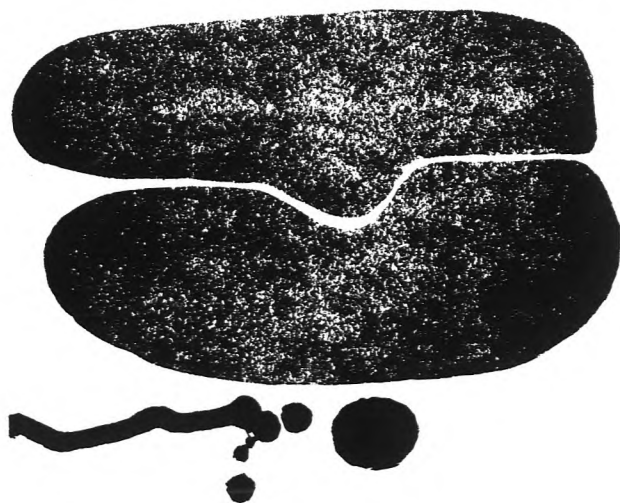


Journal of the Balint Society

2008



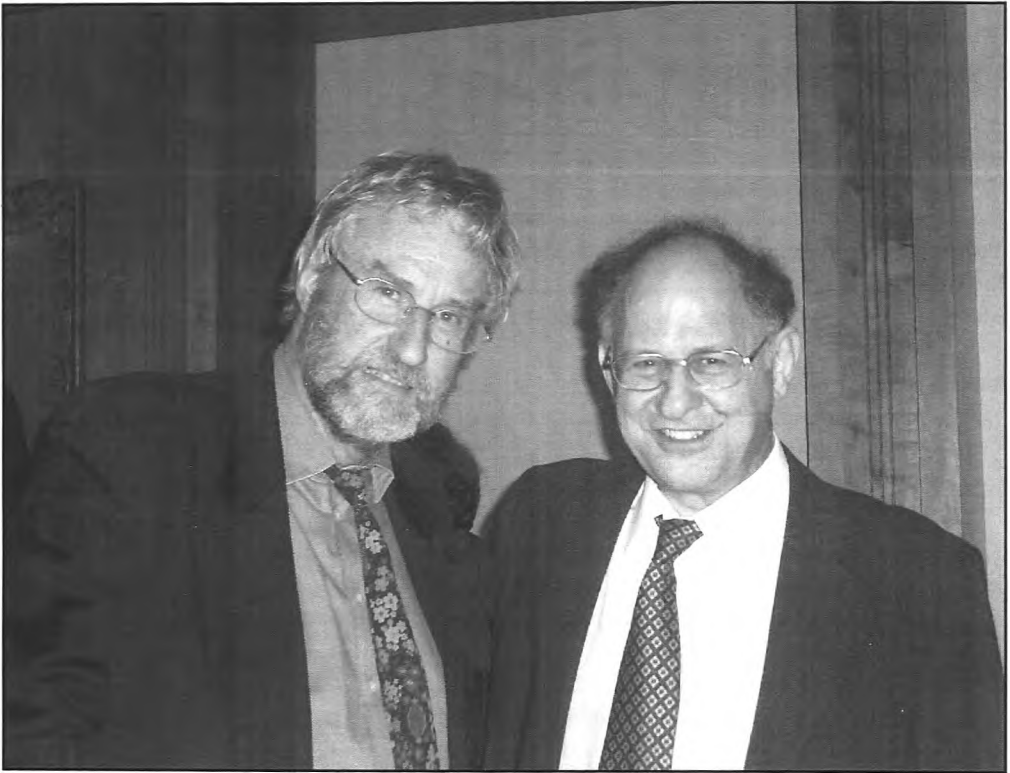
Vol. 36

JOURNAL OF THE BALINT SOCIETY

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Editor: John Salinsky
Assistant editor: Mary Salinsky



President and Editor.

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 regular 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 general practitioners and 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. Balint weekends are held each year in Northumberland(April) Whalley Abbey, Lancashire (June) and Oxford (September).

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.

Programme of Meetings of the Balint Society for the Thirty-ninth Session, 2008-2009

Lecture series 2008-2009

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.)

Serena Wilmott Tuesday 21 October
'The rewards, challenges and dilemmas of working as a psychotherapist in primary care'

Dr Nick Read, physician and psychotherapist Tuesday 19 November
'Sick and Tired: healing the illnesses doctors cannot cure'

Dr Geoffrey Baruch, director of the Brandon Centre Tuesday 17 March
'Challenges facing psychoanalytic psychotherapy
from the perspective of a psychotherapy service for young people'

The 18th Michael Balint Memorial Lecture
will be given by
Dr Paul Julian, GP and group leader on Tuesday 7 April
Preceded by drinks and buffet from 7.30 pm

London Day Conference at Canonbury Academy Thursday 19 February

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane, London NW3 at 8.30 pm on 6 November, 10 February and 19 May

The Lancashire Balint Weekend will be from 13-15 March at Whalley Abbey, near Clitheroe.

The Northumberland Balint Weekend will be from 19-21 June 2009.

The Oxford Balint Weekend 2009 will be held in September at Exeter College, Oxford.

The Annual Dinner will be held in June 2009 at the Royal Society of Medicine

Further information from the Hon. Sec. Dr. David Watt.

THE BALINT SOCIETY WEBSITE

The Balint Society has its own internet website.
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. See also the INTERNATIONAL BALINT FEDERATION WEBSITE:
www.balintgesellschaft.de/ibf

- 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, Finnish and International Balint websites. More are coming all the time.

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

Editorial:

How does the Balint group develop? A Kleinian perspective.

In this editorial we return to the question addressed last year: what do doctors gain from attending a Balint group? What are they looking for when they join? What do they need to feel happier in their work? How do they change? As group leaders, we may hope for an increased insight into the feelings of their patients and themselves. This might show itself in greater evidence of empathy, a willingness to see things from the patient's point of view. Will there be a limited though considerable change in personality? How could we tell? One way in which the leaders can observe how their group members change is to look at the kind of patients they present, the kind of stories that they tell and the way those stories are received.

Early in the life of a group of doctors new to Balint, the patient is often seen as an enemy. He is outside the door of the inner surgery, trying to get in. The doctor wishes he would go away and is asking the group for help in getting rid of him.

These patients make the doctor feel uncomfortable in a variety of ingenious ways.

They demand medication that is inappropriate (antibiotics) or not allowed (benzodiazepines). In spite of good advice, they refuse to change their life style. They may smell of alcohol. They demand absurd referrals and ask for unnecessary home visits. They may make the young inexperienced doctor feel humiliated and inadequate by asking to see someone more senior. Or they may appear in her surgery too often, showing worrying signs of an unhealthy 'dependency'.

Where do all these nightmare patients come from? Does the Balint group exist to help get rid of them? They seem so obnoxious that no one can possibly empathise with them although leaders may make heroic efforts. It appears that we here only to listen, share the pain and bandage the wounds before the doctor returns to the front line, feeling at least that he has been cared for. The patient remains angrily outside the door and we all hope he will eventually slink away.

But as the group continues, a new kind of patient appears. Or perhaps the same patient seen in a different light. We start to hear stories of patients the doctor actually likes, although she may be surprised when this is pointed out to her. These patients also cause the doctor discomfort but now they make her feel responsible. They are seen as needy rather than demanding. When they knock at the door they are invited inside and

allowed to warm themselves at the fire. Examples might be a woman supporting a family in difficult circumstances; an old man living alone and rejecting attempts to move him into a care home; a young person who is miserable and has lost the thread of his life.

We are reminded of Melanie Klein's model of infant development in which the infant's inner world of fantasy moves from the 'paranoid-schizoid' position to the 'depressive position'. In the earlier phase, everything good is kept within the self and everything felt to be bad is expelled and projected into the person of the 'bad' mother. After a while, Mrs Klein tells us, the little one begins to realise that the mother who is horrid and spiteful is also the loving mother who provides milk and care. This leads to remorse about the way she has been treated in fantasy and an urge to restore the damaged internal mother to health. We may not find this convincing as a literal account of infant development but it is easy to observe the alternation between these two modes of thought in our own adult minds and in our relationships with others.

It seems to us that in the early infant stage of the Balint group, the patients we hear described represent everything the doctor hates and fears. They need to be separated out and expelled from her mind to the space outside the inner surgery. The group is asked to listen and sympathise and endorse the expulsion. This is the paranoid schizoid group. A few months later (maybe a year) there are signs of change. Now we hear about patients who are themselves in danger and have been ill treated by their families or perhaps just by life. In telling these stories the doctor seeks relief from her guilt at having failed to protect them adequately and encouragement in finding new ways of helping them. This is often achieved by understanding what the patient really needs from the doctor. The group has reached 'the depressive position': but this does not mean they are depressed.

So let us not be dismayed if, in the first few months, the group seems paranoid and the patients hateful. With a little patience we shall see splitting and expulsion giving way to concern and responsibility and a little love.

John Salinsky

Reference:

Klein, M. (1952) Some theoretical considerations regarding the emotional life of the infant. In *Envy and Gratitude and other works* (1975) Hogarth Press and the Institute of Psychoanalysis: London.

The Function of Balint's Levels of Mind in Balint Groups

Thomas Klee PhD Associate Professor
Chestnut Hill College, Philadelphia PA USA

This article comes out of a larger project that traces the evolution of Balint groups from Michael Balint's original writings through those who have added to the understanding of Balint groups over the years. A sabbatical provided the time to travel, to read the original notes and correspondence of Michael and Enid Balint, as well as to interview experienced Balint group leaders in the United Kingdom and the United States. Early on in this project, the role of fantasy and creative speculation in finding new solutions to problematic doctor-patient relationships emerged as a particularly fascinating area for consideration, and is the focus of this article.

A study by Johnson (2004) and his colleagues to determine how Balint groups differ from support groups found that one distinguishing feature of Balint groups is that they facilitated creative speculation. Indeed, this function of Balint groups was initially proposed by Balint as an essential factor of the group in *The Doctor, His Patient and the Illness*. Others, including Courtenay (1977), Enid Balint and colleagues (1993), Brock (1999), Salinsky (2003), and Elder (2007), have described how Balint leaders establish boundaries, promote safety, facilitate cohesion, and set a frame that allows for creative speculation to promote learning and change in the group. This article looks at creative speculation through another lens, that of Balint's three levels of mind and how they might operate within the group. This perspective in no way contradicts the established literature on Balint groups. Rather, it suggests another dimension that could be helpful to Balint leaders in setting the frame, understanding what is happening within the group and helping to resolve the suffering and frustration common to a mismatched or problematic doctor-patient relationship.

Each of Balint's levels of mind is an expression of a type of relationship. Balint, as with many theorists of the object relations school of psychoanalysis, believed that human relationships were not secondary to biological drives but were motivational forces in their own right. Balint believed that all human illness and suffering, biological and psychological, could be understood only within the context of relationships. This paper examines his relationally-based levels of mind as a potential resource in understanding: 1) the purpose of fantasy and creative speculation in the group; 2) how patient suffering is empathically understood and processed by the group; and 3) how the initial frustrations presented by the doctor become the bases for patient healing and new beginnings. The goal is to deepen our understanding of the Balint

group experience by incorporating these levels of mind. Although these levels of experience have been discussed in the psychoanalytic literature (e.g. Ornstein, 2002; Bonomi, 2003), they have not been a major topic in the literature on Balint groups.

The Levels of Mind

Balint (1992) proposed three levels of mind, each occurring within the context of a different type of interpersonal relationship. The first is the *Oedipal level*, which Balint suggests is the level of mind that operates within a *triangular relationship* of three or more people, and has the essential characteristic of conflict. It originates within the family as the child learns cognitively to regulate competitive affects and channel them into more cooperative, rational, and socially acceptable expressions. This, then, becomes the prototype for future adult relationships. Balint suggests that this is the level of mind that typifies most adult-to-adult communications. It is the level of conventional language in which competition and psychic conflict are active but modulated in the striving for rational thought.

The second level of mind is more complex to describe because it originates at a pre-Oedipal level of development before language is fully developed. Balint described this level of experience as a *basic illness* or *basic fault* in the biological structure of the patient. He theorized that both physical illness, especially chronic and psychosomatic illnesses, as well as psychological disorders existed as expressions of this basic fault. Balint distinguished this level of mind from the Oedipal level as existing only in a *two-person relationship* because its origin is in the two-person bonding between the infant and primary caretaker.

The third level of mind is the *area of creation*, which, according to Balint (1992), is the least understood. Although it happens all the time, it is difficult to observe and study as it occurs within a *one-person relationship*, that is, within the individual. It does not involve another human being, even though others may be present, silently observing. It is a moment of personal insight or an 'ah-ha' experience that leads to new solutions.

The Oedipal Level

As mentioned above, the Oedipal level of mind always involves a more than two-person relationship and is typified by the adult language and communication that attempts to find rational solutions to problems. It also always involves emotional and intellectual conflict. Most adult problem solving strategies occur at this level of mind. Residency training typically functions at this level via challenging questions and

competition among residents.

Within the Balint group, the Oedipal level of mind has two expressions, which Balint understood as two different types of relationships, or transference-countertransference phenomena. The first is the transference and countertransference dynamic between the group members and the group leader. According to Balint (1963), this type of interaction, what he calls the *primal-father* transference, should be avoided in the Balint group lest it become a therapy group. Accordingly, the Balint leader typically redirects the group away from examining the relationship between the group leader and individual group members. In an update of Balint's types of relationships expressed in the group, Elder (p. 15, 2007) reframes the group-leader-to-group-member relationship as the 'relationship between the group leader and the work of the group.' This is a useful revision because it sets the context for the leader to make group-level interpretations and avoids focusing on Oedipal-type transferences and conflicts from group members to the leader.

The second type of transference and countertransference dynamic that occurs at the Oedipal level of mind is not between group members and the group leader but among the group members themselves. Balint (1963) referred to this as the *brother-herd* transference, which he viewed as more productive for the group than the primal-father transference discussed above. The norms for expressing this type of transference in Balint groups, as set by group leaders, have evolved. Initially, Balint encouraged a more confrontational approach among group members, although he did note the importance of maintaining a balance between 'sheer aggressiveness' and sugar-coated constructiveness.' Over time, the level of confrontation promoted among members was mitigated by Enid Balint and has been modulated even more in most Balint groups as a more supportive, protective and less confrontational frame has evolved.

Oedipal-level dynamics are common in the early stages of a group and may go on for some time in highly competitive groups. It is often what group leaders struggle with and attempt to control by establishing clear boundaries and modeling caring, supportive, and non-critical norms. Both primal-father and brother-herd transferences can emerge during the case presentation before the group takes the case from the presenter. For example, the presenter may attempt to get approval or create frustration in the leader (primal-father transference) by the way the case is presented. Similarly, clarifying questions from group members may have a critical tone or implication for the presenter (brother-herd transference). Again, group leaders tend to redirect member-to-leader transference dynamics via group level interventions while encouraging a supportive environment to minimize member-to-member transferences. Typically, Oedipal-level dynamics

diminish the longer the group exists and the more cohesion develops. As a result, residents in their second year of Balint often display fewer Oedipal-level transactions than those in their first year. Those who have been in Balint groups over many years typically engage in even fewer Oedipal-level exchanges as they are more likely to want to get to a deeper level of functioning, which brings us to our next level of mind.

The Basic Fault Level

Balint's second level of mind, the basic fault, is acting in what he called the *two-person relationship* and is perhaps the most useful in understanding how Balint groups produce change in the doctor-patient relationship. Balint initially proposed this idea in the 1930s while treating patients in traditional psychoanalysis, expanded the idea in *The Doctor, His Patient and the Illness*, and eventually dedicated an entire book to it, *The Basic Fault*. It was central to his thinking over most of his career and is a unifying principle in his work on the doctor-patient relationship. To understand how this level of mind is expressed in Balint groups, we need to understand the dynamics and motivational force of the basic fault.

Balint (1992) identified four characteristics of the basic fault that distinguish it from the Oedipal level of functioning: 1) it exists only in a two-person relationship (caregiver-child, doctor-patient); 2) it is a special two-person relationship that is focused primarily on the needs of just one person who must be attended to, while the other is seen as powerful and capable of either gratifying or frustrating the needs of the primary partner; 3) as a solution is approached, the dynamic force between the individuals is conflict free, although conflict may have been experienced earlier in the relationship; and 4) adult language is often useless or misleading in describing events at this level, as it simulates pre-Oedipal functioning.

The term *basic fault* is itself revealing. Balint used the adjective *basic* to imply that there is nothing deeper or beneath it in the psyche; it is a deficiency in the personality's foundation whose 'influence extends widely, probably over the whole psychobiological structure of the individual, involving in varying degrees both his mind and his body (Balint 1992, p. 22).' The term *fault* was chosen because it is the word many of Balint's patients used to describe this phenomenon, often expressing a sense that a fault within them needed to be 'put right.' Balint elaborated on the term by explaining that it is analogous to a geological fissure, a deficiency in the organism that is vulnerable to biological and psychological stress. The term was never intended to be pejorative.

Balint believed that the fault originated in infancy or very early childhood for various reasons, including genetic vulnerabilities and failure of the primary caregiver to meet the infant's biological and psychological needs. The range of ways the infant's needs might not be

adequately met is quite extensive, including anxious, depressed, inattentive, over-protective, rigid, inconsistent, over-exciting, or indifferent caregivers. In fact, the list of possible genetic and environmental failures in care giving is so extensive, that it is likely that few leave early childhood without a basic fault. However, it is the extent of the fault that is important in the later expression of biological and psychological disorders. A more extensive fault could result in a lifetime of symptomatic expression in response to the stresses of life. Balint also suggests that even a minor basic fault could produce biological and psychological symptoms under sufficient stress.

If the basic fault is significant, the long-term result of this early failure is an individual's feeling that something is wrong within, which in turn generates a great deal of anxiety that can be expressed biologically or psychologically. Although the most obvious example of this can be seen in psychosomatic illnesses, Balint (1992, p. 22) believed, based on his research and experience, that the basic fault was also a factor in a 'great number of ordinary clinical illnesses.' He also believed that under the influence of emotional stress, including medical treatment, a biological illness could give way to a psychological disorder and vice-versa. In doing this, Balint suggested that the basic fault provides a theoretical foundation for the mind-body connection, the high co-morbidity rates of biological and psychological disorders seen by the general practitioner, as well as the co-morbidity of depression with heart disease and numerous other chronic physical disorders.

Elsewhere, Balint (1969) clarified the basic fault by distinguishing between Class I pathologies which are localized, easily diagnosed and external in origin, and Class II pathologies which are internal in origin, meaning that the patient has no localizable illness but is himself ill. Balint suggested that Class I pathologies require 'illness-oriented' treatment and Class II pathologies require 'patient-oriented' treatment. Class II illnesses revolve around the basic fault and require a deepening of the doctor-patient relationship as part of successful treatment. Later, Balint (1992) suggested that even localized illnesses with external origins could stress the basic fault and produce additional symptoms not normally associated with the illness.

With his concept of the basic fault, Balint introduced an innovative psychobiological construct into traditional psychoanalytic theory, one that functions as a dynamic motivational force throughout life as the individual seeks to put together the ingredients that will heal it. He distinguishes the basic fault from Freud's motivational forces of instinctual drives (which can be gratified) and psychic conflicts (which can be resolved) by proposing that the basic fault can only, in the best-case scenario, be healed with a defect metaphorically similar to scar tissue. More typically, however, the basic fault goes unhealed, or only partially repaired, as it is difficult to find

the right mix of ingredients to promote the healing. Here Balint is clearly suggesting that the resolution has to come in the form of a significant relationship with a trained healer to provide what is missing. Given that the basic fault is expressed in both psychological and biological disorders, Balint believed that the general or family practitioner was best placed to provide this healing. This led him to the idea of training general practitioners in psychotherapy via the early Balint groups. Although the idea of the family doctor as psychotherapist was abandoned, the value of sensitizing the doctor to the psychological and relational needs of the patient has continued as a primary function of the Balint group.

Moreover, the basic fault is at the center of Balint's thinking about the doctor-patient relationship. Many of the clinical issues he wrote about in *The Doctor, His Patient, and the Illness* are based on the idea of the basic fault and are still significant in understanding the work of a Balint group. Five of these are particularly helpful in understanding how the concept of the basic fault influences Balint groups: the patient's 'proposed illness,' the drug 'doctor' in response to the patient's proposed illness, a 'deeper diagnosis,' the 'apostolic function,' and the 'collusion of anonymity.'

Balint suggests that the patient and the doctor are involved in a negotiation to identify the real illness that needs to be treated, particularly in what he called Class II illnesses, which require patient-centered medicine. The position of this paper is that the real illness in these cases is the *basic illness* or *basic fault* discussed above. The patient 'proposes' an illness in the form of a symptomatic picture to which the doctor responds. This response includes relational qualities of the doctor that have a healing potential, which Balint refers to as the drug 'doctor.' He writes that we need to understand the pharmacology of this drug 'doctor' in order to evaluate if it is the right drug and dosage for the deeper illness underlying the patient's symptoms. A deepening of the diagnosis through empathic listening and a better understanding of the patient can further the healing qualities of the doctor-patient relationship. According to Balint (1963, 1969), this requires a level of listening so different than the listening skills typically used by doctors that, once acquired, results in a considerable though limited change in the doctor's personality."

This deeper level of listening is often hindered by what Balint identified as the doctor's apostolic function, which consists of his or her conditioned beliefs about what the patient needs based on years of medical training. The apostolic function can block the doctor from hearing the patient correctly, leading to frustration in the doctor and the patient. The resulting range of negative emotions in the doctor sometimes motivates the doctor to inappropriately refer to specialists, which Balint called the 'collusion of

anonymity.' In summary, the patient initiates a process of negotiating with the doctor about an illness, a treatment and a type of relationship necessary for healing. This article suggests that the patient is actually asking for a healing of the basic fault, and that the Balint group can take the doctor to this level of mind to explore his or her relationship with the patient in a new, more meaningful way that challenges the doctor's apostolic function.

All of these dynamics, processes and clinical dilemmas are part of the cases presented in a Balint group. The initial case presentation usually includes all the phenomena just described: the patient's offer of an illness, the doctor's diagnosis and treatment response to the patient, and the physician's frustration when the patient does not seem to respond to what the drug called 'doctor' is offering. The doctor's apostolic function has been challenged, leaving the doctor feeling frustrated, angry, helpless or confused. Sometimes referrals to specialists have been made with little positive outcome. Other group members ask clarifying questions and, as mentioned earlier, it is during this time that Oedipal-level-of-mind conflicts are likely to occur among group members.

When the case is turned over to the group there is a shift in the frame. This shift occurs when the leader signals an end to clarifying questions and invites the group to take the case. It is likely that at this point a well-functioning Balint group enters a mild state of what Balint (1963) called 'benign regression.' Balint was careful to distinguish between malignant regression and benign regression. The former is a pathological need for the gratification of narcissistic needs, and the latter is an essential part of what he called 'new beginnings,' which are creative solutions to problems – exactly what the Balint group is attempting to achieve. For Balint, benign regression is a prerequisite to approaching the basic fault level of mind in the group because it frees unconscious affects that are necessary for insight and change.

In recent years, the giving of the case to the group is often punctuated by the 'pushback,' in which the presenter moves his or her chair slightly back from the circle to signal a shift to reflective listening as the group holds the case. This ritual may be helpful in facilitating benign regression in both the presenter and the rest of the group. Of course, this can only be successful after the group leader has set protective boundaries and an empathic frame that promotes safety and cohesion. Otherwise the group could not process the case without producing conflict, which would keep it at an Oedipal level of mind. If the group feels safe enough to allow the benign regression to occur, it moves toward a basic fault level of mind and conflict is minimized. At the basic fault level, the group can provide a holding environment for the two-person, doctor-patient relationship to be explored, understood and deepened. This is a process that takes time and is

unlikely to occur early in the life of a group.

When the group takes the case from the presenter, members begin to examine the relationship between the presenting doctor and the patient, which is Balint's third type of transference-countertransference dynamic in the group (the first two occurring during the Oedipal level of functioning discussed earlier). The group is encouraged to use fantasy and creative speculation to examine this two-person relationship. Although there are more than two people present, via fantasy the group encloses the doctor-patient relationship into a protective space where it can be examined and understood affectively. Each group member can imagine himself or herself in this encapsulated dyad, both as the doctor and the patient. This is a psychological state that approaches the basic fault level of mind, previously held out of conscious awareness. The rational language of the Oedipal level of mind is replaced by visual images, metaphors, and affectively based stories. This is similar to the surfacing of previously unconscious information through 'collective dreaming' that Johnson (2007) describes, which allows group members to assimilate new insights. During this time group members can experience themselves in both the needy and care-giving roles unique to the basic fault level of experience without being distracted by conflict. Through creative speculation, all four characteristics of Balint's basic fault are actualized via fantasy, if not experienced directly. This is the foundation of true empathy and over time can result in what Balint called a 'considerable though limited change in the doctor's personality.' Perhaps most important, according to Balint (1963), it is at this level of understanding that we can identify what treatment is really needed, or what dosage of the drug 'doctor' is required to help the patient heal.

