isn't long enough to develop annoyance at others mannerisms and habits as in a long-term relationship, either doctor-patient or otherwise! One of the leaders noted that quite often in the cases there seemed to be a lack of basic information and knowledge about the patient. The group wondered why this might be: either lack of curiosity, embarrassment or shyness to ask, or unwillingness to confront or delve, and again this was reflected in the group itself, perhaps in that questioning of the presenter or reveries about the scenario tended to be somewhat guarded or contained. It was refreshing that everyone in the group entered into the experience; generalisations and prescriptive interjections were few, and members grew to realise and accept that the group work isn't so much about finding medical solutions to particular problems but more about developing understanding of the doctor-patient relationship.

All those who came said they enjoyed and valued the unique Balint experience, liked the comfortable, luxurious and very reasonably-priced venue, and wanted to come again. So it seems that the Chester Balint May Weekend Workshop is here to stay as an annual fixture, and you are all invited to join us on May 14th to 16th 2004!

Caroline Palmer

Report on the Second Chester Balint Weekend Workshop 2002

One gloriously fine weekend in May 2002, if such a thing could be remembered or envisaged, a slightly enlarged group of 12, from the previous year, met together to present, peruse and ponder over patients who had caused us distress. The cocoon-like comfort of the Gladstone Centre in Chester allowed the members of the group to relax, in stark contradiction and contrast to the scenarios described by the members, and the plight of the patients, and indeed the doctors during the consultations.

During the weekend, several themes did emerge, particularly to do with coping with irritation and preserving a sense of safety. The irritation may be related to the continuing relationship that GPs have with patients who may need us to chronically contain their problems, to service their needs and to somehow 'refuel' them. The group, through specific case discussion, teased out ways in which we might be able to tolerate this discomfort. The issue of safety was also highlighted, of when it was or wasn't safe to broach issues within the consultation, how deep is it safe to go, and, related to this, emerged the issue of control of the consultation. The issue of judgementalism was also revealed and explored, with the concept of the deserving ill and undeserving ill appearing (rather like at the work-house!) and the difficulty of how to strive to be honestly therapeutic, over and above professional, with patients we may not genuinely like.

The last session highlighted many of these themes, when the situation of blurred boundaries, with friends seeking to become patients, focused on the issues of control, power and reciprocity. Fittingly, the last cases were to do with leaving, retirement, death, dying, bereavement and closure.

The participants seemed to work really well together, and the group bonded extremely well over a short period of time, perhaps to some degree because it was 'now or never' to present the perplexing case to a group of peers. All who came said they had enjoyed the weekend, felt helped and enlightened by the Balint process, and said they were keen to come again.

Caroline Palmer

The International Balint Federation

The International Balint Federation continues to assist and promote Balint work throughout the world through its network of affiliated national Balint Societies.

The Federation Council meets every six months in a different country. We exchange news about our various activities with a special emphasis on leader training and research projects. We are also keen to encourage the development of new Balint Societies and the revival of old ones. In countries without a Society there are often a few very enthusiastic people who are running groups and trying to interest their colleagues in the benefits of Balint. If you live in one of these countries, for a modest annual subscription, you can become an individual member of the Federation so that you can keep in touch with your Balint family around the world, and one day, establish your own Society.

Last September the Council met on British turf during the Oxford weekend and, if you were there, you may have noticed the International flavour our delegates brought to the gathering. We had members from Croatia, France, Belgium, Germany, Macedonia, Russia, Switzerland and USA, all taking part in the groups and putting us to shame with their excellent English. It was good to see our American friends some of whom you might have met at our Oxford International Congress in 1998.

Our most recent meeting was in the town of Miercurea-Ciuc in Romania in May 2003. Once again, the International delegates were able to take part in an enjoyable three day Balint meeting, hosted by Dr Albert Veress. We lived together in a residential study centre, on the edge of town and surrounded by rolling green hills and distant mountains. We listened to papers, took part in multinational Balint groups and had plenty of opportunities to exchange ideas. The entertainment included an organ recital, a brilliant folk dance performance and a visit to Dracula's castle featuring a personal appearance by the Count himself. So you can see that International Balint is a lot of fun and, with air tickets as cheap as they now are, you could easily join in.

During our council meeting, we had news from Denmark, Sweden, Hungary, France, Germany, Belgium, Croatia and the UK. We were sad to hear of the death of Professor Boris Luban Plozza (Switzerland) whose legendary meetings in Ascona on Lake Maggiore have introduced many students to the magic of the Balint group. The annual student essay competition which he established will fortunately continue. The details can be found towards the back of this journal and, if you teach any students, you should encourage them to take part. The prize money (usually shared between three or four) amounts to 10 000 Swiss francs which is serious money.

