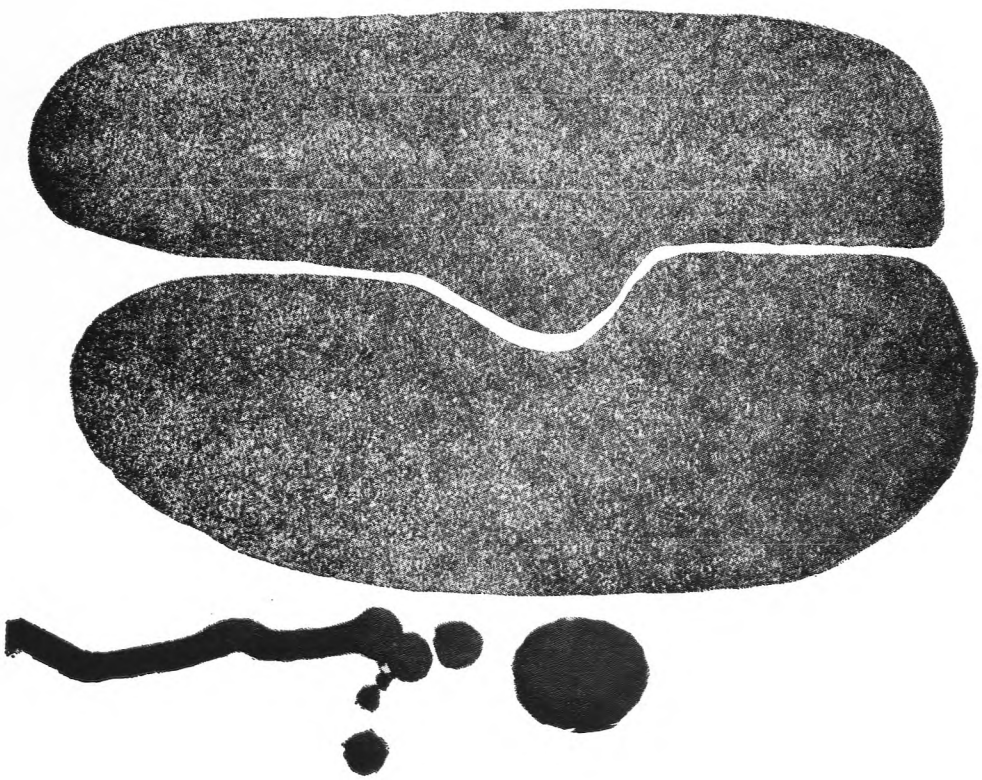
JOURNAL
OF
THE BALINT SOCIETY
1979



Vol. 8

JOURNAL OF THE BALINT SOCIETY

Vol. 8, 1979

Contents *Page*

Editor: Philip Hopkins

Editorial

In his presidential address last year Stephen Pasmore pointed out that our Society was founded in 1969, not in 1970 as shown in various publications (page 3). A search through the archives has revealed that it was the adoption of the constitution of the Society that took place in 1970. The first Annual General Meeting was held exactly a year later, on 28 April 1971, so that next year will bring the tenth Annual General Meeting.

The work started by the Balints nearly thirty years ago has continued to develop through the work of doctors all over the world. In addition to several Balint Societies, there is also the Michael Balint Institute at Hamburg, which was opened in 1974, and more recently the Balint Centre at Ascona.

The fourth International Balint Conference held in London last year attracted over 300 doctors to discuss the aims, achievements and assessment of Balint training.[1] Several speakers reported their experience in what Michael Balint predicted would be 'very uphill work' — improving the training of medical students and their teachers.[2] Progress has been made and this is further evidenced by the publication of papers such as that on 'Recognising crisis in the family' (page 11) written by two newly qualified American doctors who vividly demonstrate the effect of the Balints' influence on their approach to patients who had previously been over-investigated and ineffectually treated by illness-orientated doctors.

They also highlight another aspect of the influence of Balint training that has received insufficient attention although Michael Balint referred in one of his earliest papers in 1954 to the high cost of unnecessary referrals of patients to hospitals for specialist opinions, and laboratory and other investigations.[3] Later he reported with others the results of a study of repeat prescriptions in general practice,[4] and in an interview only two months before his death he talked about the possible saving by a better understanding of patients' needs of '. . . the enormous price paid . . . the enormous drug bill for the National Health Service.'[2]

Assessment of the results of applied Balint training has shown that the prescribing costs of Balint trained doctors result in considerable savings for the National Health Service, as well as reduction in consulting rates, hospital referrals, time lost from work and also the general effectiveness of treatment.[5] This all adds weight to the need for medical audit which is rightly a topic of growing concern not only for the profession, but also for those responsible for the provision of health care. But, to be of real value, medical audit must not only be of what doctors do — but also of how they are trained to do it.