The Area of Creation

Balint's third level of mind, the area of creation, is the most speculative. Because it is a *one-person* relationship – an internal relationship with oneself – observers can get only a glimpse of it as a person enters and exits this level of experience, which typically occurs in moments of silence. Balint (1992, pp. 26-27) writes:

True, we cannot be with him during the actual work of creation, but we can be with him in the moment just before and immediately after, and in addition, we can watch him from the outside during his actual work. Perhaps, if we can change our own approach from that of considering the silence as a symptom of resistance to studying it as a possible source of information, we may learn something about this area of the mind.

Notice that here he also acknowledges the importance of silence in the group, not as a resistance, but as a space for new ideas to emerge.

Balint believed that the area of creation is where all artistic, philosophical and scientific

innovation begins. It is not a place of rational thinking, which would be the Oedipal-level of mind. Instead, this level is reached when the fantasies, images, and creative speculation of the basic fault level lead to what Balint (1992) called *new beginnings*, which are experienced as flashes of insight, and sometimes epiphanies. According to Balint, a person may be at this level of mind for only a few seconds, while others seem to remain at this level for longer periods of time. In terms of the Balint group, it is likely that experiencing the basic fault level of mind, even symbolically through creative speculation, creates a series of brief but fertile moments in which areas of creation, or new beginnings can emerge into consciousness.

Summary and Conclusion

Balint's three levels of mind are basic to his thinking about how change occurs at the deepest level of human functioning. They provide a template for understanding the types of relating that can either inhibit or promote change in the Balint group. At the Oedipal level, the group is operating out of the rational apostolic function doctors are trained to use to process clinical information. Balint (1969) suggested that doctors need to learn the limitations of their apostolic beliefs by being confronted by the limitations of these beliefs. This work, and the resistance to it, occurs at the Oedipal level of experience.

The basic fault is a rich concept that is foundational to many of Balint's ideas including the patient's proposal of an illness (which may not be the real problem), the deepening of the diagnosis to understand the real illness, and the pharmacology of the drug 'doctor' accurately to

meet the patient's needs. Within the Balint group, reaching the basic fault level of experience through fantasy and metaphor helps the doctor learn a new way of understanding the patient and develop self-knowledge. It is the basis of true empathy that can result in a deeper understanding of the patient and the doctor.

The area of creation may occur only in brief moments in Balint groups. These are unpredictable events that emerge from the group as it reaches the deeper understandings of the basic fault level. These may be experienced as 'ah ha' moments, peak experiences, or epiphanies, great and small. It is from these experiences that new beginnings arise and the doctor-patient relationship is transformed.

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My Balint Life

By Antonia Shooter, clinical psychologist and psychoanalyst

Moved by Andrew Elder's recent lecture about beginnings and retirement, I should like to share my review of the importance of Balint work in my professional life.

The Family Discussion Bureau

Like throwing a bottle-message into the sea, I answered an advertisement in *The New Statesman* offering training in marital work, with little idea where it would land up. I was 24, a research psychologist in the arid, impersonal measurement culture of the anti-psychodynamic laboratory at Cambridge University. The reply invited me for an interview at the Family Welfare Association. You had to be Christian, happily married and over 25, so I swallowed my qualms about my recent marriage and put my hair up, and there I met Enid Eicholz, who had a warmth, maturity and beauty hitherto unknown to me. I joined the team of five women (including Lily Pincus, later to become known for her rich books on mourning). It was the Family Discussion Bureau (FDB) at 4, Chandos Street, W1, and our twice weekly case-conferences had as consultant: Michael Balint. He brought a deep understanding of the unconscious factors in marriage, insisting that we examine, in our marital cases, the dynamics of the partners' choice and collusive relationship as well as their troubles. Each partner saw a different worker and the case conference could infer from the presentation further insights into the marital dynamics. You were not allowed notes so that the order and emphases in the stories and above all the omissions were revealing and significant.

Michael, a formidable presence with his Hungarian accent and thick glasses, would get very excited, sometimes angry, so that we caseworkers were glad of Enid's calming and restraining effect on him. The experiment was to develop our psychoanalytic and counter-transference understanding without ourselves having personal analysis. We were keen to write up our casework, which was very original at that time' and we produced a book called *Social Casework and Marital Problems*.

Michael had a theory that our troubled marriages would prove to have a constellation of defining statistical factors such as age at marriage, age difference, interval till first child etc. As research psychologist to the team, my task was to compare our sample with the figures for marriage in the population at large. I spent long visits at Somerset House where they extracted for me a table of age-difference between couples. To Michael's fury and disappointment, none of these statistics identified our caseload as in any way unusual. I am afraid he made me feel quite unfairly blamed for this! Of course, his important insights were really about the nature of the marriage relationships, how and where they met and so forth. This was about 1951, coincident

with Michael's budding interest in GPs. (I note that Philip Hopkins also found Balint by answering an advertisement, in his case, in *The Lancet*.)

When Enid and Michael married (in 1954, I think) it was traumatic for the Family Discussion Bureau, for Enid's divorced status was unacceptable to the sponsoring Family Welfare Association and she had to resign! Such a dependent and vulnerable group of social workers to lose their parents! It was ironic. For a year or so, Drs Jock Sutherland and Geoffrey Thompson of the Tavistock Clinic came as our consultants. Later, after I had left, the whole Bureau moved to the Tavistock and Enid rejoined the team, which eventually became the Institute of Marital Studies which undertook training for probation officers and for the Marriage Guidance Council (now 'Relate').

My work with GPs

There was an interest in doctors 'in my blood'. My grandfather, who died when my mother was only four, was remembered locally as an ideal Yorkshire country GP. My godmother was a respected anaesthetist. We had a close attachment to our family doctor who had helped deliver me (caesarean) on our kitchen table, my mother having been just been widowed and newly diabetic. When I had whooping cough, she brought me tiny bottles of medicine for my dolls. We kept in touch till she was 90.

As a clinical psychologist on the staff of the Tavistock Clinic, in the late 1950s, I had the opportunity to train as a group leader. The training consisted of two years as an observer, discussing the GP work afterwards. The leaders had to be psychoanalysts and formed the 'GP and Allied Professional Workshop'. This comprised not only GP groups but groups for clergy, children's home staff, health visitors and lawyers. The term Balint group was not used at the Tavistock, because the work was felt to derive from the ideas of Bion and from a group of colleagues using the Tavistock Group Relations approach. Nor did any psychoanalysts join the Balint Society when it started. It was felt that there should not be a personal 'brand name' of one doctor.

Dr Stanford Bourne convened many members of this workshop at International Leaders' conferences held every two years for over a decade. I attended animated meetings at, among other places, Utrecht, Como, Montpellier and Bern. Because I spoke fluent French I was invited for about ten years to lead groups at Divonne les Bains in the Jura - the French equivalent of our Oxford weekends, but lasting five days and including psychodrama and 'psychoanalytic relaxation'. I made many French friends, some of whom I still visit.

At home, I co-led GP trainee groups at Hackney Hospital with Michael Courtenay, Paul Julian and Heather Suckling, at Northwick Park with Oliver Samuel and in Harrow with John Salinsky. This was fascinating work. I also co-led in their practices with Oliver Samuel at Pinner and Peter Graham at East Ham and was leader of a group of GP receptionists sponsored by Mal Salkind. For two years each I was leader of groups in Coventry and Bristol (recruited by the Tavistock Clinic) and I co-led at the Oxford weekend for about eight years. All this has been a rich and fulfilling experience and my regret is that I have not felt able to write up some of the group work.

Another relevant sphere of work has been at the Tavistock Institute of Group Relations in

'experiential study groups' and at the fortnight-long Tavistock Leicester conferences examining unconscious factors in leadership and organisations. In both of these I had many years on the staff, excitedly learning. I would recommend this experience to doctors to help in understanding the dynamics of the profession and of practice-groups.

At the age of 80, I have no designated personal GP, but my respect, affection and admiration for the profession enables me to expect to feel contained, cared for and suffused by them with the life-force for so long as I may have left.

Thank you, Michael and Enid and the Balint Society!



An open letter to Roger van Laethem From Marie-Anne Puel Société Balint Française

*(Roger van Laethem is a GP and psychotherapist in Brussels.
He was the first treasurer of the
International Balint Federation 1974-79
and served as its general Secretary from 1979-93.
He was treasurer for a second term 1993-2001)*



Cher Roger,

Rien du contenu de cette lettre n'est nouveau ni pour toi, ni pour moi. Il me semble cependant, qu'au moment où tu quittes peu à peu tes activités « balintiennes », il faudrait que ce que nous savons tous les deux soit connu de tous. C'est grâce à toi que je me suis engagée dans la Fédération Balint internationale. Nous avons été présentés l'un à l'autre au congrès français national Balint de Lyon (c'était quand déjà?!...). Je passe sur le plaisir de t'avoir rencontré : je crois que l'on peut te décerner la Médaille d'Or de la Cordialité et l'Oscar de la Diplomatie. Je passe sur la richesse et la qualité de nos échanges. Mais il faut que tout le monde sache à quel point tu m'as permis :

- De rencontrer des personnes d'une qualité exceptionnelle : celles que je rencontre dans les réunions et congrès de la FBI me semblent appartenir à une tranche de la population que je ne pourrais pas rencontrer ailleurs : humanistes, cultivés, attentifs, chaleureux, curieux « hors frontières », bref : brillants. (« brilliant », comme dirait Heather)
- D'échanger avec elles des interrogations professionnelles aussi intimes qu'universelles dans le climat «Balintien» qui traduit notre formation commune ou la fait disparaître.
- De voyager d'une façon particulière, proche du pays et des habitants par le biais du pays ou de la ville « accueillant » les congrès ou les réunions de conseil d'administration.
- De communiquer et d'essayer mon anglais avec des « écoutants » patients.
- D'expatrier un environnement rétréci pour l'enrichir auprès de ceux qui sont susceptibles de s'y adonner et qui s'y adonnent.

Bref, Roger, je te suis très reconnaissante, te remercie et t'embrasse.

Marie-Anne Puel

English translation:

Dear Roger

Nothing in the content of this letter is new to you, nor to me. It seems to me however, that at the point at which you are gradually leaving your Balint work it is essential that what we both know should be known by everybody. It is thanks to you that I became involved in the International Balint Federation. We were introduced at a French national Balint congress at Lyon (when was that again...?)

I pass over the pleasure of having met you: I believe that you have been awarded the Gold Medal of Cordiality and the Oscar for Diplomacy. I pass over the richness and quality of our discussions. But everyone must be told how you enabled me:

- To meet people of exceptional quality: those I met at the International Federation meetings seem to me a section of the population, whom I could not otherwise have met: humanist, cultivated, attentive, warm, curious 'outside the boundaries', in short, brilliant (as Heather would say).
- To discuss with them matters professional, personal and universal in the Balint way which the training we have in common enables us to do.
- To meet the people of the countries and towns that welcome us for our Congresses and Council meetings.
- To communicate and to try out my English on patient listeners.
- To leave a familiar environment and find a home from home in another country.

In short Roger, I am most grateful to you, I thank you and I give you a kiss.

Marie-Anne Puel

My most memorable patient

Peter Graham, general practitioner, London

When I first settled in general practice in London, I felt confident and happy that I had been fully trained in Edinburgh to meet any medical eventuality. After all, in addition to the normal medical degree I had gained an intercalated honours degree in physiology (the normal functioning of the body) although I had not done any GP vocational training. And when my senior partner went on a touring holiday in France in his open top Triumph Herald in August 1966 I was happy to be left in sole charge of the practice and never suspected for a moment that things might get difficult.

It was a hot Tuesday morning in August and the waiting room was empty when I walked a smart young woman in a green tailored costume, whom I didn't recognise. She must have been one of my partner's patients. I beckoned her into my consulting room with a cheery wave: 'Come and tell me what the trouble is.' She sat down demurely and without a moment's hesitation she replied: 'I want to murder my baby'. She seemed so certain of herself. It was as if I had been pole-axed and the roof had fallen in. If I had had a spade I would have dug a hole through to Australia. I felt completely confused and unable to think clearly and could only mumble out a few perfunctory questions. How old is her baby? 18 months. And where was she now? At home with her husband. Why did she want to murder her? 'I can't stand her', but there were no valid reasons. And yet I had an uncomfortably cold feeling that she meant to go through with it; and as quickly as I could, I expelled her from my consulting room. I said I would arrange to visit her at home and would let her know when. She had terrified me; I was quite frightened for her baby and wanted to protect her and thought that the baby may need to be removed for safety. It took me ten minutes to calm down, but there were no other patients around. I then had an idea: to ask the local child psychiatrist to see her and the baby as soon as possible. I felt quite relieved by this thought and I phoned him and he answered. Could he visit her today? Not possible; but how about Thursday week with his psychiatric social worker? Couldn't it be dangerous to leave her that long? No, he didn't think so.

We met on her doorstep by appointment, the psychiatrist, the PSW and I. The first shock was when she opened the door looking so happy and relaxed with her beautiful blonde baby Megan and her husband Francis. I was confused and nothing that was said during the next hour cleared the air for me. When we retired to the front parlour for a conference I argued for Megan to be taken into care, as the conflicting accounts had not cleared up any of the confusion. But no. The psychiatrist countered that he thought counselling sessions with the PSW would clear

the air and be more appropriate. And that was the end of the matter as far as I was concerned. She apparently made good use of the counselling sessions because I never saw her again for many years while she went back to see the senior partner. However, I later heard that she and her husband had divorced. He went back to live in Jamaica while Megan was safely adopted by his mother and brought up in the house next door to the surgery with six other children. The only positive outcome was that Miss Crowther, a fully psychoanalysed senior social worker, joined our practice as liaison worker for three fruitful years.

I was determined to find out what was missing in my training, and Dr Kahn suggested that I read Michael Balint's book *The Doctor his Patient and the Illness* which I borrowed from my partner. One year later, having been hugely impressed by the book, I found Michael Balint, and went to a selection interview at his flat in 7, Park Square West and asked to join his groups at University College Hospital. He questioned me about my hobbies of bridge and gardening and said it would depend on the group's approval after three meetings. As it was June I waited for the start of the new term in September, for which he never forgave me. I never realised his time was so short. I pursued the Wednesday afternoon group, first with Michael for 15 months before he died, and later with Enid Balint and others for nine years.

Eighteen years later, after the senior partner retired, on a damp night in February I walked the grown up daughter Megan looking glamorous even with red eyes. She was due to dance that night on stage at the Palladium, but she felt sick. 'What is wrong with me, Doctor?' 'Might you be pregnant?'—Possibly. 'Could you arrange a pregnancy test?' Yes and it was positive! If her boyfriend ever found out he would murder her! But now he was on remand in Wormwood Scrubs on a charge of armed robbery. Could she be sure that it was his baby? 'Maybe it's not his?' She seemed to be expecting violence and I felt the need to protect her again. First from her mother and now him? But something inside me was too frightened to ask about her mother.

Two years later, one Saturday afternoon, she requested a visit for her two babies with colds and runny noses. I found her a long way away in a flat on the top floor of a 22-storey tower block with two of the fiercest Alsatians that I have ever seen, for security, watching through a plate glass door as I examined the babies. She was in hiding from the vicious boyfriend. This time I felt calmer and able to reassure her about the children's illness. And then I had the presence of mind to ask her: 'Where was her mother?' 'Who knows. I hardly ever see her and I don't care?' They rarely spoke; she had disappeared again with her latest boyfriend. There was no bond of attachment left.

One year later, out of the blue, her mother re-appeared in the surgery looking distraught. Now she had terminal breast cancer and smelt strongly of alcohol. She had declined a mastectomy as she believed only in natural methods of healing, and did not want to be disfigured, much to the consternation of the surgeon at the teaching hospital. But her general practitioner would not give her enough morphine to relieve her pain. Could she register with me? I thought it was a strange excuse but I dissembled that I was pleased to see her. She chose to live alone a long way from the practice. Although there had been several toy boys, her life was now empty and bitter; but at least she did not have to share anything. She needed extra large doses of morphine at that time which I was able to prescribe. I watched and waited as she slowly

went downhill with multiple metastases, over the next six months without developing any sympathy for her as I was still haunted by the initial fright she had given me. Suddenly she just disappeared without trace – I think she wanted to die with dignity on her own. Maybe she detected my fear of death, while to die in front of me, meant displaying all our mutual vulnerabilities, and neither of us wanted to lose face. The support and continuity of care was important to her even though the senior partner was gone. This was a very loose relationship with distant attachment over many years that she needed and felt safe with, and I could allow her to be her normal aggressive self. I was left feeling empty and dissatisfied with myself.

The names of the patients have all been changed

The Doctor, the Genius and his Illness

by Michael Courtenay

Retired general practitioner and past president of The Balint Society
(a paper given at the 15th International Balint Congress in Lisbon, September 2007)

The second Balint research group (in contrast to the standard 'training and research' group) produced a book called *Asthma*¹, which reported the findings of the group led by Michael Balint, and was written by Aaron Lask. This was in what I may call the first era of Balint work, beginning in 1950 with the formation of the first famous group (sometimes called 'The Old Guard'), which gave birth to the publication of *The Doctor, his Patient and the Illness*² in 1957. What I may call the second era of Balint work began with the publication of *Six Minutes for the Patient*³ in 1973. The first era was predicated on the Balints' notion that the principles of psychodynamic diagnosis and treatment might be spread over a much wider patient base than the relatively small cadre of psychoanalysts in Britain could possibly hope to achieve. Their initiative fell on fertile ground. At that time, British general practitioners had been virtually excluded from the resources of secondary care medicine and their morale was low. Winston Churchill's doctor, Lord Moran, had pontificated to the effect that general practitioners were doctors who had 'fallen off the ladder' of medical achievement. At the same time the patient workload, in terms of the numbers of patients seen, had exploded. Packed surgery sessions and long afternoons of home visiting in addition to 24-hour on-call duties were the rule.

The expectation of Balint group members was to have a case ready for presentation every week, based on long interviews of a duration approximating to the psychoanalyst's fifty minute session. This led to GPs aspiring to be psychotherapists of a sort and it was in this context that the research on asthma was done. The main finding of the research was that a large percentage of patients with asthma appeared to adopt a child-like role in the doctor-patient relationship. This led to reinforcement of the notion that asthma was a psychosomatic condition. At the time medical treatment of asthma was primitive, adrenalin injections being the first line medication, with the possibility of intravenous aminophylline as a back up, though this was more dangerous, resulting in some fatalities. Corticosteroids were unavailable then. The case histories selected by Lask suggested that many of the patients were helped by the psychotherapeutic approach used by the GPs.

But as time went on Michael Balint became dissatisfied with the long-interview custom, mostly because the number of patients that received this treatment were necessarily only a small proportion of the case load of a GP at any one time. I also suspect, based on experiencing his remarks during the course of the research group on sexual problems, that Balint was

becoming aware of criticism from fully trained psychotherapists that untrained GPs might damage patients' chances of receiving proper treatment, sometimes with very unfortunate consequences. I think the impetus for the research group leading to the publication of *Six Minutes for the Patient*³ stemmed from these two considerations.

The second era of Balint work was predicated on the basis that every patient should have the opportunity of benefiting from the doctor's enhanced skills consequent on Balint training. The idea was that the insights acquired through the 'considerable though limited change in personality', which was the aim of the training, might benefit all patients rather than those in which work with the patient appeared to present an unusual degree of difficulty, either in making a diagnosis or in attempting treatment.

The increasing usefulness of this approach raised the question as to whether the doctor's problems in relating to some patients might be related more to the doctor than the patient, and it was in this context in that the research leading to the publication of *What are you feeling, Doctor?*⁴ was conducted. One hopes that this is the dawn of a third era of Balint work, in which the importance of every doctor being aware of his or her defences is accepted, and would mean that there should be a brief assessment by the doctor of every patient contact in terms of what was happening in the doctor-patient relationship.

To illustrate the many-sided problems of patient-orientated medicine I shall present my case: Marcel Proust. The case history is inevitably somewhat second-hand, but I rely on his great biographer, George Painter⁵. Proust was an asthmatic from childhood, and he had found that he worked better by night and was able to sleep by day. After his mother's death and when his grief began to wane, he was taken unawares by feelings of possible happiness, and resolved to try and reclaim the day for his life and work. His father had been a doctor and so was his brother. His father had thought him a dilettante who ought to get a proper day job, so Proust was somewhat anti-doctor.

During the first half of 1905 he had conscientiously read up the works of French specialists in nervous ailments, and was interested to read that the unconscious was responsible for all manner of diseases which hitherto had been supposed to be organic. Previously, Dr Merkien had ordered him to 'unlearn your asthma'. Now Dr Déjérine was prepared to admit him to his nursing home. Then he surmised that Dr Sollier might be persuaded to

treat him at home, but when promised that the treatment would only last six weeks he agreed to be admitted to his sanatorium. As Painter wrote: 'Psychiatrists are familiar with the patient who sets impossible conditions for his treatment, abandons it if he sees any risk of being cured, knows enough about the secret causes of his neurosis to be able to parry all attempts to detect them, and begins by establishing a feeling of intellectual superiority over his doctor.' So it was to be with Sollier. For Proust unconsciously preferred his asthma and the way of life it necessitated to the health of ordinary beings. The charming Dr Sollier made an unfortunate start by showing that he did not understand Bergson's writings (on the nature of time) which gave Proust the feeling of intellectual superiority. Sollier's 'isolation treatment' was delightfully free of rigour. Not only was Proust allowed to carry on his enormous correspondence by dictation, but he could also write his own letters to friends in special cases. Later, he was allowed to receive friends on three days a week in the afternoon. The isolation-chamber at Billancourt sanatorium had become a mere annexe to Proust's bedroom at 45 Rue de Courcelles, and he was living precisely as before, with asthma unabated, except that for the first time for five years he was sleeping at night and breakfasting at noon. But the six weeks were soon over and he returned home, 'fantastically ill'. His sojourn at Billancourt had not been a cure but a successful and final escape from health.

One now has to ask what the effect of current asthma management would have had on Proust. Say, a short course of oral corticosteroids followed by continued steroid inhalation plus a selective beta2-adrenoreceptor stimulant (or whatever). The odds are that he would not longer be 'fantastically ill', but would we still have the fruits of his labours in the face of the prolonged suffering he endured in struggling with his asthma? Perhaps you would like to review your own casebook for failures who turned out to be geniuses, and whose cure would have robbed humanity of the fruits of their creativity?

But there is a deeper dilemma. Over the course of my professional life, conditions that were thought to be psychosomatic have been reassessed and are now seen as essentially organic, peptic ulcers for instance, caused by helicobacter pylori infection. On the other hand, some cancers may have a partly psychosomatic aetiology through the effects of psychological stress mediated through temporary suppression of the immune system. Perhaps we should view this dilemma as an expression of a reality which might be a paradoxical duality analogous to quantum theory in physics concerning photons and the constituents of atoms (etc.) being understood sometimes as particles and sometimes as waves. Perhaps there is a place for a new biological theory based on something analogous to the wave function concept? I can never forget that I know of at least one doctor whose asthma

was cured by a Balint group

Returning to the case of Proust, Lask's idea of the asthmatic as someone who has undergone a regression to childhood resonates with Proust's seminal experience which led to the final form of his great work. It was on or about January 1st 1909 that he returned, late at night, along the snow-covered Boulevard Haussmann, to experience one of the most momentous events of his life. As he sat reading by his lamp, still shivering with cold, his servant Céline urged her master to take a cup of tea, an unfamiliar beverage for this coffee addict. When he idly dipped in it a finger of dry toast and raised the sodden mixture to his lips, he was overwhelmed once more by a mysterious joy which marked an onset of forgotten memory. He caught an elusive scent of geraniums and orange-blossom, mingled with a sensation of extraordinary light and happiness. Not daring to move, clinging to the taste on his palate, he pondered, until suddenly the doors of memory opened. The garden of his great-uncle Louis Weil at Auteuil had returned, miraculously preserved by the savour of the rusk soaked in tea, which his grandfather Nathé Weil would give him when, a child in the summer mornings of the 1880s, he visited the old man in his bedroom. At that moment he saw it as a symbol of his present theme, the nature of artistic creation; for the act of involuntary memory combined both the aspects of art of which he had written a few days before, the sensation in the depths of the self of a pure reality, and the discovery of an affinity between two feelings. He did not yet realise that this was the missing key, which he had sought ever since 1895, to the creation of his novel.