Our main business at the Council meeting was to discuss the forthcoming **13th International Balint Congress in Berlin**, which will take place from the **1st to the 5th of October 2003**. Details on the Congress website: www.internationalbalintcongress.de

There has been a positive ferment of Balint research activity in many countries (including ours) in the last year, and this will be your opportunity to hear about it and discuss it with the people who have been doing it. There will also be the chance to sample some exotic variations on the Balint theme such as Balint-psychodrama, Balint with Sculpture, Balint with Imagination, and Prismatic Balint. As usual, everyone will have the chance to be a member of a Balint group, which will meet daily during the Congress. German doctors are the most Balint-friendly in world and their Society has over a thousand members. What is the secret of their success? Come and find out. There will, of course, also be music, dancing, banqueting and a chance to see the sights of the one of Europe's most dynamic and exciting cities. Oh yes, and Air Berlin will fly you there for £20 each way.

This will probably be my last International report as I am retiring from the post of general secretary of the Federation after ten very enjoyable years. Heather Suckling has been elected to succeed me; I am sure that with all her energy and enthusiasm she will do an excellent job. We hope to see you all in Berlin!

John Salinsky

ANNOUNCEMENT

THE 13TH INTERNATIONAL BALINT CONGRESS

1st - 5th October 2003

will be held at Kaiserin-Friedrich-Stiftung, Berlin

Theme: 'The Doctor, the Patient and their Well-being World Wide'

The Congress will provide opportunities to:
Share your ideas and experiences
Hear about the latest Balint research and evaluation studies
Take part in Balint groups with colleagues from all over the world
Meet friends old and new
See the sights and enjoy the cultural events of one of the world's most exciting cities

Further information from the Congress web-site: www.internationalbalintcongress.de

Or the secretary of the International Balint Federation, Dr John Salinsky
JVSalinsky@aol.com
32 Wentworth Hill, Wembley,
Middlesex, HA9 9SG
Tel: 020 8904 2844

The Balint Society Prize Essay, 2004

The Council of the Balint Society will award a prize of £500 for the best essay on the Balint group and the doctor-patient relationship.

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 2004** and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

International Balint Award for Students

Medical students are invited to submit a paper based on their personal experience of relationships with patients. Prizes totalling SFR 10,000 will be awarded to the best essays.

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.
2. Reflection. A description of how the student actually experienced the relationship either individually or as part of a medical team. This could reflect multiple relations between students and staff of various specialties and the 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 or she 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.

NB: Inclusion of a description of the writer's experience in a Balint group will be an advantage.

Six copies of the written submission, each containing the author's name and full address should be posted not later than 31 March 2004 to Dr med Alex Amman, Graffenriedstrasse, 1, CH 3074, Muri, Switzerland.

email enquiries:alex.ammann@insel.ch

You should also send one copy (preferably by email) to Dr J Salinsky (JVSalinsky@aol.com)

Programme of Meetings of the Balint Society for the Thirty-fourth Session, 2003-2004

Lecture series 2003-2004

All lectures are held at the Royal College of General Practitioners
14 Princes Gate, London SW1 1PU
Time: **8:30 p.m.** (with coffee from 8.00 p.m.)

Dr James Willis, GP, author of *Friends in Low Places* and *The Paradox of Progress*
(Title to be announced) **Tuesday 28 October**

Sandra Linford, psychotherapist
'Experiences in Lithuania' **Tuesday 18 November**

Dr Oliver Samuel
'Being someone for someone' **Tuesday 17 February 2004**

Dr Sheila Cross, paediatrician and 'Childline' counsellor
'I know you're not a doctor, but...' **Tuesday 16 March 2004**

All the above meetings are PGEA approved
Further information from the Hon. Sec. Dr. David Watt

The **Annual Dinner** will be held on Tuesday 24 June at The Royal Society of Medicine

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Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to the Editor, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG, UK. Email: JVSalinsky@aol.com

Style

Articles should be typed on one side of paper only and double-spaced. Abbreviations must be explained. Research papers will be peer reviewed to assess their suitability for publication.

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 articles on 3.5 inch computer disk. Authors should supply the name of the file on each disk and send a hard copy in addition. Better still, you could send them by email to **JVSalinsky@aol.com**

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

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