As a coda, I shall add a little story. The first wife of my first medical chief, Elizabeth de Wardener, was a great character. She worked for a time at the Embassy of Guatemala, and when the ambassador and the chancellor shot each other dead in a quarrel, they were not replaced for over a year and so she was virtually the ambassador for that period. I introduce her because she was asked on her 80th birthday if she had read Proust, to which she replied, "I am keeping that for my old age." When she died at 86 she had missed the opportunity. My dear colleagues, don't make the same mistake! Remember Somerset Maugham called it the greatest novel of the twentieth century. On your fiftieth birthday see that you make sure you will read *In Search of Lost Time* before your sixtieth. I must confess that I didn't read it until I reached my seventies, and only after George Steiner's *Grammars of Creation* revealed that it is a myth that the novel is merely about a social snob's life in high Parisian society in the late nineteenth century. Truly, the book shines a light on painting, music, architecture, theatre, human relations and sexuality and, indeed, the whole human condition.

So take courage in your efforts, my friends, continue to strive to help patients to make sense of their lives, while being certain that any

genius among them will be sure to escape. Indeed, a lost patient may be your greatest success.

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35 years on: Attachment and Loss – The Practice as a Secure Base

By Andrew Elder



(A talk given to the Balint Society at the RCGP on 30 October 2007)

My talk seems to have become a personal reflection on the theme of Endings and Beginnings – Loss, Attachment and Generational Change. Perhaps this is not surprising. In five months time I am due to retire from the practice that I have worked in for thirty-five years. Although I'm sure there will be gains and new beginnings for me as a result of this, retirement is a major transition and loss by any standards. I have become very attached to my practice which has the quality of an extended family for me. But also, by choosing a subject that takes us to the limits of life, and invites us to think about the impact of one generation on another, I hope I am offering a small antidote to the prevailing contemporary over-emphasis on the immediacy and tasks of the consultation-at-hand.

As I approach the end of my time as a GP, I am conscious of those who helped me at the outset of my career. I arrived as a trainee, unsure of my future direction, in October 1972, at a small two-roomed shop at the bottom end of Lisson Grove. I had read *The Doctor, His Patient and the Illness* as a student and was keen on what I then thought of as psychiatry. My trainer, Harry Levitt, was one of the early generation of GPs who had worked with Michael Balint and was one of the co-founders of the Society for Psychosomatic Research in the 1950s; he later became Chairman of the College of GPs. Within a few weeks of my arrival, Harry sent me in two different directions – to a Balint Group at the Tavistock (led by John Denford) and to St Thomas' where Michael Courtenay was beginning to run a prototype, but voluntary, half-day release course for trainees. How fortunate I was. Both experiences confirmed me in my choice of professional direction and set in motion the interests that have sustained and nourished me to this day. I can recall clearly all the other GPs in that first group and can remember many of our cases. A few years later, with Michael Courtenay's help, I began working with Enid Balint and continued to do so from that time, more or less continuously, until her death in 1994. Thus Balint work has been with me throughout my career as a GP, from the first to the last. I am extremely pleased to be able to play a more active role again now as the Society's President.

My talk starts with the idea of the practice as a secure base – a place to which both patients and professionals become attached in characteristic ways. This concept is noticeably missing in most present day medical thinking, and its inclusion may help us understand better

the role that practices play in maintaining the health and wellbeing of their patients. The concept of the secure base comes to us from John Bowlby and Mary Ainsworth's work (Bowlby, J. 1988, Ainsworth, M. 1989) on the attachment patterns of small infants and their primary caregivers. I have noticed that as I have grown older my interests have become younger. As a young GP I had a strong interest in the care of the dying. More recently, it is the world of mothers and their infants that has drawn my attention. From the explosion of research that has followed Bowlby's initial work, we now know how influential these early attachment bonds are for the development and later functioning of individuals, and in addition, it has become clear that early therapeutic intervention, even in infancy, can alter the course of that development. I shall discuss a case in the second section of the paper which drew my attention to the role of practices in what is now often termed Infant Mental Health. And in the last section I shall return to the secure base – my practice – to talk about facing ending and my own sense of loss and the process of retirement from being a GP.

The Practice as a Secure Base

Michael Balint used the term 'mutual investment company' (Balint, 1957) to describe the way in which 'capital' is accumulated in the doctor-patient relationship as a result of the regular meetings between doctor and patient. Information about the patient's background and illnesses is gradually acquired by the doctor, and at the same time the patient gains familiarity with the doctor's own strengths and limitations. More important though is the shared experience gained together as they deal with whatever illnesses and crises the patient brings to the doctor's attention. The capital in this mutual account can be drawn on, when needed, as the doctor-patient relationship develops. Without wishing to stretch this analogy too far, this account is held in a bank – the practice.

Practices have human histories. When I retire in March 2008, my own career in the practice and Harry Levitt's before me will span a continuous period of 72 years. GP practices, in the present NHS at least, are embedded in their local communities. Those who work in them often contain knowledge of the significant events that have shaped the lives of their patients – in a sense this knowledge comes to 'reside' in the practice, which then begins to take on the characteristics of a 'secure base' to its patients

(Elder and Holmes, 2002). The relationship between patients and 'their' practice will derive partly from an accumulated experience of the practice's care, and partly from that individual's own characteristic pattern of attachment behaviour. A sensitive recognition by the practice of a particular patient's pattern of insecurity, for instance, may well lead to a more secure attachment relationship to that doctor and the practice. Although built up through individual contacts over time, the attachment spreads out to be held by the practice itself, even by the physical space and presence of the building. After a time, all doctors who work in the practice inherit the mantle of this collective transference. It is noticeable, however, that some patients remain firmly attached to one particular doctor whereas others, whilst also primarily attached to 'their' doctor, feel held by 'the practice' and seem to feel safe to consult more widely. As a trainee, I can remember being surprised by how quickly I was accepted and trusted as an unknown and inexperienced young doctor. Simply by working in the practice, I inherited the trust built up by my predecessors. Ten years or more after his retirement, patients would still enquire, 'How's old Dr Levitt? You know I was one of his first patients.' There were many of these 'first' patients. Truly this is Family Practice.

Attachment Theory

The term 'secure base' originally referred to the care-giver, usually the mother, to whom the infant turns when distressed. An infant's reaction to the distress of separation from the mother followed by being re-united, is classified as a result of the Strange Situation Test (Ainsworth et al 1978) into four principal patterns of attachment behaviour: secure, avoidant, ambivalent and disorganised. The Adult Attachment Interview (Main et al 1985) classifies adult states of mind with respect to attachment patterns along comparable lines. The insecure 'disorganised' group includes a high proportion of those who have been traumatised or abused. It is thought that in insecure, and especially disorganised attachment, the body becomes a vehicle for 'an introjected 'alien' other – from (and with) which the individual can neither peaceably separate nor harmoniously coexist' (Fonagy 1997). Approximately 70% of the population exhibit secure attachment and the remaining 30% comprise the different types of insecure attachment. It is important to highlight that there is a marked inter-generational consistency in the patterns exhibited by infants and by their primary care-givers, and a strong longitudinal consistency in these findings through an individual's childhood and adulthood. Thus, confusingly, from an infant's (or a patient's) point of view a secure base may provide an *insecure* attachment experience.

If there was a way of assessing the quality of 'secure base' provided by general practices throughout the country, and practices revealed the same proportions of security to insecurity as does

the general population, then at least 30% would be classified as 'insecure' practices! It is intriguing to speculate what criteria might be included in such a test and what the resultant figures, in fact, might be! Perhaps you'd like to take a moment to decide whether your practice is a secure place to work, one that provides a supportive environment for those who work there, so that they can in turn provide a secure experience for their patients – or avoidant, ambivalent or just chaotic and disorganised?! In his book *The Search for the Secure Base*, Jeremy Holmes (2001) writes 'Children whose parents are responsive, sensitive and attuned are more likely to be securely attached; those with brusque rejecting parents are more likely to be avoidant, those with inconsistent parents to be ambivalent and those with parents who themselves have experienced major trauma to be disorganised. Attachment styles seem to represent stable developmental pathways in which particular patterns of security or insecurity evoke caregiving responses that perpetuate those patterns and in which particular care-giving behaviours are consistent across the life cycle and so tend to reinforce pre-existing relationship styles. That is not to say that movement from, say, insecure to secure pathways cannot occur – for example, when depressed mothers receive psychotherapy or when they form good relationships with new partners...' In reading this passage, it would be hard not to hear a strong echo of similar patterns of relationship between patients and their care-givers in primary care.

A Useful Concept?

In his excellent brief paper 'Continuity' Andrew Dicker reminds us that '98% of the UK population are registered with an NHS GP (at present) and that 49% of the population have been registered with the same GP for ten years or more' (2007). The number of people who change GPs for reasons other than a change of address remains very small. When I was working for Central Relief Service, as a young doctor, I remember being surprised by the quasi-parental loyalty patients seemed to feel towards apparently 'bad' practices and their reluctance to change their registration.

It is a commonplace that some new patients have an initially high consulting rate before settling into a more regular pattern, having tested the trustworthiness of their new doctor. Whereas some patients bring their life crises right into the practice, almost taking up residence for months at a time, others seem to draw sufficient reassurance simply from an occasional or repeated contact with the practice. Simple proximity to the 'secure base' can have a calming, affect-regulating effect. 'I don't know why, doctor, but I always feel better when I see you.' Understanding attachment profiles might help primary care teams make better sense of patients' responses to blanket invitations to attend for various check-ups and screening examinations.

What do we know of the attachment profiles of patients with, say, diabetes, asthma or epilepsy? Maybe those patients who have secure attachment are more likely to use medical services in an appropriate and straightforward way, less complicated by the anxiety of needy but ambivalent or avoidant relationships. GPs spend the majority of their time with a small proportion of their patients, and it is quite possible that a large number of this 'small proportion' are patients who exhibit patterns of insecure attachment. It may be that an understanding of these patterns as they are manifested within the doctor-patient relationship is capable of modifying them to a small but significant extent.

For many patients, a secure attachment to a practice may have particular significance: refugees who have had their lives uprooted by trauma and displacement; those whose personalities, or mental illness, have left them on the margins of society; the elderly facing the end of their lives; new parents coping with parenthood; and those who urgently need support as they face major crises in their lives. A sympathetic practice that 'listens', and begins to make a place for a patient *as a person*, quickly becomes a 'secure base', a place of safety, in the mind of that patient. Along with Bion's ideas about the containing role of the mother in helping her infant manage disturbing emotion, the concept of attachment enables us to understand more fully the role that practices play in the understanding and containment of mental distress. As Jack Norell used to say, 'life is not a treatable condition.'

Infant Mental Health in Primary Care

Mothers and babies come in and out of our practices every day. From the first consultation announcing a new pregnancy through to the end of infancy and beyond, we are given lots of opportunities to influence these new relationships between parents and their young children. At least 10-15% of women have postnatal depression (Cox et al, 1993), and a higher incidence would be found in adverse socio-economic conditions. In addition there are also many families in which one or other parent has a serious mental illness or there is a traumatic separation or displacement that occurs in the infant's first year of life. All these circumstances can adversely affect the future development of that infant. Although much of the research about infancy is well established and familiar to psychotherapists, it is barely known by most doctors, just across the mind-body divide! Whilst our public health remit pays us to ensure high uptakes of childhood immunisation, little attention is given to this equally important emotional aspect of public health. This is still a relatively new subject for us in general practice, notwithstanding the pioneering work of Dilys Daws' 'Child Psychotherapy in the Baby Clinic of a General Practice' (1996). Tessa Baradon and her colleagues at the Anna Freud Centre write as

follows: 'A variety of emotions, experiences, expectations can get in the way of the bonding between the new dyad, or triad, of mother-baby, father-baby, or mother-father-baby. When, for whatever reason, the attachment is threatened, the baby and his parents need urgent help to restore them to the course of mutual cherishing and claiming. The urgency derives from the baby, as evidenced by current research and clinical knowledge about early development, namely, that the interactions between socio-emotional environment and genes bias brain structuralisation and that evolving mental structures influence later development. Neuropsychological plasticity, the relative fluidity of relationships in formation, allows deficits to be addressed more effectively than at later stages.' (Baradon et al 2005). And in the *Journal of the Balint Society*, Juliet Hopkins wrote (1999) 'Several studies have shown that the provision of additional support for mothers during their baby's first year increased the likelihood of the development of secure attachment....Insecure attachments can often be lastingly transformed into secure attachments in the course of a brief, focussed intervention.' I would like to describe briefly a case from a few years ago that stimulated my interest in this subject.

A case

A 35-year-old, quiet, subdued, young-looking Scottish woman came in to register with the practice. The nurse who saw her for her registration consultation wrote: 'New mother. Single. Tearful. Query post-natal depression.' Her baby Bea was just short of three weeks old. The nurse noted that Bea was a poor sleeper and that the mother had a history of anorexia, and more recently alcoholism which had continued until about eighteen months ago. The nurse spent some time with her and found that she was on her own with the baby, had newly moved into the area and didn't know anyone much. She made an appointment for her to see her new GP.

A week or so later, I sat alongside a woman in her 30s who was withdrawn and tearful. She had come to the consultation alone. Slowly she talked to me about the difficult early weeks of being a mother. She had felt tearful 'twenty four hours a day', adding quickly 'not that I'd be without her.' Her boyfriend had abandoned her. I felt quite a panicky feeling of being responsible for her. I said something about how overwhelmed she might be feeling. As she spoke she registered with me a *profound feeling of shock (in herself) that she had become a mother at all*. She had no template. It was as though it had all taken her by surprise and she didn't know what to do. Her family all live in Scotland. She has a few friends whom she had met at AA meetings.

The following week we spoke more about her family. She is the fifth of six children, and described her mother as an unhappy woman,

emotionally distant from her children. In fact she had been cruel and physically abusive to all her children (except possibly the last). They had been subjected to repeated beatings and violence. Her father was a mild man who had seemed unable to protect them. When I spoke to her of her feeling of loneliness, she broke down and told me that she was terrified of being violent herself and repeating the same pattern she had experienced from her mother. We agreed that the lonely feeling was inside herself and that she was desperate for the inner feeling of a warmer mother, now that she finds to her surprise that she is a mother herself. I explained about anti-depressants and she said she felt OK without them, and I arranged to see her again.

Ten days later, after discussion with her HV, I saw the patient for the third time, and she agreed to start seeing our practice-based counsellor. Fortunately we have never time-limited our counselling in the practice. This patient saw our counsellor weekly for almost a year. After an initial meeting, she had agreed to see her 'until Bea was on her feet.' She brought Bea to some of the sessions but not always. The counsellor recorded, initially, something 'wooden' in the contact between mother and baby, with little eye contact or interaction. According to the counsellor she was able to work through some of the more damaged aspects of her relationship with her own mother, and her feelings of jealousy/envy of her baby, and the intensity of her destructive impulses towards Bea. I saw her from time to time during all this, apparently for the usual things that mothers bring their babies to the doctor for, but I'm sure, also, to keep me in the picture. Mid-way, doubts about continuing with counselling surfaced but we were able to understand this together in the light of her difficult relationship with her parents. Her practice 'parents', at least, were able to communicate. After a while she was able to end an unsatisfactory, possibly violent, relationship with a new man who had appeared. And eventually, she visited Scotland to show her parents the baby, and *was surprised to find how much her mother took to baby Bea*. By the end of the year, she was proud and affirmative with little Bea, and seemed deeply attached to her.

This patient knew she needed help and had arrived in our practice in a distressed state. She was able to respond to the offer of help that we made. She described herself as being in the grip of a frightening repetition of her own earlier experiences, and had long delayed becoming pregnant, because in her own words, 'she was frightened of *being a mother because of her own mothering*'. At least three members of the practice team, the nurse, the health visitor and myself, were actively involved in her care. The psychotherapeutic help she needed was close-at-hand and could be integrated with her and her baby's other needs. The intervention was focussed on the mother's state of mind but might equally have been focussed on the mother-infant

interaction, with both mother and infant present in the sessions, in what is now termed parent-infant psychotherapy (PIP), a therapeutic modality that was unknown to me at the time.

It is hard to believe that there hasn't been a significant long-term benefit for baby Bea, the little future patient, as a result of a therapeutic change in the quality of attachment and responsiveness between mother and baby. Baby Bea's mother was severely depressed in the first few weeks of her life and might have continued to be so. It would be nice to know more about what kind of difference this sort of work makes to baby Bea's later development. And whether the experience in the practice has helped to foster an attachment between the mother (and her baby) and the practice which is not then anxiously dependent and frequently attended, but more like a secure base which need not be repeatedly visited but is available when needed.

Facing ending

Of course it is not only patients who become attached to their practices, it is also doctors. I mentioned at the beginning that I'm in my last six months as a partner in my practice. 'Poised between past and future, every ending encompasses both hope and regret, accomplishment and disappointment, loss and gain. The inherent ambivalence of endings tests our capacities to tolerate ambiguity and to cope with both optimism and sadness in the face of loss.' (Holmes, 2001)

Although I'm sure there will be gains and new beginnings for me as a result of this, retirement is a major transition by any standards, and can include deep feelings of loss. Loss is always painful and often problematic. For myself, I fear that encountering loss with courage (as so many of my patients seem to manage) is not one of my strengths. My family experience exposed me to loss at an early age, boarding school at eight and the deaths of both my father and one of my older brothers during teenage. I was away at school at the time of both events. I have always thought that the experience of these early losses, and maybe particularly the benevolently misguided way in which they were handled, was a potent factor in bringing me into medicine in the first place. I have probably been better at helping others with their reactions to loss than dealing with such feelings myself. As I mentioned at the outset, one of my earliest interests, as a young doctor, was in the care of the dying.

Does any surgery pass without loss, or grief, being a major factor in why the patient has come? If you stay quiet long enough in any surgery, most patients will end in tears. Bereavements, anniversaries of deaths, ageing and loss of function, declining sexual interest, relationship breakdown, leaving home, job loss – and if not loss itself, the fear of loss. And in every consultation there is a beginning and an end: an opening and a parting. Frank Kermodé says when writing about time in his book 'The Sense of

Ending', '...the ticking of a clock. We ask what it says: and we agree that it says *tick-tock*. By this fiction we humanise it, we make it talk our language...tick is our word for a physical beginning, tock our word for an end.' And the great Bengali poet, Rabindranath Tagore (from 'Stray Birds') writes 'Death belongs to life as birth does. The walk is in the raising of the foot as in the laying of it down.'

The doctor must move on, from one person to the next every ten minutes or so. An encounter may have been full of meaning but the work of the surgery must continue. Little wonder that we defend ourselves against too much of an emotional encounter with our patients as they come and go. And then, when retirement comes, one of the greatest difficulties is in dealing with your own feeling of loss as well as thinking about the meaning for the patient. In leaving general practice, you are always leaving a fast moving river. Ending, like death often does itself, comes with an activity half-complete; a serious diagnosis recently made, a crisis breaking, a new chapter in a patient's life just opening up.

What help can we give each other in coming down the final straight? Are there any guidelines? Perhaps a protocol, a correct way to do it? There seems very little. Little seems to have been written, either reporting on how GPs manage this transition, or researching the effect on themselves and their patients. Anecdotes abound. Some doctors finish by being ill, some simply never turn up again. Others can never bring themselves to go. There is important research to be done on this subject. But don't forget, this is the personal side of medicine, the all-important but non-existent side – exactly what Balint work is all about. Registration is now with practices. In truth, the relationship between a patient and his or her doctor can be one of the most intimate and emotion-laden relationships that people have. And yet, there is not much acknowledgement that this is so. Not much of a structure for leave-taking. No roadmap. This phenomenon is, of course, at a cultural and social level, what makes medicine possible. And is also, the reason why the Balint approach, for the foreseeable future, will always be at the edge, and not part of the mainstream. It is not unexpected that the one piece that has been written about retiring from practice is by our Balint colleague, Oliver Samuel, in the BMJ, in 1996, '*On Hanging up my Stethoscope*.' Oliver concludes his piece with the words, 'It is hard to stop being a family doctor.' I agree.

Of course, there is always the advice of friends and anecdotes. I remember vividly a group at Oxford when a colleague presented a patient who was asking whether he could contact her after her retirement. How to respond? I would certainly recommend a Balint group during anyone's last year. Good advice came from another colleague who said, 'make sure you do what you want to do.' He had found himself doing a duty surgery for his last. I have asked for

a system which enables nearly all the appointments in my last few weeks to be reserved for my own patients. A GP who retired last year from his practice in South London told me of his last two patients. One before last, 'Doctor, you've been part of my family for 30 years, what makes you think you can just leave us now. How dare you.' And the last was an academic who didn't even know he was going. Possibly the best advice, came from my friend Jeremy Holmes, a psychiatrist. I think of this, now, as Holmes' Law but I think it works better in a regularised setting, such as out-patients, rather than in a syncopated setting like General Practice. 'Have three appointments, one for telling the patient, one for discussing how they feel about it, and one for saying good-bye.'

And of course, as always, to help you through, there are your patients. Most wish you well, tell you you're deserting them, want to discuss who will look after them, check that you're not ill, ask about plans, reminisce a bit (actually, rather a lot) and express their thanks for your help over the years. Healthy narcissism quickly takes over... 'oh, oh, really and who will be looking after me?...'. Others can't think about it at all. One couple whom I've seen a lot over the years, to whom I had given advanced warning, 'Sorry, Andrew, when did you say?...Oh, we'll both be dead by then, anyway...' I also remember a patient coming to see me, a year or so after one of my previous partners had retired, explaining to me that she had not even been able to come to the building for six months after he left. I'm not sure that he would have known how much he mattered to her. We know little about how these things affect people.

What of the process itself? A long notice period, if you can bear it, helps the patients and the practice. I started telling patients a year before I left. Fortunately my partners agreed to a period of overlap with my successor. For a year we have been able to have a weekly discussion of patients and are now planning to do joint visits to say good-bye (introduce him) nearer the time. Personally I would have found it very difficult to leave without a known person to be handing over to. Balint work tells us, anyway, that many of my patients have been in a kind of marriage with me, by no means necessarily in their best interest. Now, they will have to change partners, start off again. It will benefit some and be a loss to others.

Our capacity to mourn is fundamental to our capacity to change, grow and develop throughout the course of our lives. Every loss encountered gives rise to ambivalent feelings – but our overall ability to internalise the good aspects of the person, or place, or experience being lost – helps us move on, without too much regret, denial, splitting, projection, or turning the lost object bad. These processes are really the stuff of life itself, beginning as they do at its earliest moments and continuing until we have to face the loss of life itself. And our capacity to face any of this is not unrelated to the security of our

earliest attachments. As we now understand more fully, it is through these early attachment relationships, that patterns are passed from generation to generation. From the 'secure bases' of our practices, we can make small but sometimes significant differences to this process. Maybe through helping a mother and her infant be more attuned to each other, but also in noticing and being sensitive to the many individual ways patients attach themselves to their doctors and to their practices as they seek our help in encountering the many difficulties that they (and we all) have to face at one time or another during the course of our lives.

I would like to finish with two vignettes - which I hope illustrate these themes and indicate something of the impact of these inter-generational influences, as viewed from the perspective of having been a GP in the same area for 35 years.

Breaking down doors is part of a GP's job

Getting doors broken down is part of a GP's job. 'I haven't heard a sound for days, doctor. Do you think he's all right?' Dying unnoticed is a common dread. Once inside, usually, there's evidence of a sudden collapse: a simple chore not quite complete. A spilt cup of tea, a body lying by the side of a chair. On one occasion I remember vividly, I found a man hanging from the ceiling. And most recently, with a young policeman attending his first sudden death, I walked around a flat which had been untouched, undusted, undecorated, utterly unaltered for over thirty years. The occupant, a single man in his late sixties, was dead and slumped over the side of the bath. I knew who he was and remembered his occasional, painfully awkward, visits to see me at the surgery. *Then I realised suddenly I had been in the flat before.* Just once. About thirty years ago I had come to see his father, a sad elderly widower with cancer of the bowel who couldn't cope and lay in bed crying. Every day, his great friend, a survivor from the First World War battle of Paschendaele, arrived to look after him, wash him, and try to cheer him up. One day, the friend, an old Jewish entertainer, who was also a patient of mine, walked with me to the front door of the flat. Apologising for what he described as the pathetic state of his old friend, he turned to me and said, 'Dr Elder, I feel sorry for the poor old man. Really I do.' But then he continued, 'but just you wait, Dr Elder' he said, shaking his head in despair, 'you should see the son. My God, the son!'

Nothing had been touched. The old parents' armchairs had been preserved under plastic covers. The dust was inches thick on every surface and had settled on every small indentation of the wallpaper in every room. His small divan bed had a crater in the middle where he must have slept for thirty years or more, perhaps since childhood.

Four generations

Last week I walked across the waiting room ... a two year-old little boy is toddling around, and a smiling young mother who I know well, greets me. I go over to chat to her and enquire about this and that. When I first started I knew this little boy's great grandmother and great grandfather well. I looked after the great grandfather's terminal heart failure. The great grandmother died slowly from dementia and ended her days in a psychogeriatric hospital, and I looked after the grief of her daughter as she watched her mother slowly slide away from her over a painful period of some years. That daughter is now the little boy's grandmother, and is herself unwell with spinal stenosis. She and her husband had two children: one, the little boy's father, had epilepsy; the other, a girl whose Cushing's Disease we managed to diagnose as a teenager. A year ago, I had seen the young daughter-in-law; yes, the woman in the waiting room, when she was tearful and depressed trying to cope with her the little baby boy's repeated vomiting from a severe hiatus hernia. Her feeling of rejection as her baby vomited back almost every feed she gave him, was overwhelming. I saw her regularly for a little while and considered a referral for parent-infant psychotherapy (PIP) at one stage but never made one.

This family will miss me after my retirement, as I will miss them. We have been part of each other's lives for a long time. But they are as much rooted with the 'practice' itself as with individuals. After all, I had taken over their care from my trainer, Harry Levitt, whose wife and family they might still enquire about. They have had many difficulties but there also seems to be a warm and friendly quality which helps each member of the family deal with things in a generous, even robust manner, generation by generation: they seem securely attached to each other, and to the secure base of their practice.

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Snapshots of Balint

By Jeremy Holmes, psychoanalyst
(A talk given after the Balint Society dinner
at the RSM on 18 June 2008)

When my friend and ski-companion (see below) Andrew Elder, Chair of the British Balint Society, himself a distinguished GP, invited me to speak informally at their 2008 annual dinner there was no hesitation in my acceptance. Here was an opportunity to express gratitude to a towering figure who had had such a powerful influence on my career. I also found myself wondering it had taken this long (can it really be 40 years?) to say 'thank you'. Perhaps back then I was too callow; it would have felt too ingratiating, too humiliating, too undigested.

I was one of the smallish band of 'Balint boys' (and girls) who were lucky enough to be in his seminars for medical students at UCH which ran for a couple of years in the mid-1960s, several of whom, like myself, ended up as psychiatrists. I remember that first electrifying seminar well. He instantly reminded me of my maternal grandfather, a powerful influence in my life: stocky, bull-necked, thin swept-back hair, obviously Jewish in an assimilated way, myopic, intriguingly deformed hands, a bossy yet an acute listener. In retrospect, the resemblance was probably pretty superficial, but Balint, like all charismatic people, had the ability to evoke strong transference reactions. One could not help projecting onto him significant aspects or figures from one's life: the father one wanted to please, the feared critic, the Goliath one would have to slay in order to find one's manhood, the encyclopaedic polymath one admired and envied, the attentive and protective lover. My title comes from the latter feature; the mother of a friend of ours was his patient, always referring to him as 'my darling Balint'. She was still seeing him at his premature death, and, like many others, was not given time to resolve her positive transference.

His skill with medical students was to persuade us that we – role-less lowly nothings in the medical hierarchy which then prevailed in hospital medicine, even in a liberal institution like UCH – were the 'experts' on our patients. Only we – not the Consultants and other Gods – had the time, he insisted, to sit and talk with our patient, to hear their fears, hopes and frailties. He taught us how to take a psychological 'history' – the real histories of people's lives, their attachments, losses, traumas, dreams and disappointments – that complemented and illuminated the medical histories we were being groomed to extract and regurgitate on ward rounds. This subversively seductive message was manna to the subset of our year who became Balint devotees. Not only did it make us feel special, but its down-power view

also chimed with the zeitgeist – this was the 60s after all.

Once we told our stories in the seminar, Balint's facilitative dogmatism opened up new vistas. Incredibly, he seemed to want to know what we *felt* about our patients, and had the ability to get us to talk without embarrassment about our reactions in a group of peers! He had a master-narrative to help make sense of our patient's (not to mention our own) lives. The child was father of the man. We have to separate from our mix-up (and some cases mixed-up) mothers; find, fight, and love our fathers; discover our sexuality; identify and dis-identify with our heroes; adjust to the realities of life without compromising our desires. Illness can be an escape route from these vicissitudes. Our patients were regressing to earlier stages as they stepped off, by choice or necessity (Balint, a diabetic and GP's son, knew all about illness), the developmental train.

Part of Balint's magic was his insider/outsider role. Thrice married, he had the transfixing charm typical of the Hungarian male. Two of his three wives, Alice, who died tragically young in 1939, and Enid, were co-creators of the 'Balint' approach. At the same time he was clearly drawn to and respectful of British values of fair play and the democratic traditions embodied in the NHS. He had perfect command of English (his third language, after Hungarian and German), yet used it in that creatively idiosyncratic way that only non-native master stylists (one thinks of Conrad or Nabokov) can. Phrases like 'interpenetrating harmonious mixup', (mother-baby intimacy), 'the drug doctor', (positive transference and the placebo effect), 'the basic fault', (the deep pain of disturbed and traumatised 'pre-oedipal' patients) have a vividness and unforgettability that is uniquely Balintian. Interestingly his neologisms, 'philobats' and 'ocnophils', never really took off, even though, as a Bowlby devotee, they beautifully describe the avoidant and ambivalent varieties of insecure attachment. As an antidote perhaps to his exceptional verbal facility, the polyglossic Balint was also an advocate of the healing powers of silence in psychotherapy.

Another aspect to Balint's appeal was that, despite his accompanying psychoanalytic mysteries, he remained very much a *doctor*. That is, he combined an acute analytical and theoretical mind with down-to-earth pragmatism. *If it works, use it*, is intrinsic to his attitude. He is famous in the psychoanalytic world for 'the somersault' episode. A patient had complained on

his couch for years of her fear of physical exertion: "I've always wanted to do a somersault, but never had the courage" she bemoaned. "Why not do one right now?" says Balint. Up she gets, twirls on his consulting room carpet, and never looks back. Or so the story goes.

This is often cited as example of psychotherapeutic integrationism, combining psychoanalytic and behavioural techniques in one session. Balint earned opprobrium among some psychoanalysts for that sort of thing; it is exactly what makes him so appealing to GPs and psychotherapeutic eclectics like myself. It is also part of the legacy of his own analyst, Ferenczi, also Hungarian, who pioneered 'active techniques' (pressing against resistance rather than waiting interminably for free association to circumvent it) and maintained that, in the end, it is the analyst's love that cures the patient.

The somersault paradigm also illustrates another Balintian insight: that psychic change rarely proceeds in a simple linear fashion. He once told me that a seminal moment in his life was when he came to Budapest for the first time aged 17 and heard Bach's St Matthew Passion. Life was never the same for him after that and he glimpsed his pathway to medicine and psychoanalysis. This damascene view corresponds with contemporary ideas from chaos theory, which suggest that fluid systems within a closed container (whether these be the weather, mixtures of gases, or the human psyche) can, given an injection of external energy, reach new levels of complexity. Balint's concept of 'the flash' captures these moments of spontaneous insight shared by doctor and patient: e.g. "Oh my goodness, perhaps my tummy ache is all about how furious I am with my step-Dad and the things he did to me". This quasi-paradoxical approach calls for courage and confidence on the part of the therapist. Balint used to encourage us as students to take risks, for example in delving into our patients' sex lives, reminding us that the way to ski safely was, counter-intuitively, to lean down the slope rather than away from it (perhaps boasting here of his prowess on the piste, and elsewhere).

One easily forgets what an innovator Balint was. He was one of the few psychoanalysts to take epidemiology seriously. He realised that psychoanalysis could never be available for 'the masses'. The Balint movement was a response to that insight: since most people consult their GP several times a year, equipping GPs with psychological-mindedness is a way of touching those parts of the psyche that conventional medicine can't reach, and reaching populations for which the ivory couches of Hampstead are inaccessible.

He was also a world pioneer in psychotherapy process-outcome research. David Malan's Tavistock brief therapy studies were instigated under the tutelage of Balint. Here too he was trying to find ways to abbreviate psychoanalytic work, and thus to widen its

applicability. The concept of 'focality' in therapy – that at any given moment in therapy the themes of a session centre around one pivotal psychic point – is another Balint coinage, today taken for granted. He was a relational psychoanalyst before its time, or indeed its name. He insisted on a 'two-person' psychology to understand the analyst-patient relationship, abhorred analytic omniscience, did not eschew limited and judicious personal revelation in therapy, and saw the therapeutic relationship as a more significant curative factor than any specific technique or interpretation.

Finally, what would Balint make of today's scene in psychoanalysis and General Practice? I think he would have welcomed the advent of relational and attachment-informed psychoanalysis, and might have provided a powerful counter-weight to the prevailing Kleinian orthodoxy of the British Society. He would have been happy to see the establishment of a vigorous psychoanalytic research culture, mostly in the USA and Scandinavia; sadly the Tavistock has hardly managed to maintain Malan's magisterial momentum.

How would he have reacted to today's developments in General Practice? With counsellors and CBT therapists embedded in most practices, and group experience firmly embedded in GP training and CPD is the 'job done'? Are we all Balintians now? I think he might have demurred. Psychological mindedness is always hard won. The mind and its institutions have myriad ways of avoiding pain and failing to face the truth. Social fragmentation, neglect and trauma, mobility of populations (Balint knew what it was like to be an immigrant) take their toll in ways that impact on the GP surgery. A recent joint document by the Royal Colleges of General Practice and Psychiatry acknowledges this and makes useful suggestions about training in psychological therapies for GPs and Psychiatrists (including Balint groups). De-professionalisation, abdication of leadership, the retreat of whole-person medicine, lack of continuity of care are endemic among doctors, breeding cynicism and self-servingness.

Redressing these tendencies, and bringing out the full potential in medical workers is never easy, but the basic Balintian principles remain as true today as they did 40 years ago. These include:

- A fundamental belief in the primacy and healing potential of relationship, including the doctor-patient relationship
- Understanding and valuing the potential of groups as a secure base within which to explore feelings and the power of many minds when they set to work on an 'impossible' problem
- The importance of moral courage, and the ability to risk anxiety as one seizes the moment, including the therapeutic moment when it arises

- Trusting the 'butterfly effect', the small change that makes a big difference, whether this be in brief therapy, or the 'small but significant' change in personality that a Balint group can induce in its members, if fully committed, even in the absence of personal therapy
- Acknowledging the ubiquity (including in the consulting room) of the demands of sex and aggression, and, if unmitigated, of their possible destructive consequences
- Valuing the constructive potential of secure attachment and creativity.

Hearing Michael's voice and values echoed in this credo, is my concluding tribute to Balint, a great man.

*Jeremy Holmes is a retired psychiatrist and visiting professor of psychological therapies, University of Exeter, UK
j.a.holmes@btinternet.com*

Time for Change

Jennifer Johns, psychoanalyst

(talk given to the Balint Society on 18 March 2008)

I have called this talk 'Time for Change' for a mixture of reasons, because I want to give my thoughts, and to share yours about change, about the time taken to achieve or survive changes, about the ways changes get fixed, either consolidated or rigidified over time, and about the way changes can be good or bad, useful or counterproductive, depending on, among other things, their timing. The elements that have come together for me to be interested in the linked topics of time and change are undoubtedly my own experience – I am now 70 and am contemplating the inevitably accelerating life-changes ahead of me, and I have made the change of leaving my part-time job in the NHS, a big change for me after working even part-time in the NHS since 1962. My expanding career as a grandmother is so far great fun, and I still have a private practice, so I haven't changed that much, but the change of possible retirement beckons. Also, in my work I have been interested in the question of time and change, how long it takes for psychological change both to occur, and then to consolidate, how it is that some patients are able to make use of quite short-term interventions, while others seem so attached to their symptoms that I can find myself wondering whether, should their symptoms be miraculously removed, they would even recognise themselves, the symptoms being so inherent a part of them.

But first, something about where I stand in relation to you, and your interests. Coming from a medical, indeed a psychiatric and psychoanalytic family, I thought early in my career that I would not be a psychoanalyst. Newly qualified, I dithered between the possibilities of choosing paediatrics, obstetrics, or general practice as a career. My father ran Balint seminars, and the full transcripts of each recorded meeting often lay about on his desk, so I had read them. I had tried reading Freud and been disappointed. At that stage I found his descriptions of mental workings dry and his hypotheses seemed laborious. I wanted clarity and proof, and firm ideas about what to do to make people better. I believed, naively, in normality, and cure as a return from a pathological state to that normality. The Balint seminar transcripts completely failed to give me that certainty, but seemed much more alive than Freud. I could see doctors struggling to meet their patients' thoughts and feelings and using sometimes painfully acquired insight of their own to understand how and why the relationship with their patients had come to their present situations, and I also saw how gaining understanding alone, without the need for interpretation, subtly altered the doctors' attitudes towards their patients, who responded in turn. Long before actually coming into contact with any patient, I began to see that

understanding was a powerful and also a potentially dangerous weapon. However correct, it could sometimes be unwelcome to the patient, who after all had not asked for it overtly. Sometimes I read how an overenthusiastic doctor would almost bludgeon his patient with it, eliciting flight, or rage, which would then puzzle or alarm the well-meaning doctor. Those reports that showed, in an understated way, that the doctor's increased awareness of his own reactions, as well as of the patient's situation, internal and external, might be enough to act as catalyst for change, were the most moving, the most human. So people like you were the ones I admired, and I went into general practice. It was only during my own analysis that I found that I wanted to take that analytic thinking further, but in order to fund my own analytic training I spent a number of years doing not only morning and evening surgeries, but also local authority child welfare clinics, family planning clinics, working with the Brook Advisory Centres as well as a clinical assistantship in obstetrics in my teaching hospital. I was very busy indeed, and when I had small children I eventually rather sadly realised it was too much, and became a psychoanalyst, relinquishing the rest. Those are some of my changes, but I will continue with a story, though it also is part of me.

A small girl, three years old, was being put to bed by her grandmother. After the bath and the stories, while being tucked in to bed, she got quite confidential, as small children sometimes do. She said, very seriously, 'Grandma, when I am grown into a big girl, I will miss myself...' As the grandmother, I was surprised to discover that so much conscious awareness both of time and of change existed in so young a mind. I had perhaps assumed, in a rather self-centred and elderly way, that it would be the perception of the passage of time, and of the many changes experienced during that time, that would lead one to the knowledge that my granddaughter so clearly already had, the knowledge that time inevitably brings change, and that even a longing for change such as growing up inevitably involves loss of the previous state – even that mourning the loss would be a consequence of that process. In a sense, I felt that in voicing that thought, she was showing me that she was already engaged in some anticipatory mourning, a process that we know is very useful in managing change and loss. I hoped that if she was successful in that task, she would be able to greet changes in her life with interest and curiosity, and look for the excitement inherent in new possibilities – aware of the gains to be made from changes rather than being stuck with regrets and nostalgic idealisation of 'the old days'.

As a psychoanalyst, I was chastened to

realise that my immediate assumption that I knew more about change and loss than a three-year old was to say the least arrogant, and that I had bypassed what should have been my awareness that my granddaughter had all too recently suffered one of the greatest losses of all, the loss of the breast and that closest relationship to her mother inherent in weaning. She knew all about loss and was facing it in a thoughtful and brave way. The very change of birth itself was fairly recent, and it is the awareness that the inevitable rapidity of change for a small person is so great and potentially overwhelming that makes us instinctively want to slow down with small infants and provide calm, consistent, reliable surroundings for them. We can often find ourselves wanting to do the same for patients – the words 'It's all too much!' can arouse powerful protective feelings.

It was little Alice's seriousness in facing the changes in her life that made me realise something of my own denial of the importance of changes and the effect they were having on me, since at the same time my NHS work was undergoing serious changes which I'll explain later. I'll start with a patient whose treatment I have been involved with as a supervisor, and whose case is such that there are many points of possible discussion around change and time, including the original assessment, a revised assessment during treatment, and a probable premature ending. I have disguised the patient's identity.

A case history

A man with a familial disability was born into a family in which communication was minimal and there was an idealisation of coping. Emotions were never spoken of. The eldest, he apparently had a warm relationship with his mother until, at the age of three, two things happened. A sister, who has the same disability, was born, his mother became almost completely taken up with her new baby, and he was sent to a school for the disabled some distance from his home, necessitating two hours' journey each way in the school bus. He still remembers sobbing at the first parting from home. He apparently withdrew emotionally from his mother at that time, and now in his thirties has never been close to her since, regarding her as uncommunicative and dull, only generous with material things that he doesn't really want. The parents divorced shortly after this, and his father, a cold and distant man, contacts him only rarely.

An intelligent man, despite the generally low achievement levels of the two special schools for the disabled that he went to, he got to university where he was valued for his intellect, and got a first-class degree in a technical subject. He studied hard but made no real friends at university and had a brief affair with a girl that he knew from his secondary school, resulting in the birth of a son. The son is also disabled and the patient feels guilty for his failure to be in contact. He wants to avoid the child's mother, who he

describes as stupid, only interested in having a good time, clothes, clubbing and drinking too much. He went on to obtain a higher degree, and is highly specialised in his area, but has been unable to get employment, partly, if not only, on account of his disability, which prevents him living the normally active life that people doing the work he is qualified for would ordinarily have, but perhaps partly due to his social difficulties. Frightened of contact, he tends to hide behind a mask of indifference that can look disdainful.

Needless to say this man was very lonely, isolated and depressed, his only social contacts being his disabled landlord, and a disabled group with which he goes on holiday. Socially inept, all the girls he has known well seem to want to take care of him, and this makes him suspicious. Some of the able-bodied who help with the group also arouse his suspicions, and he is wary lest their interest border on the perverse. There is some evidence that his fears may have a basis in reality – one of the able-bodied who accompany the group has in the past approached him and some others in an over-intimate and excited way. He has little contact with his family, and though mother sends him clothes and gifts, he feels they are inappropriate. He still attends a specialised unit some distance from his home for his physical problems, and the doctor noted his depression and referred him to the attached psychiatrist who recommended NHS psychodynamic psychotherapy. After a year of once-weekly therapy his therapist felt that he was being kept at bay by the distancing schizoid defences and arranged an application for special funding for longer and more intensive treatment from his local PCT with the support of the NHS psychotherapy unit. He got two years of funding for three times a week low-fee treatment and a bursary for travel, since he lives outside London. His therapist turned out to be right; the work began to come alive, they were able to work on the patient's suspicions of the therapist, especially his wish to help.

During these two years he has been able to obtain and move to accommodation of his own, and begin a new relationship. He has also begun to explore the possibilities of working more actively and realistically, using the help of a contact in his field. He has also distanced himself from a political group in his social life that idealises handicap, awarding themselves a kind of moral superiority over the able-bodied, and he can express his anger at having been born as he is and voice his wish to be normal.

However, and this is an ongoing case, the two-year funding comes to an end later this year, and the therapist has recognised that, with the previous one year of once-a-week therapy, the relationship with the therapist was facing an ending at three years, exactly the same period of time that he had had with his mother before his sibling was born. At the prospect of ending, the patient became at first agitated, then cut off, accepting with a passive resignation that 'normal

people get the good things. There is nothing for people like me.' There is at present a desperate attempt by the therapist to get the PCT to extend funding; the outcome remains to be seen.

That therapist is in the painful situation that we all know. The patient has implicitly been invited to regress, to open up in such a way that a certain degree of emotional dependency has been allowed – and the unstated but assumed bargain is that the health professional is saying – 'rely on me and I will look after you as best I can'. The therapist cannot fulfil that promise, feels full of guilt, believes himself to be a failure, and sees that the let-down patient is likely to retreat once more into an isolated pseudo-independence with his defences against closeness and vulnerability even stronger. He is angry at feeling so bad, and there are of course many targets for anger – the PCT, his own Trust's finance department for not supporting him and his patient better, etc, etc. And I, the supervisor, wonder whether I should have been aware from the patient's history and the timing of the likely length of treatment that such an outcome was on the cards.

The experience of many years sitting in case discussions with colleagues of all psychological disciplines and varying degrees of expertise has led me to recognise that while assessments can be very thorough and decisions about appropriate treatment carefully thought out mistakes can still happen. It can happen that a patient whose need is urgent may be offered less than optimal treatment simply because it is the earliest available, or perhaps the optimal treatment is not available or likely to be, and the patient may be slotted in to whatever vacancies there are. The assessment of their ability to use long or short-term work is an important part of the assessment, but may take second place to the urgency of the situation, or perhaps the recognition is that in a particular case if one doesn't 'strike while the iron is hot' the opportunity to engage a deteriorating patient in therapy may be lost, and it is felt that any intervention, while not the best one might prescribe if everything was equal, is better than delay. The capacity to say no, to point out that what one can offer is certain to be inadequate, is valuable, but it isn't always so clear; therapeutic zeal or a particular patient's appeal may tilt one's opinion and that is where mistakes creep in. And one can't be certain. This man, who has gained quite a lot, may come through his apparent relapse, may be able to use his new relationship to consolidate the changes, and it is possible the outcome may not be so bad. Or so we hope.

The original assessment was that this man had enough capacity for change to make use of a year of once-weekly therapy. He did use it to some extent, but it became clear that the defences against taking the risk of getting close were preventing him from engaging with his therapist enough for substantial change to take place. He was not going to take the risk of becoming vulnerable to hurt or abandonment, and his 'old

ways' seemed safer than changing. When the therapist demonstrated his concern for the patient by arranging more intensive and longer treatment he did engage more, and some real changes began. Now living independently, it did seem possible that he could develop his new relationship and obtain employment, and despite his apparent present relapse into sullen passivity, it is still possible that his girlfriend and the professional contact may be able to support him further into a permanently changed life.

Most patients come to psychological therapies because of the recognition that it is 'Time for Change'. And part of the consideration in the assessment is the question of how much time will be required for that change to occur. The question of how long it may take for any change to consolidate is unfortunately rarely thought about these days. Most outcomes are judged on the short-term results, and unfortunately cost in financial terms is nowadays never far from the clinician's mind, and that may be to the detriment of another consideration, that of the cost that is incurred, both financially and in terms of quality of life, when treatment is inadequate to ensure its effectiveness in the long-term.

Patients come not only because they recognise the time has come for change, but because they also recognise that they need help in gaining that change, help from someone who can see their difficulties and find ways of thinking about them that open up new possibilities, 'new beginnings' as Balint said. So when we have worked with the patient, and found perhaps the unconscious or forgotten cause of the problem, and even linked it with the problems of today, why is it often so hard to make and consolidate the important, even essential changes in thinking or relating that could make the difference to the patient's quality of life? What is so attractive to some people about their symptoms that makes them reluctant to abandon them? How is it that we frequently find patients who enthusiastically embrace a piece of understanding and initiate a change only to come back later with the original problem that seems even more embedded?

From the point of view of a keen therapist this can be maddening and even feel like a personal attack by the patient on the therapist's wish to help. Patients who repeatedly offer us hope that they may change, and then 'backslide' can arouse fury and hatred which hopefully will be conscious enough in the therapist so that he or she can restrain themselves: how often do we find ourselves listening for instance to a patient's complaint that their life-partner has lost patience with them only to find ourselves thinking, 'I know just how he/she feels!' The temptation to abandon the patient, refer them perhaps to a 'tougher' colleague, even to arrange some form of chemical 'cosh' may be hard to resist. Of course this is not new, and psychoanalytic thinkers have put their minds to it as much if not more than any other problem. Freud wrote about resistances, Melanie Klein about the death instinct and envy,

Masud Khan about the patient's grudge and Michael Balint about cases of malignant regression.

There are of course those who can accept insight and use it in a straightforward and confident way, taking a new idea enthusiastically with perhaps the remark, 'I never thought of it like that!'; just as there are those who are completely uninterested in any deeper understanding of their own inner world and simply want to find ways of modifying their behaviours so as to find the world responds to them more positively and rewardingly. For them change is relatively simple, and can be quite quick and long-lasting. Prolonged mourning for the previous state is unnecessary if the new state is really rewarding. Marital or family therapy therapies in which immediate or at least fairly rapid changes are supported by a parallel and benign change in the other partner or family members, and support for the change and its rewards are fairly obvious, can be short-term and effective. Those are not the problem people. Those are the people whose inner world is either fairly secure, with constant enough early relationships that have built a strong sense of self that can anticipate and manage change without it threatening actual breakdown, (and I hope that my grand-daughter may be among these) or those who have built such strong defences against any awareness of the internal world that it takes an emotional earthquake to break them down.

But those people are not the problem, as we know. It is the 'difficult', the resistant, those whose struggles cause us pain, but who seem entrenched in their self-sabotaging ways of being who are probably the reason that each of us is here tonight. We want help for them, and it seems it can't be quick. For years the psychoanalytic world seemed the only possible hope, and for many it may be, but it too has got stuck, and is finding the changes in the world difficult.

The psychoanalytical world has been particularly poor in 'selling' psychoanalysis or even psychodynamic therapy as treatment, maybe because for so long it was the only alternative to the physical treatments of psychiatry or to a series of magical remedies, and failed to appreciate the need. But things are different now, when other people can claim to be effective. Psychoanalytic thinking has been attacked as not being scientific, in that we cannot organise a replication of clinical observations or even forecast our results. We have not found an easy way to respond to the present demand for what is called 'evidence'. Small numbers of cases, an approach that sees the developing and unique relationship between clinician and patient as being both the subject for study and the therapeutic agent, finding ways of standardising such unmeasurable matters as transference and countertransference, these have put much of the psychodynamic world off from even attempting to claim that our techniques can sometimes be more useful than those psychological techniques such as CBT, or various

combinations of drugs and support. And we are thought to take too long, to use too much time to help people. We are said to be too expensive by those who measure outcome in the short-term. Little allowance is made for the possibility that time may be needed to instigate and consolidate change.

But as well as looking at time and change from the point of view of a patient, important as that is, there is also the fact that doctors and other health professionals are themselves subject to change, and that we may find changes easier or more difficult depending on ourselves and the systems we work within. The Department of Psychological Medicine that I have recently retired from has been the subject of several unrequested changes during the last few years. I am aware that general practice too has changed enormously since I had anything to do with it other than as a patient, and that the process of change will continue.

To go back to being autobiographical for a while: as the child of a psychiatrist, I spent my earliest years living in a hospital-owned house in the grounds of a large mental hospital in the beautiful countryside of Northumberland. Ten years before the British National Health Service, such enormous institutions cared for the chronic as well as the acute patients and also those whose low level of intelligence precluded an ordinary life. The hospital had its wards for the acutely ill, but also large grounds, with three farms and a market garden, orchard, bakery, and so on, where those patients able to manage in a protected community occupied their days, resembling a small, rather eccentric village. The older 'burned-out' schizophrenic patients, the chronically but not suicidally depressed and the simple, including Down's syndrome patients and others congenitally damaged, were a part of everyday life for the children of doctors and nurses who played around the staff houses where we lived. People who looked or behaved peculiarly were not alarming, just part of life. They tended the farm animals, delivered the milk and did the gardening.

In 1948 things began to change, the new Health Service needed to realise its assets and sold much of its land, and through the fifties and sixties medications more effective than barbiturates and amphetamines came in. Then, gradually, it was felt to be politically incorrect to segregate the mentally ill, medications became even more effective and the movement towards integration into society began. It was felt that the place for psychiatry was the general hospital and the last of the old 'bins' went. With the introduction of hospital Trusts, however, this integration stopped, and separate Trusts for Mental Health and Social Care emerged.

For some years the Department of Psychotherapy at UCH, despite being part of a Mental Health Trust rather than the Hospital Trust, occupied part of the fourth floor in Cecil Flemming House, over the A&E Department,

sharing the floor with the Family Project and some psychiatric out-patients as well as the psychiatric liaison team. Although the accommodation was far from modern, it was self-contained and comfortable, with a security door between the waiting room and the consulting suite, so that patients could be admitted for their appointments one by one. The secretarial staff, trained to deal with distressed patients and to relieve tension when necessary, also acted as receptionists and could survey the waiting room safely from within a secure office and deal with unhappy or distressed patients face to face, or on the phone. The clinical staff had quiet rooms, simply furnished, which the patients came to know and find familiar. In a calm and consistent setting, patients were able to speak their fears, relate their painful stories and be helped to understand their conflicts and begin to resolve them.

I know I'm preaching to the converted in saying that the kind of consistent and reliable attention that is therapeutic for psychologically disturbed patients can only happen when the professionals concerned feel secure themselves, and that for this reason a reliable and consistent therapeutic milieu is an important element for both patients and for all staff. Part of the reassurance for staff, who sometimes have to defuse difficult and stressful situations such as obtain with suicidal patients or those on the edge of breakdown, was the fact of having the psychiatric staff working in close proximity. Their friendly co-operation was valued, and the support became mutual. Informal communication in addition to the more usual letters and e-mails often helped in understanding the dynamics around a particular referral, for instance. Staff were also reassured by having a departmental alarm system, which warned other staff in the vicinity immediately of any problem that might arise while seeing particularly disturbed patients.

In April 2005 the Department was informed that due to the imminent redevelopment of the building we should have to move to the 15th floor of the new UCL Hospital, on a temporary basis, until permanent accommodation could be found. This proposed move unsettled some patients, but we kept them informed and did our best to contain the anxieties that arose, especially with those patients whose disturbing experiences were those of instability and fear of catastrophe and loss. The staff were also unsettled by the immediate news that in future our secretarial staff would not in fact be present in the department, but on account of modern communication techniques would be able to work at a distance, several blocks away. We could e-mail, or telephone them. When their function as an adjunct to clinical care was explained to the powers that be, and that their personal presence and special experience was essential in providing a point of contact as well as a containing environment for patients this difficulty was resolved, and we were allowed to continue to

move together. It was necessary to close the Department for a week in order to pack up, interrupting the continuity of weekly sessions for patients in both group and individual therapy. On account of lack of space on the 15th floor, many sets of notes and other documents including the Department's reference library were put into semi-permanent storage, and were unavailable when old patients got in touch or enquiries received for summaries, etc.

During the moving week, staff were photographed and issued with high-tech security cards; they attended lectures on how to access the new hospital and the importance of the security systems, which seemed to have been designed to prioritise the prevention of unauthorised entry, fire and theft rather than provide a welcoming or containing atmosphere to suffering patients or their relatives. Those of us more used to holding doors open for patients as a matter of courtesy were surprised by the strict instruction never to let anyone slip through a security threshold behind us, and we began to wonder whether things were considered more important than people in the new surroundings.

At first the 15th floor, though bright and clean, designed to accommodate private in-patients, had its drawbacks. The rooms, each with its own bathroom and wonderful view of London, led off a wide corridor. No room was really suitable for a waiting area, and a section of this corridor had to serve, and so all patient and staff movement was visible to all. The secretarial staff, integral to the familiar way of working, had no proper accommodation or even desks of a suitable and healthy height for their work. They were crammed close together in a crowded and therefore noisy office, where confidentiality of patients' phone calls was compromised, while the filing cabinets had to be housed in the various available bathrooms around the department. The quality of patients' contact with the Department changed, as the different security system meant that the remotely controlled doors to the department, once passed, allowed them free access to the whole department, with no barrier between staff and patients once they were inside. There was no departmental alarm system, and staff were told that in the case of emergency such as a violent or self-harming patient we should have to wait until the security staff arrived from their central control point several floors away. Very soon a psychotic patient found a way into the department via a back entrance from the rest of the private patients' wing, and the staff became increasingly anxious. Medical students on the other hand, whose attendance, and indeed work is valued, were forbidden passes, and had to be met at the main entrance each time they attended meetings or teaching. It was found necessary to have a uniformed security guard on duty at all times in the department, from 8am till 8pm. Although this was initially alarming to both staff and patients we were lucky enough to get a very reliable man, who became a sympathetic and firm

presence in the department. Much reassurance was needed for some patients owing to the physical situation of the department. Those patients alarmed by enclosed places could not use the lifts, and the splendid views from the 15th floor reminded others acutely and painfully of their suicidal thoughts and impulses.

Not all the patients were able to continue their treatment, despite very hard work on the part of the staff to accustom them to this situation, which was made more difficult by the fact that we were no longer working alongside the psychiatric liaison team, now housed elsewhere. One secretary suffered severely from both feeling unsafe, and from back problems exacerbated by the unsuitable desk, and left. The senior secretary, who had been the department's mainstay for many years, announced her retirement.

Adaptation to these circumstances was tricky, but things were being adapted to, when the next difficulty came with news that we should have to vacate the 15th floor shortly, but were not immediately told of our destination except that it would again be an interim arrangement. Anxiety rose as the patients were again informed of an imminent move, but not of our destination, which was at first unknown. Relief came when we were told that we would be going to a soon-to-be emptied surgical outpatients block, followed by immediate concern at the prospect of a further move to the old private patients' wing of the hospital in the near future, date unknown. We were warned that there would probably not be enough rooms to accommodate all members of the department in the new temporary accommodation, and there was also uncertainty as to whether the ex-private wing accommodation could take all members of staff.

A few weeks later the Department closed for another week during the next move, again supervised by the secretarial staff, who in fact packed up and carried much heavy material, files etc, themselves, and once more proved their good will. This did, however, taken its toll in subsequent back problems and the increased need for sick leave.

Adapting to the third floor of the surgical block proved easier in some ways, more difficult in others, and staff morale suffered, partly because the accommodation that we worked had so hard to get used to and make work for us on the 15th floor of the new building was still vacant for some months, and it was quite unclear what the purpose of this last move actually was. After the new hospital with its emphasis on security, where only authorised personnel with swipe cards could get access to the Department (even though this could be subverted), the grubby and old-fashioned ex-surgical block opened directly onto the street, and anyone could walk in, and sometimes did. A rickety table in the entrance space was occasionally manned but I never heard any enquiry from or to its occupant. It was necessary to retain the security guard to monitor entrance to the actual department, but there was a

further temporary loss, since the kindly man the patients had got used to was suspended from duty for a few days for the apparent 'offence' of wearing a sweater unofficially during a spell of freezing weather. He had been particularly useful in redirecting those surgical patients who had not been informed of the changes and continued to arrive in the department even after the transfer of the previous occupants to other premises. In addition to the lack of security there was now the disadvantage of being cut off from the computer system which was not connected to these ancient premises, so that obtaining old records proved impossible, and in addition very few of the inadequate number of rooms had phones with outside lines.

As there was only one dedicated secretarial office, the senior secretary, who had volunteered to postpone her retirement until the department was finally settled occupied it, while the rest of the secretarial staff built themselves a small redoubt with filing cabinets set around their desks in the open centre of the department, so that they could preserve some privacy and confidentiality as patients wandered past them to and from their sessions. Many patients stuck it out, and continued to attend, despite the walls between the consulting rooms not being completely soundproof, and there being a permanent noise like a burglar alarm persisting all day on the north facing side. The group therapists noticed the fallout most.

Three months later, approaching Christmas, that time of year which psychologically disturbed patients find the most difficult of all, and through which they need the most support the next move was announced, to the old private patients wing. Despite being told that the Department would be settled there for at least the next five years staff morale continued to fall, and any trust that we were seen to be of value by management was becoming replaced by cynicism. It was again necessary to close the Department, this time for nearly two weeks, since the Christmas holidays took up some of the available time for packing up and also for unpacking, including retrieving notes and books from long-term storage at last. Already alarmed patients had a few days to be told where and when they would be seen after New Year. New appointments were sent out late on account of the fear of having to change them with little notice. Staff anxiety was rife about the capacity to provide a suitable level of psychological care for anxious and depressed patients or those only just holding breakdown at bay.

Luckily the fourth floor of the 'new' building was solidly built, and had been painted and re-carpeted for the Department's arrival. There was a good waiting room visible from the secretaries' office, and dedicated space for records and supplies. Unluckily the accommodation was split in two, being divided by a stairway and lift shaft, requiring two security doors which separated one half from the other.

These did not always work, and thefts began. Gradually the psychiatric teams working alongside us in these premises were moved to community premises, and despite the promise that we would stay for at least five years, there was an air of gradual attrition. The senior secretary retired, as did a clinical colleague and I decided to do the same. It was actually two years later that the Trust decided to move the Department again, away from the hospital to a building in King's Cross. I have not worked there, but it seems light, and pleasant. New staff have joined, and I hear good reports.

Part of the distress which affected both staff and patients can be put down to our experience of increasing helplessness in the face of apparently arbitrary managerial decisions, as well increasing belief that if we were moved around in this cavalier way it must mean that we were at the very least unvalued, and perhaps not really understood at all. That the department did not fragment totally can be put down to the careful management of Peter Schoenberg, the Head of the Department, who has a gift for containment and communication and sharing the pain of his colleagues that is remarkable. To have steered the Department through all this is a great achievement. He has done it carefully and sensitively.

So where does this get me in terms of Time and Change? I've spoken mainly about difficult and painful unwelcome changes, where the time element has not been carefully considered. Welcome and exciting change takes little time to accommodate to; unwelcome change arouses resistance and mourning, maybe a

nostalgic idealisation of the old state. The feeling of helplessness, of being 'pushed around' can arouse the belief of not being valued, as demonstrated by the handicapped man I spoke about first. 'Normal people get the good things. There is nothing for people like me.' That is how morale drops, unless much work is put in to maintain it.

People are creatures of habit. It is easier to repeat behaviours than invent new ones on the whole, and so we carry on doing things in the same old way till someone says they've thought of a new and better way. This can feel like an attack, as if we are being told that our previous state or way of being is not good enough. We may get affronted at this stage and resist change, particularly if the reason is not clearly explained. Our old ways are our friends, and if they are a little eccentric, a little clumsy, at least we are used to them, they are familiar, and if they fail we know how to fix them. It takes confidence in ourselves, to be able to consider new things and if we are lucky, agree and decide on the change. But even then change takes time to accept. Old ways creep back. New ways of working need to be tried out and evaluated before being accepted as new friends. We have to deal with the disloyalty of having abandoned old familiar ways – 'what was good enough for my father...'

So I get back to mourning – denial, rage and grief, guilt at one's disloyalty at accepting change, guilt that perhaps one is actually excited by the possibility of new, untried things, the thought that there may be new possibilities, that life goes on, and might be even better. But like mourning, it takes time. Time for change.

Advances in intuitive diagnostics in psychosomatic psychiatry

Uncovering individual and transgenerational psychological trauma in childhood

Peter Heint MD MRCPsych

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General practice work fulfils a crucial front line role in recognizing medical conditions. Recognizing whether a given medical condition is a serious one or not and, indeed, diagnosing the exact nature of a medical condition can pose difficult challenges. Recognizing whether a condition that at first sight presents as a physical condition is in fact due to underlying psychological causes adds yet another dimension of complexity, because of the involvement of unconscious mechanisms.

I would like to present two case reports and outline the conclusions I draw from this work. I hope that the case histories will demonstrate the importance of an accurate diagnosis in conditions that present as medical cases although they are due to underlying psychological causes. I hope to demonstrate that psychosomatic thinking is not an academic or highly specialist issue but a fascinating one of huge relevance for patients' wellbeing in general practice. I say this, as I believe that the future of primary health care lies in an integration of somatic and psychological thinking.

The first patient: Mrs D

Mrs D, as I shall call her, was born in 1942 in East Prussia at the Baltic seaside. In 1944 she and her mother fled from the advancing Red Army. The traumatic impact of war-induced experiences on a two-year-old girl had very significant psychological consequences for Mrs D's whole life. Throughout her adult life Mrs D felt a lack of security. She suffered extremely from the mere thought of possibly losing loved ones, and from existential anxieties such as fear of hunger, poverty, disease and from fear of failure. She experienced panic attacks and an uncontrollable fear of catastrophes. Having been a refugee from East Prussia she felt alien and inferior in West Germany, unfortunately a rather typical experience amongst refugees.

There were also somatic symptoms affecting Mrs D's neck. Mrs D described a set of symptoms that had affected her cervical spine for as long as she could remember. Her cervical spine was, as she said 'the centre of pain', and of sensations such as of a 'blockade', of a 'strangling', or even of an 'explosion' as if there was a 'metallic bang' inside her head. Only by involving her shoulders could Mrs D carry out rotational movements of the head. An extreme

sensitivity to cold affecting the neck forced her constantly to wear a scarf, no matter what the actual temperature might be. A nasty rotatory vertigo associated with feeling dazed or experiencing a 'blurred head' occurred frequently. A worsening of symptoms and increased stiffness of the cervical spine forced Mrs D to give up sports activities. All in all, she felt 'as if my cervical spine was not part of my body...'

Radiological examination of the cervical spine and ENT tests did not reveal any abnormality to account for the vertigo. However, being a trained health professional, Mrs D pursued the search for a remedy as the symptoms interfered significantly with the quality of her life. Unfortunately however, a series of treatments proved fruitless. Physiotherapy, if anything, only intensified the symptoms. Similarly massage, thermotherapy and acupuncture failed to produce a lasting improvement. Stretching the cervical spine only increased a sense of bodily instability and worsened the vertigo. Whilst pursuing the search for a cure Mrs D was prescribed altogether 12 different drugs. They included anti-inflammatory, muscle relaxant, pain, anti-migraine and blood pressure medicines. Although some of these drugs caused side effects, none of them removed or even alleviated the cervical spine symptoms. Eventually Mrs D was prescribed four different psychopharmacological drugs. The last of these drugs induced nasty withdrawal effects that 'tormented' her 'over months.' 'Autogenic Training', a relaxation technique, brought about some easing of tension, but, again, no lasting improvement. Mrs D seemed to have arrived at a point where all treatment options had been exhausted.

When in the course of psychotherapy with me Mrs D first mentioned the cervical spine symptoms I was baffled about the neck problem. I may be equipped with some somatic medicine 'genes' as both my parents were orthopaedic surgeons. However, I am by no means working in somatic medicine to the extent as is the case in general practice.

Faced with Mrs D's account of her neck problem I resorted to what might be described as 'soft' skills by relying on a mixture of common sense and intuition. I suggested that she avoid any further outside professional interference with her neck. Instead, I advised her to try to see whether

she might improve the situation herself by very gently touching the sensitive neck area. I was intrigued to note that Mrs D reported a slight sense of improvement. This subtle sign of progress encouraged me to try to shed light on the onset of neck problems in her childhood, given the long duration and tenacious persistence of the neck symptoms.

It quickly emerged that as a girl she had once had to endure a puncture of the cervical spine when she had fallen ill with diphtheria. The puncture had been excruciatingly painful as it had been carried out without anaesthetic. A traumatic experience of this kind might well have qualified as a root cause for the intractable neck problems. However, Mrs D, an intelligent and articulate person, was adamant in her view that this procedure, however unpleasant it may have been, was not the cause of the neck symptoms. Finding the notion of the 'expert patient' a rather attractive concept, I had no difficulty in accepting her view, although this made life more difficult for me as the cause of the neck problems seemed to be as elusive as ever.

If the traumatic puncture was not responsible for the neck problem, what was the cause? As far as I was concerned, there was no clear-cut diagnostic pathway and there was no textbook guide I could rely on. If I wanted to shed light on the obscure cause of the neck problem there was only one option left and this was to continue searching.

I was aware that, on one occasion, Mrs D had been forced to witness the shooting of a young man when she fled with her mother from the Soviet into the Allied Sector after World War II. At the time she had been a three-year-old girl. She had remained unharmed in the incident, but I could not help feeling that witnessing such a dreadful killing, whilst sensing her own and her mother's life in mortal danger, might have left a mark – but what kind of mark? I was very much aware of the speculative nature of my thinking as I had no proof. I was also aware that at least some of medicine is a curious mixture of logical science and intuitive art. Therefore I decided to explain to her that there might be a link between her witnessing this killing scene and the chronic neck problems.

Immediately afterwards Mrs D had a dream. In this dream she saw herself standing in the clearing of a wood surrounded by a dark forest. This was a setting similar to the one in which the fatal shooting had occurred more than 60 years earlier. Then, in the course of this dream, she saw a big animal coming from the right. She said to her mother, 'Look there is a wolf.' Her mother grabbed her hands while telling her that the animal was not a wolf, but a big dog. 'In that instant,' Mrs D stated, 'the dog jumps at me from behind and bites into the right side of my neck.' Here the dream ended. However, on waking she felt a strong jerk, a crunching sensation, a 'de-blocking' of her cervical spine and a 'big bang' in her head. All this scared her until she noticed a

pleasant sensation of warmth flowing through the area of her neck and head.

Since this moment, six months ago, to Mrs D's and, indeed, to my own surprise, all the neck and associated symptoms described above have vanished. She expressed her 'joy about the new-found freedom from complaints that even allows sports activities'. This made her feel her 'body and cervical spine as a whole, a unity,' indeed, an experience she had had for the first time in her life after more than 60 years.

The Second Patient: Mr K

Let me now invite you to look at the second patient, Mr K, a 50-year-old health professional, who first attended one of my seminars on psychosomatics about two years ago. Mr K came with the aim of improving his psychosomatic skills. He also hoped that the seminar might help him to 'save his right hip' as he put it. Mr K had suffered from pains in his right hip on and off over the years. By 2003-4 the pains had intensified to the degree that Mr K was unable to walk for longer than a few minutes. Various physiotherapeutic and other healing measures had not produced a lasting improvement. Eventually he was given the urgent advice to undergo endoprosthetic hip surgery. This would clearly have represented a major intervention for an otherwise healthy man of his age. As a last resort, and before consenting to such a step, Mr K wanted to explore the question as to whether psychosomatics might offer any help. He first consulted my late mother, Dr H Heinl, who was a pioneer in orthopaedic psychosomatics, and then me, although I have no formal training in orthopaedics.

In the first seminar Mr K impressed me as a delightful man who talked calmly and with a self-deprecating sense of humour. Given this first impression it would have been difficult to get a sense of some hidden underlying psychological issue that might account for the psychosomatic hip pains. However, the unexpected is never far away in psychiatry, psychosomatics and psychotherapy, often enough lurking invisibly in the background and waiting to strike. On this occasion, however, it did strike me by unfolding a vivid scene in my mind that was in complete contrast to the relaxed atmosphere I experienced whilst listening to him. Suddenly I saw in my mind *Rumpelstielzchen*, the figure from German folklore who used to dance on one leg and who, when his name was found out, got himself into a frenzy, stamping the ground so madly and hard with his leg that the leg was pushed into his body splitting the body into two.

The contrast between such an entirely unexpected inner perception and my impression of Mr K puzzled me. The question captivated me whether this inner image had come out of the blue, or whether it was in some way related to my encounter with Mr K. The only way to obtain an answer was to tell him about my perception of the *Rumpelstielzchen* scene and to wait and see what might happen.

Mr K's account

In order to describe what happened I quote from Mr K's account: *Giving my account in the seminar was a new experience for me- new insofar as I did not provide the account in the way of telling a series of anecdotes as I usually do within the family circle. Instead I was talking to someone who seemed to listen very attentively... I was completely taken aback when you [Dr Heintz] interrupted my account in order to tell me about your Rumpelstielzchen image... as I had intended to report about my anger and indeed, outbursts of temper. My first association to the image was that of a little, red haired furious figure who had been betrayed. At this point I experienced, for the first time, a feeling of prickling under my skin running from the back of my head, down my spine, and further down my legs right into my feet. Since then this sensation has been overcoming me, whenever- and I do not quite know how to express it through words- a deep and/or far reaching and very emotional event is touched on.*

Telling Mr K about my Rumpelstielzchen image in no way changed his courteous behaviour. However, it became immediately clear that the atmosphere had shifted to one of much greater emotional intensity. He now gave me a disturbing account of his childhood. Between the ages of six and eight years he made three very serious attempts to jump out of the window of the fourth floor flat in which he was living with his family. Fortunately his brother, who was four years older, succeeded on each occasion in grabbing him and holding him by the legs. Without the brother's presence of mind he would have jumped to a certain death. In the end the windows of the flat had to be secured with wooden bars in order to prevent a tragedy.

As I tried to shed some light on this unusual and determined behaviour of a young boy, it emerged that Mr K had experienced two repetitive and 'dominating' childhood dreams. The first dream occurred for the first time when he was only three years old. The key figure of this dream that he described as his 'traumatic companion' was the devil.

Mr K remembered vividly crossing the dark corridor at night in order to seek protection in the bedroom of his parents. Later, at the age of five or six, there was a second dream about Superman that started when he began to look at Superman comics.

The dream about the devil had stayed vividly in his mind: *The never changing content of the dream about the devil was the banging, smoking, red glowing appearance of this demon at the emergency exit of our flat- behind a glass door protected by a wire grid. I saw the devil in full 'robes:' glowing in fiery red, a goatee beard, horns, thick eye brows, a tail with a tuft, a trident, long fingernails and a cloven hoof. Then, in the dream, the devil burst into the flat, screaming and falling over Mr K with the intent of guzzling him up. Remaining surprisingly cool, he suggested to the devil that he should go with him to town as*

there were more 'palatable' individuals to find. The beginning of the dream frightened Mr K more with the devil's banging appearance at the emergency exit than the actual presence of the 'Red' (as he described the devil). Although this dream had stayed so clearly in his mind, it had never occurred to him to reflect on its meaning.

The *leitmotiv* of the Superman dream was one in which Mr K appeared as a heroic saviour of lives. He saved humans as well as animals and prevented a whole range of objects from being damaged or destroyed. Interestingly he declined *...whatever reward or praise I received for my heroic deeds.*

Reflections and revelations

Listening is a fascinating process. It involves simultaneously following a *melange* of different yet somehow connected strands of information. There is the story as it is being told through words, the subtle murmur of the unconscious undercurrents and the colourful mosaic of feelings, thoughts and images evoked and emerging like kites in the mind of the listener. Before long, questions lighted up in my mind. What drove a young boy to such determined attempts to throw himself out of the window? Where did the devil come from? Was the devil's appearance linked to the family's Catholic affiliations? And last but not least, in which way, if at all, was the early childhood dream of the devil related to the very real clinical problem of Mr K's hip disorder? And even if there was such a link between dream and hip problem the question arose whether there was any prospect of a cure.

Plentiful permutations of thoughts and hypotheses seemed possible and meriting further exploration. However, before I was able to filter and organize the wealth of information the unexpected struck again. This time it confronted me with another inner image. In contrast to the Rumpelstielzchen scene, the new image was not taken from the realm of fairy tales, but from Germany's bloodstained history. I would have preferred not to see what I saw projected onto my inner mental screen. What I did now see evolving was a transformation of the devil's cloven hoof into a club-foot. Then the process of transformation spiralled to another dimension as the devil taken from Mr K's dream changed into what might be described as a devilish variant of the human species.

Suddenly I saw the former Third Reich propaganda supremo Joseph Goebbels emerging on my inner mental screen. Having climbed up the emergency stairs with his (real life) club-foot, he appeared behind the glass door of Mr K's childhood flat and now terrified him. I was perfectly clear in my mind that I had neither desired this image nor consciously construed it. As before, the question arose as to whether this image too had surfaced out of the blue or whether it was, in some mysterious way, connected to Mr K? The only way to test the image's meaning was

to convey it to Mr K. At first I did not know in what way a possible link between him and Joseph Goebbels could be established, but then a potentially useful idea occurred to me. As soon as I had mentioned my Goebbels image to Mr K, I wondered whether the house in Frankfurt where he had grown up, might be linked to Joseph Goebbels or the infamous Third Reich.

When I described the image of Goebbels to Mr K he displayed no particular emotion. He was not able to confirm as to whether there might have been a Nazi link to the house. However, he was keen to make enquiries through his parents in order to test the validity of the image. Walking towards me the next morning Mr K appeared intensely moved. The words with which he greeted me, speak for themselves: 'I am electrified', he said, 'It is like in a thrilling movie.' His father had confirmed to him immediately that the house of his childhood had been known in Frankfurt as the 'brown house.' The Nazi 'bosses' had been visiting the house. They may have included Joseph Goebbels. There was a possibility that the cellar of the house had been used for interrogation and torture. In line with such a suggestion Mr K told me that he had always felt uncomfortable when entering the cellar. There had been a printing press in the cellar. Mr K remembered that he had had a childhood dream in which human heads were crushed by the press.

When Mr K questioned his mother she cried out with horror, confirming as well that this had been the 'brown house' of Frankfurt. It was then that Mr K understood ...*suddenly and for the first time knowingly and consciously the dimension of my childhood experience, the consternation and anger of my mother, her anxieties, fears and aversion regarding this house. For the first time I comprehended the rage of my mother against the Brownshirts whom she held responsible for the death of my grandmother as she was refused proper medical treatment for her life-threatening medical illness. I had never been aware of this degree of emotional burden affecting my mother. It may have been this aspect which shaped the image of my mother as a 'fighter' - fighting to keep the family running and fighting to prevent herself from being pushed down even further by the 'house feelings' that weighed her down.*

Summarizing the causal relevance of these revelations, Mr K wrote: *At the end of the day it is an obvious, convincing and highly probably explanation that the feelings triggered and transmitted through the history of the house, its atmosphere, the history of the suffering of the people in the house and through my mother's discomfort, have to be seen as the cause for me not having wanted to be born there.*

From a clinical point of view, establishing this link to his childhood had a striking impact on Mr K's hip symptoms. Immediately after the seminar session he was able to walk the first time in two and a quarter years for two hours without

pain and without interruption. Since March 2005 he has been virtually free of pain. He has experienced only residual restrictions as far as the hip joint is concerned. The vast clinical improvement is described by him as being *something highly enjoyable and sensational*. This extremely positive state of affairs has now lasted for two years.

Equally significant has been the impact of the revelation on the quality of his emotional life. *Following the seminar I have experienced a more intense emotional perception of my life. A substantial part of the emotional distance from my own self has melted away. I feel pleasure, joy, pride, irritation, anger, although only a small degree, in a different way and a different kind, and somehow more directly and less filtered. Talks with my parents have enabled me to perceive them with a higher degree of emotional perception.*

I should emphasize that I had never seen the house in which Mr K had grown up from 1957-67 nor had I known of its existence. Nevertheless, the image containing the disturbing transformation of the devil into Joseph Goebbels had triggered a hypothesis that Mr K had been able to confirm which, in turn, had produced an entirely unexpected cure, literally saving a middle-aged man from a surgeon's knife and life with a hip joint implant.

Let me say just a few words of about the history of the house, as it is so strangely fascinating. Built at the end of the 19th century it had served as a hotel until an Arab sheikh moved into it together with his camel and other exotic animals. After the sheikh's departure the hotel had become uninhabitable. In the 1920s the house served as an office for the German communist party, the implacable enemy of the fascists. After the Nazis seized power they confiscated the building, using it as a Gauleiter office, the Gauleiters being the heads of Germany's administrative regions. After the end of World War 2 the house was used again, but this time by the democratically elected regional government. In recent years, however, the house has remained empty, as if exhausted from its turbulent history.

In the course of Mr K's enquiries yet another unexpected historical link to the Nazi period emerged. Although he was not able to establish any further links to Joseph Goebbels, he unearthed a disturbing link to another demonic figure of the Third Reich, the immensely blood-thirsty, powerful and ambitious Reinhard Heydrich, SS leader and mass murderer. Mr K discovered that the story of the house was intimately linked to the fate of Mr A, who had been a friend of his father. Mr A had been detained and interrogated in the house by Reinhard Heydrich. Whether Mr A had been mistreated or tortured remained unclear.

Intuitive diagnostics

I have presented these two case vignettes in order to illustrate the effectiveness of intuitively

pinpointing, i.e. diagnosing the underlying psychological causes of significant psychosomatic problems and of treating them successfully. I would like to briefly sketch out some aspects of this approach that I define as Intuitive Diagnostics. I would also like to touch on some conceptual issues that I feel are relevant to working in psychosomatics.

The approach of Intuitive Diagnostics that I have developed over the last 30 years has been immensely valuable to me in my clinical work with adults. It has helped me to detect a wide range of early childhood traumas that include childhood war trauma and their trans-generational transmission over two and more generations. Whilst serving as a diagnostic 'torch' into the obscurity of the unconscious, Intuitive Diagnostics has provided crucial diagnostic insights towards the successful detection and decoding of unconscious childhood war trauma underlying a range of clinical symptoms and conditions.

Essentially, Intuitive Diagnostics is based on the perception, assimilation and processing of communicative information transmitted to me from a given individual I am working with. Such communicative information usually contains verbal information, but it is also enriched by a whole spectrum of non-verbally transmitted information such as facial expressions, eye movements, gestures, body posture etc. Rather than consciously trying to screen the perceived information for signs of pathology or inconsistencies, or with other words, rather than trying to rationally filter and interfere with the perceived communicative data, I allow them to organize themselves within my mind. Adhering to a *laissez faire* stance, I allow things to happen until cognitive insights are generated or images are displayed on my inner mental 'screen.' As in the second case history the images produced in this manner on my inner mental 'screen' may then be expressed through words. However, inner images may also be represented through complex arrangements of objects which I have described as object sculptures. Relaying the insights or images or, indeed, object sculptures back to the individuals who transmitted their verbal and non-verbal communicative data to me in the first instance, closes what might be defined as a feedback loop and also produces the therapeutic effects described in the two case histories.

The precise dynamics of the mechanisms at work in Intuitive Diagnostics are still somewhat obscure. However, the framework of thinking required for Intuitive Diagnostics to unfold is fairly clear. This becomes evident if the diagnostic and treatment failures prior to my interventions are analyzed and if the question is explored as to why the diagnostic puzzle of the two case histories was not resolved much earlier, which, in the cases I have described, led to wasted years of unsuccessful medical treatments. In fact, the two psychosomatic case histories illustrate the 'classical' feature of childhood trauma

respectively; trans-generationally transmitted trauma falling through the diagnostic net for years, if not decades.

I presume it is fair to say that a traditional, entrenched and influential strand of medical thinking focuses on only diagnosing objective symptoms and therefore on only treating objective symptoms. The value of such a thinking mode with respect to the diagnosis of a wide range of medical conditions should not be questioned. However, the inflexible and uncompromising application of such an approach to psychosomatic problems is unlikely to be successful as the exclusive focus on symptoms is unlikely to uncover any underlying psychological sources of the problem. This situation reminds me of one of the first patients in whose care I had been involved during my medical training. The patient had presented with a symptom of fever. Accordingly his GP treated him with medication to bring down the fever. For a little while this symptom-focused approach seemed to work. Unfortunately, however, before long the fever got worse so that the patient had to be rushed to hospital. In the light of greater diagnostic scrutiny it emerged that the patient who had recently returned from Africa, was actually suffering from malaria.

Conclusions

The point I am trying to make is that in medicine as in psychosomatics it is important not to confuse symptoms with underlying causes and to regard a psychosomatic symptom not as an end in itself, but as a pointer towards the underlying cause. Enlightened, objective, scientific, understanding, examinations and tests have brought about amazing medical advances. I would not in any way want to appear to question the merit of such advances. However, if the belief in objectivity is taken to the extreme by invalidating subjective experiences, then the absence of objective pathology is likely to be interpreted as proof for the non-existence of any pathology. Invariably such a scenario will lead to any underlying subjective pathology to be overlooked. The baby of subjective pathology will be thrown out with the bathwater of objectivity – exactly what happened for so many years in the case of Mrs D and Mr K.

The conclusion is obvious: successful psychosomatic thinking requires the recognition of subjective experience as providing a basis for the development of symptoms or conditions. Relying dogmatically only on objective clinical examinations and tests will lead into a blind alley. Therefore efforts are required to overcome the remnants of the 'iron curtain' running between somatic and psychological models of disease by advancing a 'unitary' psychosomatic thinking.

I have referred to the limitations due to an approach zooming in exclusively on symptoms. Such an approach is likely to contain yet another important limitation. Experiences of pain were key symptoms in both Mrs D's and Mr K's cases.

Not surprisingly, both Mrs D and Mr K described the pain as occurring in specific somatic areas, i.e. neck and hip, as this reflected their subjective pain experience. In both cases the medical thinking accepted this description regarding the localization of the pain. This reflects, I presume, a deeply ingrained medical thinking about the localization of symptoms. Again, I do not wish to dispute the usefulness of this kind of thinking as it allows the exact localization of underlying pathology. I am always grateful if my dentist is able to identify and treat the right tooth by taking into account my description of the localization of the toothache. However, Mrs D's and Mr K's case histories demonstrate the principle that, although the neck and the hip were described as the areas in which the symptoms were experienced, the brain has to be regarded as the real source of the symptoms. It is the brain that generates the sensation of pain. This provides the explanation as to why tests relating to the neck and hip did not reveal underlying objective pathologies. The problem was not with the tests; the problem was that the wrong parts of the body had been looked at, as the perception of pain had been stored in the brain. If modern advances in brain imaging technology progress to the extent that early psychological causes of psychosomatic symptoms can be visualized, then proof of the primary, i.e. brain, localization of the subjective pain experience will be provided. Therefore successful psychosomatic thinking requires the awareness of the key role of the brain in generating and maintaining symptoms.

My final point refers to the need to overcome deep-seated 'pigeonholing' of humans into adults and children and to be aware of deeper 'sub-surface' links between childhood trauma and their adult manifestations. It is evident from Mrs D's and Mr K's case histories that the failure to explore or even to consider such links played an important role in overlooking the correct diagnosis. The principle of tracing the course of diseases back to their roots and onset in childhood is not new in medicine. However, I have come across too many cases in which this principle has not been adhered to in relation to psychosomatic illnesses – usually to the detriment of the patients involved.

In my view the various facets I have described will provide a framework within which

psychosomatic thinking can develop and flourish. A medical decision-making process, blending the traditional emphasis on the retrieval and use of accumulated medical facts and knowledge with 'soft' intuitive skills, will be invaluable in order to detect the underlying sources of psychosomatic symptoms and conditions. This will prevent diagnostic oversights, and failed and wasted treatments with their inevitable disturbing consequences for the lives of the human beings affected. Evidently this will improve the quality of the medical service for many patients.

I am very much aware of the challenges ahead and I am very much aware of the impressive spectrum of modern X-ray and imaging techniques, that, within barely a hundred years have done so much to improve the access to and visualization of physical body spaces that were hidden to the medical practitioners' eyes before Wilhelm Conrad Röntgen discovered the X-rays. However, I am confident that the kind of 'human' imaging technique in terms of Intuitive Diagnostics that I have described may go some way towards shedding light on the unconscious space and, indeed, some light on the workings of what the famous astronomer Johannes Kepler once described as the 'mysterious firmament contained within the skull.' It is therefore hoped that Intuitive Diagnostics will have the potential to stimulate a greater interest in what is at the heart of every diagnosis, i.e. the decision-making processes evolving and taking shape in the medical practitioner's mind.

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Any Space for the Patient's Agenda?

Keynote address to the 2007 Oxford Weekend

David Watt, secretary of the Balint Society

Welcome to this year's Oxford Balint Weekend.

Each year we have a loose topical theme for the conference. As you know this year it is 'Space for the Patient's Agenda'. Balint work tries to place the patient's needs at the top of the agenda. It can do so by assisting the professional in tuning into the client's world. We can try to help with what they want and also try, where necessary, to reach deeper levels of need, masked perhaps by confusing psychosomatic symptoms.

Currently, I think, many of us in general practice are encountering a new obstacle to this work. It is not insurmountable but is making our work even more complex. This is the growing preventative or Public Health agenda, led by medical research, as applied to populations not to individuals. This was originally embodied in the UK in 1992 by the document 'The Health of the Nation', which laid out targets for public health improvements in the future. These were goals such as reductions in smoking, reductions in teenage pregnancies, reductions in suicides and reductions in heart disease. For GPs this agenda is now enshrined in target based payments called the Quality and Outcomes Framework. Already in 2003 an Icelandic group published a paper entitled 'Is opportunistic disease prevention in the consultation ethically justifiable?'. They argued that consultation time was limited, and that the patient might not have enough time to address his or her needs when activities might be driven by the doctor's preventative agenda. A survey in the USA in the same year showed that an average primary care physician would need 7.4 hours each day to implement the recommendations of the US Preventative Services Task Force.

In my day-to-day practice I used to begin each consultation with an opening gambit such as 'what brings you here today?'. Today I would estimate that perhaps 50% of adult consultations may not be patient initiated, or may have at least a component of the visit initiated by the practice. 'You sent me a letter!' 'It said I needed my annual review.' 'It said I needed a blood test.' 'It said I needed a medication review.' 'It said you needed to give me a result'. With many of our patients it now seems difficult to get to the fresh remit of what the patient might actually want. I am now delighted to see people who have not been seen for a long time, because their visit may well be self-motivated. This, however, may not last much longer, as the epidemiologists and drug manufacturers are seeking to treat premorbid conditions earlier and earlier. Also the authorities are trying to check up on the existence of people who do not visit their doctor, a procedure known as 'list cleansing'.

Public health work is of great value, but it is different kind of work for us, and one which

encroaches on the time we have for our traditional role as general practitioner, which has been to focus on the problems of the individual as they present themselves to us. Some commentators have also questioned the value of some of this preventative work. Iona Heath et al have recently written in the BMJ about the lack of good evidence (in an evidence-based world) for some of this new work, particularly in the elderly, who are becoming a larger part of the population. The PROSPER study of the use of statins in a group of 70-82 yr olds to reduce serum lipids found no decrease in overall mortality. A slight decrease in ischaemic heart disease was counterbalanced by increased cancer diagnosis.

So we, particularly in the Balint world, must keep fighting for the Patient's Agenda in our consultations. We can also individually work to keep space in our minds and thoughts for it. With this in mind I would like to give you what I find a very beautiful spatial metaphor for what we can do and experience in Balint work, for both the benefit of the patient and ourselves. It is from a paper given at the 11th International Balint Congress in Oxford in 1998 by Richard Addison. He is a hermeneutic researcher in Santa Rosa, Ca, who leads Balint work in a family practice residency and is involved in Balint research in the USA.

'The morning surgery is like a walk in the forest, each patient a tree. All so close together it may be difficult to get a good view of each individual one. When we get to the edge of the forest, to a lovely green meadow clearing, we can start to look back at each tree we have seen, and at the context in which we were walking or working. We then have a space from which to look back and study each interesting tree, including the ones we may have tripped on or knocked against. The Balint group may be such a space, or clearing, where we can see light, can reflect and give the patient space, which may have been under pressure in the consultation, or in the way we are having to work. On our own, and on the patient's behalf, we can also "reflect on the stresses of the day, about patients, about life as a physician, about the ideals that brought us to medicine, about what we care about, what matters and what has meaning, and how one can express that meaning in one's professional and personal life".'

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St Scholastica's Day

Talk given at the Balint Society 2007 Oxford meeting
by Mary Salinsky

Walking through the centre of Oxford you may have seen a plaque set in the wall of the Abbey bank at Carfax. It is on the SW side – where Queen Street and St Aldate's meet. The plaque notes that 'This was the site of the Swindlestock Tavern 1250-1709'. There must be dozens of sites in Oxford of old buildings that are no longer standing. So why is this one commemorated in this way?

The answer is that it was at this tavern in 1355 that an event occurred which would govern relations between the University and the City for centuries afterwards.

On Tuesday 10 February 1355 some students who were drinking in the Swindlestock Tavern at Carfax complained about the quality of the wine. The landlord (John of Barford, who happened to be Mayor at the time) is alleged to have responded to their complaint with 'stubborn and saucy language'; whereupon a student threw a quart pot at his head. Local townspeople came to the landlord's aid and had the bell at the City Church (St Martin's at Carfax) just across the street from the tavern, rung to summon the townsmen to arms. The University retaliated by rousing its students, and battle commenced, with both townsmen and students making good use of their bows and arrows. There ensued three days of rioting, three days that were to have repercussions for hundreds of years.

What you think happened depends on which account you read. The citizens themselves produced their version of the story soon after. In that, after the pot-throwing episode, '...the bailiffs came and prayed the students to amend and redress the trespass, but they issued forth from the tavern and at once they had bows and arrows. The scholars made great noise and great debate, for which reason the mayor, bailiffs and sergeants approached the Chancellor of the University and prayed him to have the malefactors arrested and to aid that the peace should be kept on his side. The Chancellor doing none of these things, there came two hundred and more of the scholars, armed in the manner of war, and beat and assaulted the mayor, bailiffs and sergeants, whereby there is despair of their lives.' So according to the town, the students began it and the university authorities resisted the citizens' plea to restore order.

What did the University think happened? Their report says that 'though the scholars at the command of the Chancellor did presently withdraw themselves from the fray, yet the townsmen thereupon did more fiercely pursue him and the scholars and would by no means desist from the conflict. The Chancellor perceiving what great danger they were in, caused the University Bell at St Mary's to be rung out, whereupon the scholars got bows and arrows, and

maintained the fight till dark night.'

In the City's version, the Mayor was nearly killed by the scholars; in the University version, the Chancellor was nearly killed by the townspeople; and each blamed the other for not keeping order.

It is clear from both versions that the rioting and attacks continued the next day. The city's account briefly records that when 'the next morning, the bailiffs were gone to Woodstock to complain to the King of the said injuries, the scholars came with royal power and fought by plan and openly, and set the town on fire in divers parts, and broke open and robbed divers houses of lay folk, and wounded many people and killed many; by which alarm of fire and of the fighting the common people arose in aid and defence of the town.'

The University however, claimed that the townspeople deliberately planned to continue the attacks, and 'had hired people to come in and assist in their intended conflict. One scholar the Townsmen killed, some they wounded mortally, others grievously, and used the rest basely. All of which being done without any mercy, caused an horrible outcry in the Town... and divers scholars issued out armed with bows and arrows in their own defence. Then entered the Town by the west gate about two thousand countrymen. The scholars being unable to resist so great and fierce a company, withdrew themselves to their lodgings. The countrymen advanced crying, "Slea, slea...Havock, havock...smite fast, give good knocks". The Townsmen finding no scholars in the streets to make any opposition pursued them, and that day broke open five inns or hostels of scholars. Such scholars as they found they killed, or maimed or grievously wounded. Their books and all their goods which they could find, they spoiled, plundered and carried away. All their victuals, wine and other drink they poured out; their bread, fish etc. they trod underfoot. After this the night came on and the conflict ceased for that day.'

The next day, Thursday, it was the turn of the Chancellor and some University dignitaries to go to see the King, only this time by royal command. While they were away, 'no one scholar or scholar's servant so much as appearing out of their houses with any intention to harm the Townsmen, or offer any injury to them, yet the Townsmen assembled themselves together in a numberless multitude, desiring to heap mischief upon mischief, and to perfect by a more terrible conclusion that wicked enterprise that they had begun. They invaded the scholars' houses which they forced open with iron bars and other engines; and those that resisted they killed or else in a grievous sort maimed. This wickedness and outrage continuing till noontide without any

ceasing...thereupon all the scholars being fled divers ways, our mother the University of Oxford, which had but two days before many sons, is now almost forsaken and left forlorn,'

In fact the town had carried on the fight until nearly all the members of the university who had not been killed or wounded fled Oxford. Around sixty members of the university are thought to have been killed, and presumably a similar or larger number were injured. We don't know the casualties among the townspeople but there are likely to have been at least some.

Retribution was swift and punishment severe. The town was put under an interdict, involving a total suspension of all Church activity: no masses, not even Christian burial. To medieval people this was a dreadful punishment and it was not lifted until March the following year. As a condition of its removal the town had to perform an annual penance, or act of reparation. On the anniversary of St Scholastica's Day, the Mayor, bailiffs and 63 Burgesses (the number of scholars killed) were required to proceed solemnly to the University Church and attend a special Mass at their own expense for the souls of the slaughtered students. Each was to give one silver penny – quite a substantial sum. They also had to swear to uphold the university's now extended privileges.

In addition the Mayor and Bailiffs were sent to Marshalsea Prison, and the sheriff of the county removed from office. The city was required to restore property looted from the students and to pay an immediate fine of 500 marks – about £330 – an amount whose size in fourteenth century values indicates just how atrocious the offences were considered to be. An annual fine of 100 marks was commuted if the city carried out its penance, although more than once the fine was imposed for non-performance.

If we compare what happened on St. Scholastica's Day with earlier town and gown conflicts we can see just how bad it was. The first major disturbance of this sort in Oxford occurred

in 1209 when two scholars were hanged by townsmen after a student had killed a woman. This riot resulted in a group of masters and students leaving Oxford and setting up in another town, Cambridge, where they hoped, vainly, that life would be more peaceful.

Further disturbances occurred. For example, in 1226 the town was set on fire; in 1248, a scholar was killed. In 1272, after a particularly vicious dispute, the city was ordered by the King to make amends to the university; in 1298, a scholar and a citizen were both killed, the perpetrators were excommunicated and the town was fined £200. In 1334 some masters and scholars once more decided to abandon Oxford, this time for Stamford in Lincolnshire. Although the King ordered them to return, Oxford graduates taking their MA degrees were allegedly at one time required to promise not to undertake any lecturing at Stamford. While the riots had become increasingly frequent and violent, what began on St. Scholastica's day was much more than just another town and gown spat. It was in fact unprecedentedly bloody, and this is why the penalty was so severe.

The university held the city to the obligations to pay the fine and attend the church ceremony for centuries and the ritual was not abolished until 1825, nearly 500 years after the riot. But that was not quite the end of the story. The University was the first to make amends, conferring honorary MA degrees on three mayors, two town clerks and a city librarian during the 1940s. In 1955, at the commemoration of the 600th anniversary of the riot, the Vice-Chancellor of the University was made an honorary Freeman of the City of Oxford, while the then Mayor was awarded the honorary degree of Doctor of Civil Law, the highest honour the University could confer. And so, as one Oxford scholar put it, the lion lay down with the lamb – though he then coyly remarked that he would not venture to say which was which.

The White Elephant

Shi Zhuan Tan, medical student, Edinburgh University

(A prize winning essay in the 2007 Ascona International Balint Essay Competition)

My introduction to psychiatry

Psychiatry was my first rotation in fourth year of my medical school training. I started with enormous scepticism about the whole specialty and high doubts about my chance of survival among the 'lunatics', thanks to the horror movies introduced to me since I was young about mentally ill patients. The psychiatry rotation was one of the longest rotations throughout medical school training. It comprised four weeks of clinical attachment in the fourth year.

I was allocated to shadow a psychiatrist consultant, Dr. Campbell, who was in charge of the general adult psychiatric ward. It was a gloomy Monday morning on the first day of my attachment. It took me a while to get myself orientated. When I finally found my way there, I was immediately welcomed by the incredibly high-pitched buzzing of the emergency alarm. Apparently an in-patient was trying to escape from a depot injection of an anti-psychotic drug, and the staff were running frantically after him. Some patients on the ward were astounded by the loud alarm and responded with loud cries; a few grimaced and continued walking up and down the room as if nothing had happened, and those in the smoking room could not be bothered by anything other than cigarettes held between their highly tar-stained fingers.

The White Elephant

Amidst the chaos happening on the ward at that time, a bold man looking to be in his sixties with 20 to 30 degrees of kyphosis shuffled past me. Heading back to his room in his emaciated body, he was shaking his head repetitively in a frustrated way and refusing any form of eye contact. Somehow, I had this gut feeling that the man was different from other in-patients but could not rationalise any further. A student nurse, Laura, saw my stunned look at the man. She approached me and whispered in my ear, 'He says he's turning into a white elephant'. Interesting, I thought! I shall be the zookeeper who washes the elephants. My provisional diagnosis based on one look from the back and Laura's brief statement was late stage schizophrenia presenting with negative symptoms: social withdrawal, abnormalities of movement and psychotic symptoms. I realised that in fact this was the problem with medical students: jumping to conclusions based on basic instinct, neglecting other important clues. Later, I learned from Dr. Campbell that John, otherwise known as 'the white elephant' by the staff, was under the care of our team. I was thrilled to hear that, as I knew I would stand a chance to interview the man who had successfully ignited a flame of curiosity in me.

First interview with John

Without thinking twice, the decision to make the 'white elephant' my first psychiatric patient was made. Before jumping into John's case notes and learning all about him on paper, I thought I would accept the challenge of clerking him like a new patient. After obtaining the charge nurse's permission to speak to John, I started structuring an interview plan in my head, not forgetting the safety measures practised on the ward. Visions of the worst outcome of the interview were flashing through my head every second.

I carried along a big stack of paper to scribble down important points and a safety alarm. I arrived in John's room. His shiny scalp was distinctive. I saw him sitting on his bed in daze, still in his pyjamas and looking unkempt, just like a deflated balloon. I took a deep breath and did the standard thing that I was taught to do in communication skill sessions when meeting patients for the first time. I extended my right arm in mid-pronation and tried to reach out to John's right arm,

'Good morning, John. I am a fourth year medical student. Do you have a few minutes to have a chat with me?'

I suddenly realised that I was about to speak to a possible psychopath. My opening speech might not be appropriate in this setting but I was so used to the opening formula. Medicine is all about a formulated structure, is it not? Doctors use the same phrases repetitively subconsciously with every patient. John stared at me, the stranger intruding into his personal space. However, he managed to force a warm smile and kindly agreed to come with me. I escorted him to the most spacious interview room on the ward. Instead of running through the usual questions, I was switching myself to an alert mode just in case something went wrong during the interview and I had a good chance to flee. 'Always remember to protect yourself in your medical career. Your remuneration does not justify unnecessary risk taking.' Phrases like these were ringing in my head at that time. These were the things I had learned with time from senior doctors who, I supposed, had seen the real medical world and were no longer idealistic beings... I picked the seat nearest to the door as advised by the charge nurse during the safety induction, and invited John to take the seat suitably angled on my left.

'Observe every single move of your patients from the first moment you see them.' I remembered that from the communication skill sessions as well. Never had the sessions been so useful to me as I had never before felt threatened by patients. John sat himself down cross-legged. His mouth was turned down, head inclined forward, gaze directed downward and shoulders bent. Most of the signs of clinical depression were

present. I felt safe at that time; at least I knew he would not have the energy to assault me. Hang on! What if his diagnosis was manic-depressive disorder instead of chronic schizophrenia with clinical depression? I would know soon.

'John, could you please tell me when and why were you admitted to the ward?' I constantly reminded myself to ask open-ended question. Unexpectedly, John bombarded me with two further questions, the answers to which I should have made clear before the start of the interview. 'Before that, do you mind telling me the purpose of this interview? Are you going to treat my condition?'

I felt my face blushing instantaneously. I politely told him that I was a medical student with Dr. Campbell and the interview would be for my own education and hence I was not qualified enough to give him any medical advice. I could have said that I was part of the team taking care of him. However, lack of self-confidence and self-esteem, and inadequate practice had unfortunately put me in a responsibility-dodging position. John nodded and uncrossed his legs, leaning back on the comfy cushion to relax himself and indicating his agreement to give out some information, perhaps not all. Students were less intimidating, I could see clearly.

I continued with my interview, asking question after question conforming strictly to the standard psychiatric history subheadings. John was not a chatty man but he was trying his very best to be patient with my questions as I could see. The interview ended in half an hour's time when he started looking disconcerted and edgy. Perhaps he had repeated his life story at least three times to different doctors before he ended up on the ward and another medical student, who was not going to treat him, was just about to make him repeat the same thing.

The interview went much better than I expected. Well, at least I survived the seemingly never-ending half hour and I knew that my instant diagnosis of John was wrong. I summarised my findings and made a note on his file:

John, a 56-year old high achiever, a middle class civil servant, came to the ward two days ago from the psychiatric emergency team as an informal patient. His presenting complaints were depression and suicidal ideation. He was accompanied by his worried wife and his only daughter. John was unable to eat and sleep for three weeks before admission. He was also unable to concentrate and suffered from frequent panic attacks at night. When asked the rationale behind his severe depression, John was almost certain, saying that it was all due to his prominent veins on his scalp which seemed to him to be proliferating aggressively and his main concern was that he would turn into a white elephant and a social outcast one day.

Although I did not have enough guts to ask for his meaning of a 'white elephant', from his mental state and behaviour. I fathomed it as an expression of fear of being made redundant and

useless in society as a consequence of his alienating appearance. Throughout the first interview, John admitted that he had always been a conscientious person and also a perfectionist. For a moment, I was able to empathise with him. At the back of my mind were scenes in which I had spent a huge amount of effort trying to look the best in front of people (even strangers) but at the same time questioning in my heart the need for over-working myself just to be someone that I do not even know. However, the ability to recognise the fact, and stay focused, is highly dependent on a strong will and an intact coping mechanism. John, I believed, was just one of us a highly competitive and cynical society who endeavoured to please others more than himself and his admission to the psychiatric ward this time was an answer to his cry of suffocation accumulated over years and a sign of break down in his coping mechanism.

What is the diagnosis?

After my first interview with John, I was left puzzled. On the one hand, I was ashamed of myself for jumping into a wrong diagnosis imprudently and taking the literal meaning of 'white elephant' so superficially. On the other hand, I was trying to convince myself of something insane about John that warranted his admission to a ward full of acutely mad people. From his notes, I gathered that the working diagnosis for John was 'psychotic depression': severe depression resulting in psychotic symptoms, principally the delusion of proliferating veins. There was also a family history of a similar condition where his mother was diagnosed with psychotic depression at her mid-forties. During that time, she had always held a strong belief that she suffered from some undiagnosed physical problems. Unfortunately, no organic diseases were identified until ten years later she died of end-stage cancer. It did not take a genius to make an association with that. Sometimes I wondered if family history was more misleading than helpful in the process of making a diagnosis.

Dr Campbell takes charge

The next day, I presented my interview findings to Dr. Campbell during the ward round. She seemed to know almost everything that I mentioned although she had not had the chance to see John personally. Obviously, she had been getting reports from the junior doctors, and the working diagnosis was made after coming to a consensus with other members of the team. Unfortunately, it was just how things worked on the ward: a new patient would be assessed by a psychiatric nurse along with a junior doctor at the acute receiving unit; the decision to admit or not was then made. It might not be until the third or fourth day on the ward that the patient got to see the consultant. After a short discussion about John with Dr. Campbell, I was then given a mission to set up an interview with John for her

while she finished off her paper work.

I headed to John's room once again. He was sitting almost motionless on his bed. I invited him to the family room and sat down with him. I was just going to make some small talk when he said: 'You don't have to sit here with me because I am not going to talk to you.' My heart sank immediately. I did not think I had done so badly in my first interview with him that he hated me so much. Given a choice, I thought to myself, I would rather sit in the sun and read my favourite novel instead of wasting my life seeing how psychotically depressed you were getting. I could feel all the negative thoughts spilling out from my porous brain. However, I managed to create an impervious wall just in the nick of time before my emotions took control of me and my reflex directed me to stomp out the room. It would be the end of our relationship if I failed to tame my temper.

'Well, just ignore me if that's the case, John. Dr. Campbell will be here shortly.' I managed to blurt out that sentence followed by a grin. I was quite impressed with how I handled the acute situation. There was at least five minutes of silence. I grabbed a magazine on the coffee table next to me and pretended to be attentively flipping through the pages.

'Do you not have any questions for me today?' John broke the silence after a while; maybe he was feeling bad for turning me down so blatantly. After all I had done no more than listening to his problems patiently.

'Well, if you don't feel like talking I shall respect that,' I replied calmly. Just when he was about to continue with our strained conversation, Dr. Campbell opened the door and took control of the situation. John was sitting cross-legged. His speech was low in tone and volume and his hands were slightly tremulous. Throughout the interview with Dr. Campbell, he was crossing and uncrossing his legs frequently, gesturing his anxiety and nervousness. Consultants have their ways of inducing fear and commanding the patients to tell them what they need to know as precisely as possible. Dr. Campbell tried to explain that his delusions of proliferating veins were due partly to his depressive illness. The use of an anti-depressant was discussed as well. Although John was obviously not convinced, he agreed to give it a try. After all, his own efforts to cope with his negative feelings must have been futile before he resorted to self-admission to a psychiatric ward.

Daily sessions with John

Hence, John was commenced on mirtazapine immediately. It was the first choice of anti-depressant due to its additional weight-gaining property. Although I was expected to evaluate his progress every day, the fear of rejection was holding me back. He had just killed my initial flame of curiosity. However, I knew I had to please Dr. Campbell who was going to assess me at the end of the rotation. Drearily, I managed a

ten-minute interview with him every day, most of the time taking a more passive role during our 'conversations' for fear of upsetting him and being rejected again for asking too many dim-witted questions. Our conversations were as boring as ever: 'How's your mood today?' 'Any improvement?' 'No, my veins are getting bigger... I saw a new one on my scalp this morning...' For a moment I wished he was a bipolar patient or a schizophrenic patient so that my days on the ward would be more enticing and educational as at least I would be able to learn to recognise more psychiatric symptoms described on textbooks. Once again, I had proven my greater interest in medical science than the psychological aspect of patient-doctor interaction.

After a few sessions, John was getting used to me, or maybe I was getting used to him, and the idea of sitting in the same room was less intimidating but still as dreary as before. On the bright side, he had not given me a hard time ever since the second day at least. However, each time before I ended the interview, John would ask eagerly if Dr. Campbell would see him soon to discuss his treatment plan and I would always be asked to convey this message to her. I wondered if the only reason John was willing to speak to me was because he needed a messenger to get hold of Dr. Campbell, the only person who was believed to be able to salvage his veins but too busy to spare more than an hour a week for him.

John and his scalp veins

Moving on to the third week, John was showing no signs of improvement. On the contrary, his mental state was deemed to have deteriorated after he saw a vascular surgeon who was convinced that his prominent veins were within the normal variance. The same obsession with his scalp gradually crept to his limbs and he was even less able to engage in conversations, not to mention any activities. His insistence on consulting more private dermatologists and vascular surgeons had not faded to the slightest extent. After Dr Campbell's twice-weekly assessment of John, she decided that he needed more aggressive treatment. John was strongly against the idea of accepting an anti-psychotic, as he had never admitted to his 'madness' from the very beginning. At one point he asked to have a look at his progress notes. This was to confirm that the emphasis of his treatment plan was on finding an explanation for his prominent veins and not on his 'madness'.

John threatened to leave the ward after being told that his deteriorating insanity needed an anti-psychotic drug. As usual, he insisted that we were going in the wrong direction. Although I had been taking a passive role in his care, I felt obliged to speak out for him this time as I considered myself to be the person who spent most time with him and I felt, despite my inexperience, that John did not look mad nor sound mad and this ward was just unsuitable for

someone like him. I did an extensive search online in the hope of identifying, perhaps, some rare organic causes of vein prominence on the scalp but to no avail. However, I went on to suggest to Dr. Campbell the possibility of John being right about his prominent veins. Interestingly enough, ever since my first interview with John, I found myself more observant of the scalps and veins of bald and elderly people and I had not seen anyone with more prominent veins than John. I had to agree with him that his veins were unusually prominent for his age, although I was not convinced that they were proliferating.

After listening to my views, Dr. Campbell expressed her concern about my excessive obsession with John's veins and advised that I needed to be more emotionally detached from my patients and focus on the psychiatric problems. She made a very good point. I did find myself feeling absolutely drained after a long day on the ward.

More medication

Finally, Dr. Campbell managed to get John to agree to a trial of anti-psychotic medication for a few weeks on top of his anti-depressant. Silently, I was admiring the way Dr. Campbell handled her patients. Although she spent the least time with her patients compared to other doctors, she earned the highest respect from her patients. Could this be due to an unexplainable aura that comes only with experience? Or perhaps it was nothing to do with Dr. Campbell at all. John might have reached a point of desperation where he would be willing to try anything to get rid of those unpleasant thoughts and feelings. Whichever it was, I knew John was driving *me* insane, as I could not reason out how someone deemed to be psychotically depressed could still converse like a normal adult apart from his obsession with his veins. Finally, with much analysis and further thinking, I knew I needed to change my perception and interpretation of 'insanity'. Psychiatry is not just about crazy people running around naked. A disturbed mood, interfering with daily activities with a varying degree of retained insights, can be a form of mental illness. John was obviously disturbed but the key question remained: was he best treated on the ward with other floridly psychotic patients who had no insights at all? This decision was subjective. Dr. Campbell felt strongly that John needed to stay on the ward to be treated but I did not agree. However, there was no questioning of a senior doctor's decision, as she was far more experienced than anyone else in the team. I gradually took a more active role in the management of my patients, especially John. I started giving active feedbacks and suggestions (or counselling?) cautiously during the interview session, making sure that I would not upset him. I did not dread our conversations as much anymore and I was no longer doing it to please Dr. Campbell but more for my curiosity again. I was

eager to find out if John would improve with the drugs prescribed and my trivial 'counselling sessions' (if John saw those as counselling sessions) every day. As a means to convince him of the existence of his delusion, I suggested a method to map his veins on the scalp as a baseline for comparison. However, Dr. Campbell spoke from her experience that patients of this category would not respond to such methods. I was left with no choice but to wait for the drugs to kick in and miraculously exorcise the devil of depression and delusion that had seized John's soul away.

The final interview: speaking out

Time flew by quickly and four weeks had past. I was given grade A by Dr. Campbell for my overall performance at the end of the four weeks. She was obviously impressed with my dedication. Although being highly praised by Dr. Campbell, deep down in my heart was a sense of dissatisfaction and incompleteness as after all the time I had spent trying to understand John from a bio-psycho-social point of view, he was still showing no signs of improvement. There was a strong call for me to see John for one last time although I was not expected on the ward anymore after the assessment. Hence the decision to make my way back in the evening was made.

I found John in his room. It was 5pm and he was still in his pyjamas. However, I was surprised to find that he was actually doing a crossword puzzle from the newspaper. That was unusual. It had been a while since he last engaged himself in any form of activity requiring high concentration. He saw me and for the first time in four weeks, he was able to give me a big warm smile. For a moment I thought I was talking to the wrong person. I tried to be professionally nice and friendly to him but buried in me was an overflowing passion to convey my last message to him. I could not believe that there were also streaks of anxiety within me and I actually felt my heart racing, just like the first time I stepped in to the ward. I knew I had to do it to live with no regrets.

We came to the interview room where we had first met and where he clearly stated that he refused to say a word to anyone but Dr. Campbell. Interestingly enough, we had both chosen the same seats we sat on every time we used this room, and in the presence of Dr. Campbell, it would be a different seat preference altogether. It was unintentional. I was intrigued by how human brains made associations with humans and objects subconsciously.

We started off with the usual small talk. John's mood was definitely brighter that day. When asked how he was feeling, he said his mood had undoubtedly improved but insisted that the underlying problem, his progressively proliferating veins, was still present. Obstinate as usual, or psychotic just like his usual self, I was not at all surprised... To make the whole thing more predictable, he went on telling me all about his discovery of new veins on his lateral canthi

that morning. I suppressed my surging anger and tried to reassure myself that there was still a glimpse of hope. Cool, hang on there, be emotionally detached, remember? I kept reminding myself. Well, it finally came to the time when I made my speech. For once, I did not hesitate to pick the words that I thought John would like to hear and I did not care if he would accept them. Without dilly-dallying, I fired my words,

'Look John, I understand your fears and worries about the veins on your scalp. I understand how important looks are to people in today's society. However, you are it your late fifties now. You have lived for 58 years. You are successful in your career, have a wife and a daughter who love you so much and who are both now worried about you every second. You should know better than anyone else that your family will always stand by you no matter how bad your veins get. Give yourself a break! What does it matter if your veins proliferate badly in the next 5 or 10 years and to be truthful to yourself, you have sought the opinions of the vascular surgeon, dermatologist and also a psychiatrist and no one thinks that those veins are pathological. If you stop dwelling on your thoughts now and try to enjoy life, at least you will have another 5 to 10 years of quality life with your family which I believe would be much better than spending your life in this mental hospital, a place that you don't really belong to. You are tired of being so self-conscious for years aren't you? Today will be my last day on this ward but before I go, this is the one last thing I wish to tell you.'

It was a long speech I realised, the longest I had ever made in my four years of medical training. I was silently impressed with my fluency although the speech might not have been appropriate in relation to the guidelines for management of psychotic depression. The next thing I saw was John's smile on his face. He took a deep breath and said,

'Perhaps Dr. Campbell was right. There might be a genetic predisposition to my depression and I could be over-reacting just like what my wife has been trying to tell me. However one cannot really control one's emotions.'

I was really touched to hear that. 'One cannot really control one's emotions.' How true! I could feel my face flushing and tears fighting to stream out. Although John was vague in showing his insights into his delusional or obsessional thoughts regarding his veins, for the very first time, he agreed with what Dr. Campbell and other medical staff had been trying to put across to him since the first week of his admission. There was a sense of triumph in me as I finally felt that a chat with him was not simply a waste of his time. Feeling more inspired, I continued,

'John, I choose to believe that at least to a certain extent, human beings are in control of their emotions. I always think that one has to be really strong to survive everyday and since you have successfully lived 56 years, I wouldn't even

doubt your strength in taking charge of yourself.'

I thought I sounded a bit patronising. For a moment, the lengthy communication skill sessions introduced by the medical school as part of the new curriculum to meet the General Medical Council's good medical practice criteria had come in handy: establish good rapport with patients by trying to gain their confidence and then slowly steer them into your direction. John nodded as if he was in agreement to what I had just said.

'I was expecting to get some counselling sessions on the ward but unfortunately I have not been getting any. I also feel that I am over sedated during the daytime. Could you find out the possibility of reducing the dose of my medications?' He did not admit that he felt much better after our conversation but thought it would be a good idea to have more sessions to explore his thoughts. Egoistic man, I said to myself. However, I felt a sense of importance when he asked my opinion on his medication. He accepted me as part of the team, finally. I promised him that I would inform Dr. Campbell of his wish to accept counselling and advised him that Dr. Campbell most probably would not be keen to reduce the dose since the medication had just kicked in. I was delighted when John seemed to be satisfied with my answers.

Saying goodbye

I ended the conversation by wishing him all the best. He reciprocated by wishing me the best of luck in my future career and enquired in a low tone if I would be working on the same ward in the future. I jokingly told him that I would never consider it at all if he continued to dwell on the veins. John did not react to the joke. Small talk was just a waste of time to him. We left the room. He opened the door for me and allowed me to walk first. That was an unusual behaviour of his as well. I sighed in relief. It was not that bad at all. My initial fear of provoking and upsetting John were proven unnecessary. I was not too convinced that a session like that with him was going to stop him from thinking about his veins but I was surely glad to feel that I had at least tried my best. If he did continue to dwell on the same old matter, I would have no choice but to agree with Dr. Campbell to treat it as a delusion secondary to his depression.

A week later I learned from my colleague that a discharge meeting had been planned for him on his request. Dr. Campbell's review of him described drastic mood improvement and brighter future outlook although he was still holding on strongly to his belief. John was also planning to take up a part time job after discharge.

Final thoughts

Whatever was wrong with John probably was not important. A medical diagnosis is just a label after all. I realised from my last conversation with John an often neglected thing in medicine. Patients at times are just on the verge of getting unwell and

often on the first consultation with the doctor, they are suddenly reassured of their problems and immediately put on magic drugs that are proven by studies conducted by the pharmaceutical companies to be able to solve all the problems. It has been suggested in a paper published in *The Lancet* that somatisation is a joint responsibility of doctor and patient and this should be sought in doctor-patient interaction rather than in patients' psychopathology. Both patients and doctors are found to have a preoccupation with finding biomedical causes for the presented health problems; patients fear serious diseases and doctors fear missing a medical diagnosis with all its potential judicial consequences. Along with the ingrained ideas of the 'right' thing to say and to do in order to avoid legal troubles, defensive medicine is practised to the extent that patients are always ill people in the eyes of medical professionals, and seldom have a chance to realise that, at times, the main reason for seeking consultation could be because of a breakdown in their coping mechanisms. What they need are some pointers to help them to identify the root of their problems rather than a medical label and a series of investigations. However, the average consultation time is a pathetic 10 minutes long and it is unfair to put the blame on medical professionals who fail to identify the underlying psychological problems that might have been present in the patients for a long time. Having said that, doctors and medical students should be consciously made aware of the occurrence of somatisation in certain groups of patients as a result of inadequacy in the patient-doctor relationship.

I really enjoyed my psychiatry attachment with Dr. Campbell. Although I started off with immense scepticism and endless worries, in no time I came to acceptance of the nature of this field. History taking could take up to an hour at least, and it was particularly energy draining as it was equivalent to taking a life history of the patient in a short one hour. I ended up spending most of my time on the ward listening to patients' stories and daily occurrences. I could not help questioning to myself the educational values I acquired by talking to patients and the value of time spent on the ward. It was not rocket science that I learned in the four weeks of my attachment, but for once in four years of my medical training I felt really useful. Throughout medical school training, no one has explicitly stated the responsibility of medical students in the care of patients' and a student will not be marked down for not being actively involved in the care of

patients on the ward. Most of the time students are required to clerk in new patients with no expectation of continuous management. There will always be house-officers to do the daily ward routine and the more senior doctors to make major decisions for the patients. In big centres, most staff are simply too busy to delegate responsibility to medical students. The last thing I want is to get in the way of the small busy cohort on the ward. Psychiatry was the first rotation that I had done in my four years of medical training which gave me a chance to follow up a patient for a long enough period to feel a sense of responsibility towards him. I enjoyed the feeling of being part of the team. It had been a great opportunity for my personal development' and not just my medical knowledge' as I was finally exposed to a true relationship with patient. I experienced the hopes, fears, transference and counter-transference involved in the professional care of a patient and also my own feelings in the entire process. It is an art to find a balance between being able to empathise with patients but without being too emotionally involved to the extent that a doctor's life is affected' and to master this art requires true understanding of the patient-centred relationship. I strongly feel that the state of awareness of a student of this important relationship can definitely be enhanced by delegating more responsibilities to him whenever possible. It will no doubt be a great character building opportunity for an upstart desperate to shine.

The experience with the 'white elephant' makes me realise the importance of being capable of acting as I think best and being deemed important in others' eyes. Along this life journey, we fall and stand up again stronger, for unfulfilled achievements are the driving force behind us. However, at some point in life, even more difficult obstacles arise and once again we challenge ourselves to the limit, in hope to brace ourselves at the edge. An unintentional slackening in strong wills will tip the balance and we resort to seeking help from others when we find ourselves no longer coping. Such is life, especially an eventful life. Such is medicine, a never-ending marathon and to run this marathon requires strong will and determination. Competition and comparisons make the run even more strenuous and draining. However, I believe being a doctor is a noble profession for a lifetime and I have to pay the price.

'Knuckle down, enjoy the work and endure the sweet pain.'

Book Reviews

***Sick and tired. Healing the illnesses
doctors cannot cure***
by Nick Read.

Phoenix, London 2006 paperback.
288 pp. £18.95

Dr Read belongs to this rare and unusual group of doctors who have dared to cross the boundary between medicine and psychiatry and found themselves in this uncomfortable in-between place we call psychosomatic medicine. Dr Read started his professional career as a gastroenterologist. Initially he became intrigued by an increasing number of patients whose symptoms could not be explained by pathological abnormalities and for whom there was no effective treatment. Gradually he discovered that the best approach to understand their condition was to give them the opportunity to talk about the circumstances in which the symptoms started. This realisation led to him specialising in psychoanalytic psychotherapy in order to develop this skill further. At present he works in private practice as a consultant physician and psychoanalytical psychotherapist and uses both skills to help people manage their functional illnesses. He is also the medical advisor of the Gut Trust, an independent charity dedicated to support inform and advise people with irritable bowel syndrome. Dr Read writes eloquently and elegantly about his work and understanding of the issues involved. His book is written in the tradition of specialists who make their subject intelligible to the educated public. It is divided into nine chapters that deal with various aspects of functional somatic illness: descriptive, physiological, psychological, evolutionary, social and political. The theory is brought to life with clinical examples informed by the narratives related by patients in the author's clinic. The book covers a broad range of topics but a few points stood out for me.

Over the ten years between 1993 and 2003 Dr Read conducted detailed assessment interviews on over a thousand people who suffered from unexplained medical symptoms. Over 90% revealed that their illness had been preceded by changes in their life, which they could not come to terms with. Dr Read believes that people get sick when they cannot regulate, through the creation and resolution of emotion, the physiological reactions of their emotional arousal. People who deal with their feelings by blocking them, or by resisting their expression, or by attributing their unhappiness to the physical manifestations of their symptom are less likely to come to a resolution of their emotions. Upbringing is very important in deciding how these methods of regulating emotion are established. Another very interesting factor that influences the development of functional symptoms is Dr Read's research finding that

patients who were very anxious or depressed at the time they suffered a medical condition such as gastroenteritis or a viral infection of any kind, were more likely to experience a continuation of their symptoms well beyond their recovery from the disease. It is as if the emotional conflict recruits the symptoms of the disease in order to express itself. Sometimes the symptoms themselves are like an encrypted body language that can be deciphered by the astute therapist who can identify the meaning of the symptom by discovering the theme of the patient's emotional conflict.

Giving the patient the opportunity to talk about his life and his feelings in a safe environment could help him find his own solution to the dilemmas he is facing and by resolving the emotional conflict find relief from the severity of the physical symptoms he is suffering from.

However, a lay person reading Dr. Read's book may be forgiven for thinking that listening to such patient's narratives is a simple matter. His elegantly presented and condensed vignettes do not make explicit the expertise and humanity demanded of the therapist for active listening and psychodynamic understanding at this deep level; for tolerating the intensity of the patients' feelings, understanding the meaning of their symptoms, being patient with their resistances; for having the capacity to modulate his own emotional response towards the patients in a way that allows them to calm down and relax into a dialogue with creative possibilities.

Until a few years ago, it was much easier for general practitioners to find time to listen to their patients' stories and offer sympathetic understanding. However, with the constant reorganisation of general practice in recent years, the vast majority of general practitioners have less and less time to listen to their patients. They are torn between the patients' need to tell their story and their own need to protect their income by filling templates and hitting targets. General Practitioners who attend Balint groups continue to have an interest in their patients' narratives, but their numbers are very small and they are unlikely to have a significant impact. And hospital specialists are either unwilling to listen to their patient's narrative or incapable of making sense of their suffering. So who these patients are going to turn to?

It seems that the gap in care left by so-called orthodox medicine has been filled by complementary practitioners. The number of complementary practitioners in Britain now exceeds the number of GPs and more visits are paid to complementary therapists than to casualty units.

The effectiveness of complementary treatment has often been dismissed by orthodox practitioners as a placebo effect. However, if we consider the placebo effect to be the healing effect of belief and of hope for a positive

outcome, we may begin to learn what is the effective ingredient in complementary approaches: the time to listen, the development of therapeutic rapport, the reduction of emotional tension, establishment of a sense of harmony and the space for creative possibilities to take root and grow. In other words the art of medicine. Unfortunately our health service, like the rest of our society, appears too preoccupied with waiting lists, efficiency, accountability and audit to think about holistic aspects of health and well-being.

With his book Dr Read correctly identifies the alarming increase in the incidence of functional somatic illness and challenges the medical profession to integrate the science with the art of medicine if we are going to be effective in reducing the burden of functional illness in our society.

Sotiris Zalidis

Primary Care Ethics
edited by Deborah Bowman and
John Spicer.

Foreword by Roger Higgs.
Radcliffe Publishing 2007. Paperback
208 pp. £24.95

This book is a compilation of essays on medical ethics, not the ethics of IVF or end of life issues on ITU, but about what goes on in a GP's surgery. In his preface, Roger Higgs quotes Paul Freeling: 'show me a consultation and I'll show you an ethical issue'. Higgs elaborates this himself as 'show me a strong emotion in primary care and I'll show you an ethical issue'. This immediately threw me into the world of the Balint group, which is perhaps conspicuous by its absence from the text of the book.

The book sets out the need for teaching of ethics in medicine and its rise over the last 30-40 years. Its authors cover various themes which interest them, as applied to primary care. Ethical issues in primary care may seem small but may be very complicated, embedded in day to day work, and ever present.

The first chapter covers the doctor patient relationship in terms of the recent medico-legal crises in the UK: the relative importance of and interaction between trust and rights. The second suggests the limits of modern autonomy of the patient in primary care, recognising that it may limit the rights and needs of others. Chapter three discusses the idea of perhaps rationing care in the light of patients' responsibility for some of their own medical condition, but finds this a poor and invalid idea. Katherine Wright in chapter four looks at the sequelae (with examples) of the introduction of European Human Rights legislation. Some chapters are very philosophic, while others are more practical. Essay five, on dementia issues is one of the most practical.

Peter Toon follows with his work on

Virtue ethics, about which he has previously spoken to the Balint Society. He explores our professional and human boundaries with cases, using examples of archetypal human behaviour such as the Good Samaritan. Teamwork in primary care is covered next in a complex theoretical essay by Ann King. Chapter eight discusses complexity theory and how well it suits primary care. Guidelines are continually bent due to the interactions between patient, doctor, society and the system. It places guidelines where many Balint doctors would put them, as mere tools forming a basis for complex practice.

The last three essays focus on doctors. Andrew Dicker discusses the obligation of doctors to look after themselves, in order to help others. He is passionate in calling for change in our attitudes within medicine towards each other, though this may already have started to take place. Chapter ten is about the hot topic of competence. It sees competence as far from simple to determine. It then discusses how to approach a poorly performing colleague. The last essay is about how to place ethics in our everyday work. Where should we go with an ethical problem? Should there be an ethicist in every PCT, or in every hospital? A more practical idea, somewhat passed over, is the ability to talk to a group of peers about such problems.

This brought me to how I learnt what ethics I understand. This was not in medical school 25 years ago, or from books such as this one. It was in Balint groups, discussing cases with groups of peers, doctors, therapists, nurses. I think that we in the Balint Society should probably start to stress this element of our work with students, doctors in training, and doctors in practice. I valued reading this book, as I am sure will others. It has illuminated areas of my general practice and my Balint Group practice.

David Watt

Behind the Consultation: reflective stories from clinical practice
by André Matalon and Stanley Rabin
2007 Radcliffe Publishing, Oxford 2007
paperback 93pp. £21.95

Wouldn't it be nice to be able to talk about your difficult patients to a friend who can really understand? A sort of Balint group for two, or maybe three? Here is a book by two Israeli clinicians who have been sharing their difficult consultations with each other for a number of years. If you have been to some of the International Balint Congresses in the last few years you may have met them. André Matalon is a GP and his pal Stanley Rabin is a psychologist and the two of them have written an absorbing book in which they show us the benefits of their friendship and collaboration. You might think that the experiences of a GP and a psychologist would be very different but they are not. Both

have been in practice for many years and they believe in continuity. And both can be deeply affected by the emotions that some of their patients evoke in them. They are especially troubled by the patients who remind them in some way of themselves. A troubled young man who needs his therapist to be a father reminds Stanley how he misses his own father whom he left behind in South Africa. An attractive young woman who tells him about her secret lover makes him fear that he is getting vicarious excitement. Meanwhile André, the GP, feels angry and frustrated with a depressed old man who reminds him of his need, since the age of eight, to be a doctor for his depressed mother. Then there are the patients who seem to pick you out to be the only recipient of stories of suffering that perhaps you would rather not hear because

they remind you of your own losses. Other patients seem to make us identify so closely with them that our feelings seem 'unprofessional'. We clinicians need to unburden ourselves too with someone who can help us to clarify our thinking. At the end of each case history the two friends write a response to each other's stories. This gives the reader a real sense of the warmth of their friendship and their mutual understanding. The replies offer reassurance but also fresh insights, and always the feeling that 'I've been there too.' As a postscript a friend and colleague, Dr Ben Maoz, adds another layer of reflection. I can recommend this book to anyone who has ever brooded over their relationship with a patient and needed to discuss it with a friend.

John Salinsky

Secretary's Report 2007-2008

The year began at Oxford in late September, delayed to make way for the Lisbon International Federation Meeting Sept 1-5. 24 people attended, including four medical students and three new group leaders. Five people came from abroad. We ran three very successful groups. My keynote speech is published in this journal.

There were four lecture meetings at the RCGP this year, the first being given by President of the Society, Dr Andrew Elder, musing on his imminent retirement. There was an audience of 30 for him. Sonia Leff on 20th November was heard by eight on the changing face of paediatrics over her career. At least (my register is not compulsory) ten heard Peter Heintz talk on the 12th February. Neither the president nor I were able to hear Jennifer Johns on March 18th but eleven members enjoyed her talk. The last lecture (Dr Greg Battle) was cancelled. Most of these lectures appear in this journal.

Dr Elder and I had been unable to attend as we were in Italy, guests of the Harvard Programme for Refugee Trauma. They are interested in using Balint groups to support workers dealing with clients in terrible situations and asked us as experts to demonstrate the model. It was a fascinating four days of hard work with senior medics who have seen things we hoped we would never be near. Our possible collaboration is only just beginning and we are not sure what future this link may hold.

April 25-27 saw us at Longhirst Hall in Northumberland for the second Northumberland Balint weekend. There were three groups including a Group Leaders Workshop group, run by Dr Elder. The final Balint weekend of the year was at Whalley Abbey (the Lancashire Balint Weekend) on 15-17 June. It was large enough to have two groups. It is particularly significant as a subgroup of the Council was able to meet to discuss the development of Balint work in the North West. The Balint Society has been promised a large sum of money by a charity, called the Society for the Investigation of Human Values. This is to be spent largely in the North West but may have collateral benefit for the Society as a whole. A group in the North West, led by Dr Ceri Dornan, has been responsible for bidding for this grant and we thank them sincerely.

The group leaders workshop met three times, twice for leaders of new groups to discuss their work, and the third a group on group leadership. We continue to invite leaders to present their work which can be a part of their accreditation process.

The Annual Dinner took place on June 18th, again at the RSM. 29 people attended and were stimulated after dinner by Jeremy Holmes talking about Michael Balint, and including some fascinating stories few of us had heard before.

David Watt

The International Balint Federation (IBF) 2008

Heather Suckling

Membership:

The Austrian Balint Society has now joined the International Balint Federation as its 22nd member.

All members of the British Balint Society are welcome to attend the international meetings. These are advertised on the website www.balintinternational.com and most of them are conducted in English.

Ascona Prize:

This biennial award for medical students' essays will be awarded at the 16th International Congress in Braşov, Romania in September 2009. Full details about the Prize are on the IBF website and in this Journal.

Events 2007-2008:

**15th International Congress in Lisbon
September 2007**

(see the account on next page)

**6th Israeli Balint Conference at the Dead Sea
Garden Hotel, Israel, March 2008:**

The Israeli Balint Society put on a programme of talks and Balint groups (in English) together with tours to Jerusalem, Masada and the Negev for overseas visitors. The IBF council also met and discussed plans for the next International Congress in Romania in 2009.

Dubrovnik, Croatia 2nd -7th June 2008:

The theme for the annual Muradif Kulenovic School of Balint in Dubrovnik this year was "The Subconscious". Once again it lived up to its reputation of providing excellent presentations and groups as well as a delightful social programme.

Future events:

For further information about all future events, including those listed here, please see the IBF website www.balintinternational.com

- **IBF Council meeting 17th -19th October 2008:**

The Dutch Balint Society has invited the Council to meet in Leiden, the Netherlands from. There will be a full programme of workshops (in English) open to all.

- **IBF Council meeting Spring 2009:**

The American Balint Society has invited the Council to meet in Chicago in April 2009, but the details have not yet been confirmed.

- **Dubrovnik, Croatia 1st -6th June 2009:**

The Croatian Balint Society will organise the annual School of Balint again next year. It is a wonderful experience and highly recommended.

- **16th International Balint Congress, Brasov, Romania 5th -9th September 2009:**

"Balint Work and Globalisation"

Subtitle: "*Writing a prescription is easy – understanding a patient is not.*"

The First Announcement and Call for Papers have already been distributed and appear on the website. If you wish to submit a paper, the full text must be sent to the Scientific Committee by 31st December 2008. This promises to be another excellent congress and a large UK contingent is expected.

- **15th WONCA (Europe) Conference, Basel, Switzerland 16th-19th September 2009:**

"The Fascination of Complexity: dealing with individuals in a field of uncertainty."

The programme will include Balint groups arranged by the International Balint Federation in conjunction with EURACT and the Swiss Balint Society.

Heather Suckling
heathers@doctors.org.uk
General Secretary,
International Balint Federation

Fifteenth International Balint Congress in Lisbon 2007

The 15th International Balint Congress took place from the 2nd to the 5th of September 2007 in the Portuguese capital, Lisbon. This was our first meeting in Portugal and we were looked after with care and style by our hosts in the Portuguese Balint Society. The Congress was attended by 156 delegates from 18 countries and it was a memorable and enjoyable occasion both scientifically and socially. Lisbon is a delightful city with many different aspects. Its architecture begins with the Romans, goes on to reflect the Moorish inheritance and continues with the spectacular Gothic architecture exemplified by the San Jeronimo monastery in Belém. After the disastrous earthquake of 1755 a major part of the City was rebuilt resulting in the delightful and evocative streets and squares of districts such as the Baixa, the Chiado and the Bairro Alto. Lisbon is a lovely city to wander round. And in the evening we could eat and drink outdoors at friendly little restaurants where the staff not only cook and serve but entertain their guests by singing and playing *fado*, that very special haunting and soulful music of Portugal.

The Congress was held on top of one of Lisbon's many hills. Our venue was the University Faculty of Medical Science where generations of Portuguese medical students have learned to be doctors. Opposite the building is a pleasant park with ducks and geese, where we could relax in between sessions and eat our lunch. Presiding over the scene was the statue of Lisbon's much-loved physician, Dr José Thomás de Sousa Martins (1843-1897). His benign figure is surrounded by marble plaques expressing the thanks of his many devoted patients.

The theme of the Congress was *Medicine, Evidence and Emotions 50 years on...* In the scientific sessions we listened to a variety of papers grouped under four broad headings: Past and Future; Research; New Contexts and Training. In the first session we heard about the beginnings of the Balint group and its development over the last half century. Michael Courtenay recalled working in a very early group led by Michael and Enid Balint and invited us to consider how we might have treated Marcel Proust and his psychosomatic asthma. (His paper is reprinted in this journal.) Michelle Moreau Ricaud who is a distinguished Balint historian as well as an analyst reminded us of the importance of responding to the evidence of our patients' emotions. The papers on Research continued the

theme of empathy and demonstrated how Balint work can enhance our empathic capacity and intelligence. There was also the question of how much empathy we can bear and the role of our defences. Widening our gaze to take in New Contexts we learned about Balint groups for clergy, hospital doctors and patients with chronic illness. The place of Balint in our Post-modern world was also considered. The Training papers told us about the encouraging results of offering Balint groups to residents (trainees) and students, whose emotional responses were often very moving. Finally it was a great pleasure to hear from students themselves when the four winners of the Ascona student essay prizes told us about their student-patient encounters. All the papers have been published in the *Proceedings of the Congress* and the book includes a group of papers that were not read out but are well worth reading.

When we were not listening to speakers and discussing their work we had the opportunity to take part in Balint groups in Portuguese, English, French and German. These included some groups for leaders in which members were able to experience and discuss some very different leadership styles. The Congress began with some wonderful music from a group of instrumentalists. The Social Programme also included a Balint Lisbon Trek, up the hill to the Castle. And it culminated in a lavish dinner with entertainment by a very accomplished *fado* singer who completely seduced and delighted us. Dr Antónia Lavinha then showed us that she was a pretty good amateur *fado* singer herself and could even write some medically themed lyrics for her own songs. After that everyone had to sing and we were treated to a series of solos and ensembles featuring songs from all the participating countries in a sort of EuroBalint Song Contest. A great time was had by all.

As in the previous Congresses in Berlin (2003) and Sweden (2005) there was a sense of community with our extended family of Balint enthusiasts taking up the ideas from the previous conference and developing them further. We are very grateful to our Portuguese hosts, and especially Drs Antónia Lavinha and Jorge Brandão for organising such a brilliant Congress. We are already looking forward to the 16th International which will be held in the ancient Saxon town of Brasov, in the Carpathian Mountains of Romania in 2009.

John Salinsky

Whalley Abbey Weekend Workshop June 2008

By Caroline Palmer

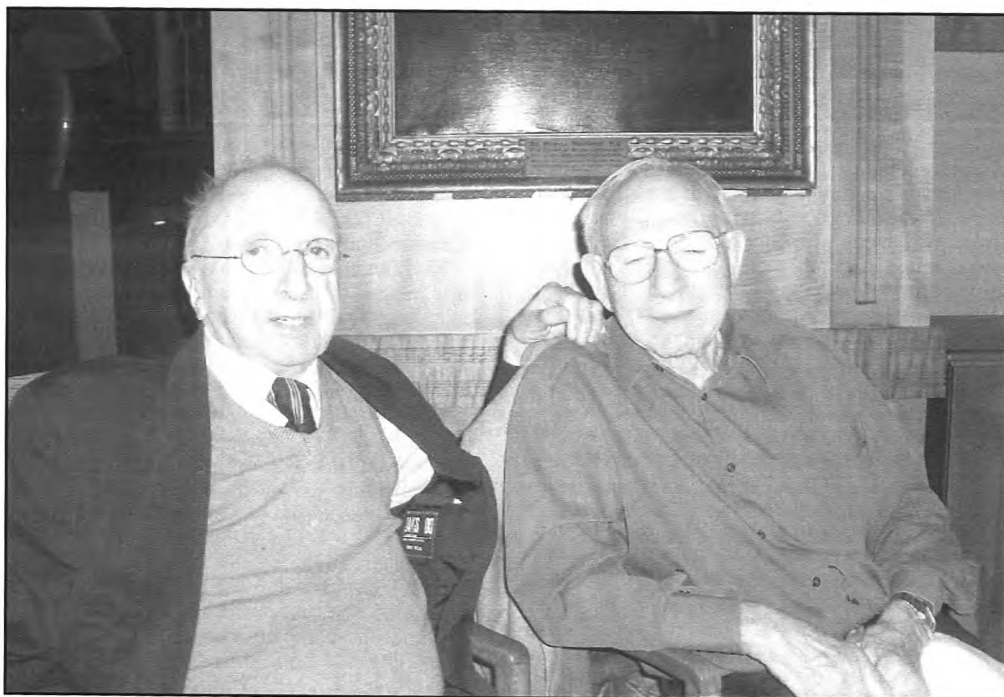
It was with great excitement but also apprehension that I set off to Whalley this June. For seven years we had nurtured the hope of a growing band of Balintees at the weekend workshop, but stubbornly there had only ever been enough participants for 1 group. This year there had been a good response to the workshop flyer, with enough participants to be able to run two groups in parallel and I almost felt with growing pride that I was expecting twins! There were several crises affecting participants in the last few days before the workshop, and I was concerned that a group would be lost or 'miscarried' as a result. Once it was clear both groups would run, there was then the concern that they might not function as lively groups, that one might be stillborn, or need resuscitative special care. In the event, two healthy boisterous lively groups were delivered with characters and identities of their own and even a normal degree of sibling rivalry, which of course was new territory to me as a 'parent', having only experienced singleton one group workshops in the preceding seven years.

Certain themes emerged within the groups, cases often echoing the preceding case, subconscious choices in presentations occurring perhaps. The groups were quite different, though both rich in themes. One group seemed to concentrate on conscious boundaries, between the personal and professional selves, the conflicting needs of each and the interplay and transition between the two in relation to time, place and phase of life. There was also the theme of impotent rage against the medical system, helplessness, loss, accepting our limits, being a 'good enough' GP and acquiring the strength and resilience to accept patients as they are without expecting change, enduring them sometimes, and even managing to contemplate them getting worse! This seems in retrospect to have been the

'Broadsheet' group.

In the other group, which on reflection was more of the 'Tabloid' stable, there seemed to be a theme of covert or perverse sexuality, running through the cases, with shadowy questions about possible child abuse, incest, equivocal or denied sexuality, hidden HIV infection and prostitution, in turn. With these blurred boundaries of behavioural norms within the cases, there also emerged the theme of blurred boundaries in the doctor-patient relationship, with a polarity or duality of role for the doctor or therapist, e.g. doctor or friend, therapist or trainer, doctor or surrogate son, GP or mentor, benign therapeutic GP or reckless over-prescriber and even therapist or escort! The cases were all fascinating, the doctor often mirroring, and supplementing the needs of the patient, like a couple sequence dancing, but left wondering who is in control, where are they going and how can the couple respond effectively and respectfully to The venue was tranquil and beautiful, the gardens ravishing, the abbey ruins glorious in the sunshine, the company convivial and the cases compelling. We worked hard with head and heart, on the dramas presented, and with compassion, empathy, rationale and humour, we grew to understand and appreciate, and in the end accept and perhaps like our patients, our jobs and probably even ourselves more. All who came said they'd felt relaxed and comfortable and yet stimulated and invigorated in their perceptions and work, and would come again, so you had better book early for next year's workshop in 2009, which is on March 13th to 15th (when the grounds should be ablaze with daffodils,) and then also on May 14th to 16th in 2010! Who knows? Perhaps this multiple birth thing will have really caught on, and maybe we will be expecting triplets or even quads by then!

Pictures from Annual Dinner 2008





Ascona Prize for Students 2009

An International Balint Award for Medical Students Ascona Model (WHO)

For the 33rd year the Foundation for Psychosomatic and Social Medicine invites medical students to apply for the International Balint Award 2009.

The "Ascona model" was invented by Boris Luban-Plozza and developed by university teachers, students and patients. It has its origin in the pioneering work of Michael and Enid Balint who emphasised the importance of "patient-centred" consultations. It provides an educational method which particularly values an empathetic Doctor-Patient relationship and a narrative based approach while simultaneously encouraging the practice of evidence-based medicine. The award was founded in 1976 in honour of the Balints.

The prize is awarded every second year to medical students, the next in 2009. The successful students are expected to present their papers to the International Balint Congress in Brasov, Romania, in August/September 2009

Papers in English, French and German are accepted. They should describe a student-patient relationship, an experience, or experiences, from the student's medical studies and include critical reflection on personal meetings with patients. The papers should be between 3,000 and 10,000 words.

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

1. Exposition:

The paper should include a presentation of a truly personal experience of a student-patient relationship. (Manuscripts of former medical theses or diplomas cannot be accepted.)

2. Reflection:

A description of how the student experienced this relationship, either individually or as part of the medical team.

3. Action:

The student's own perception of the demands to which s/he felt exposed and an illustration of how s/he responded.

4. Progression:

A discussion of both ways in which the student's own approach might change in the future, and also possible ways in which future medical training might enhance the state of awareness for individual students.

Submissions of 3,000-10,000 words should be sent by email, as a Word attachment to: geschaeftsstelle@balintgesellschaft.de and

They must be received before 31st December 2008

The awards will be presented at the 16th International Balint Congress in Romania in August/September 2009

The prize-winners will be expected to present a shortened version of their papers at the Congress and the full text of the papers will be published in the Proceedings of the Congress and other Balint journals.

The prize-winners will receive financial support for travel and subsistence.

The Balint Society Essay Prize 2009

The Council of the Balint Society awards a prize of £500 each year 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 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 2009 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

The Balint Society (Founded 1969) Council 2008/09

President:	Andrew Elder	Hon Secretary:	David Watt 220 Tollgate Road London E64JS Tel:020-7474 5656
Vice President:	Andrew Dicker	email:	David.Watt@gp-f84093.nhs.uk
Hon Treasurer:	Doris Blass	Members of Council:	Jane Dammers Tessa Dresser Caroline Palmer David Price Sotiris Zalidis
Hon Editor:	John Salinsky 32 Wentworth Hill Wembley Middx HA9 9SG email: JVSalinsky@aol.com		

Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr John Salinsky by email: JVSalinsky@aol.com as a word file.

We welcome research papers, personal reflections, case studies, book reviews and reports of Balint events and ongoing groups.

References

References may be in the Harvard or Vancouver style. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

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