---

1. *The Human Face of Medicine* (1979) London. Pitman Medical
2. *Patient-Centred Medicine* (1972) London. Regional Doctor Publications
3. Balint, M. (1954) *The Doctor, his Patient and the Illness. Brit. Med. J.* **1** : 115
4. Balint, M., Hunt, J., Joyce, D., Marinker, M., and Woodcock, J. (1970) *Treatment or Diagnosis; a Study of Repeat Prescriptions in General Practice.* London. Tavistock Publications.
5. Hopkins, P. (1979) *Applied Balint Training in The Human Face of Medicine.* London. Pitman Medical.

Michael Balint and John Hunter*

by STEPHEN PASMORE

This year the Royal College of Surgeons and the Hunterian Society have been celebrating the 250th anniversary of the birth of that great surgeon and anatomist, John Hunter. I had the honour of being asked by the council of the Hunterian Society to deliver their annual oration last year, and in the course of my researches into the life of John Hunter I was struck by the remarkable similarity between his life and that of Michael Balint. Both men were ardent advocates in their day of something new in medicine, both were keen teachers with zealous pupils, both met with considerable opposition to their beliefs and both had a Society founded in their name to perpetuate their ideas. I thought, therefore, that this would be a fitting occasion to address the Society on a comparison of the life and achievements of these two men, and of the two medical societies founded in their honour.

The Hunterian Society was founded in 1819, twenty-six years after the death of John Hunter, by Mr Armiger, an assistant surgeon at the London Hospital and by Dr William Cooke, a general practitioner, who had studied under a former pupil of Hunter's, the famous Bart's surgeon, John Abernethy. Mr Armiger and Dr Cooke carried out their practice in the City of London in the areas of Moorgate and Bishopsgate, which were comparable to the neighbourhood of Harley Street and Wimpole Street today. They prevailed upon their neighbouring colleagues to form a local medical society. Sir William Blizard, a distinguished surgeon at the London Hospital, who had also been a pupil of John Hunter, gave his full support to the proposed society and was elected its first president. It was he who suggested that the society should be called the *'Hunterian Society'* instead of the *'London Medical and Physical Society'* which had at first been proposed. The Society decided on the motto *'Ratio Societas Vinculum'* — 'The bond of community is reason'.[1]

The Balint Society was founded exactly 150 years later, on 19th November 1969 (not in 1970 as erroneously appeared in the first issue of the Balint Journal), on the suggestion of Dr Philip Hopkins, a general practitioner in Hampstead and a member of one of Michael Balint's first seminars in London. The members of this seminar had just returned from a particularly inspiring demonstration in Aberdeen and felt a stronger bond with each other than usual. So when Philip Hopkins proposed that it would be encouraging to form a British Balint Society on the lines of the French Balint Society which had already been formed and with whom he had been in correspondence, the other members immediately agreed. The foundation meeting took place at the CIBA Foundation, to which a number of doctors who had been associated with Balint seminars had been invited, and the first general meeting of the Society, which was originally named *'The Medical Society of Balint Groups'*, was held at the Royal College of General Practitioners in Kensington on the 29th October 1970 with Michael Balint in attendance, and Philip Hopkins as the first President in the Chair. Sadly Dr Balint died two months later.

Of these two men who inspired the formation of these societies, it would be appropriate here to summarise the life of Dr Balint first.[2 3 4] Michael Balint, the son of a general practitioner in Budapest, was born on 3rd December 1896 and died at the age of 74 on 31st December 1970. He was brilliant at school and at university, studying languages, classics, chemistry, physics and mathematics. His early ambition was to become an engineer, but in 1914 he decided to study medicine. He had hardly started as a medical student when he was called up for war service. He was wounded in 1916 and demobilised following an injury to his left hand. He returned to his medical studies in Buda-

*Based on the Presidential address given at the 9th Annual General Meeting of the Royal Society of Medicine, London, on 20 June 1978.

pest, and graduated M.D. in 1920. After qualification he occasionally acted as a locum for his father in general practice. He married in 1921 and moved to Berlin to study biochemistry under Professors His and Zondek.

He also developed an interest in psychoanalysis, and while training to be a psychoanalyst under Hans Sachs obtained the degree of Ph.D. in biochemistry. He started to write papers on psychosomatic illnesses about 1922. In 1924 he returned to Budapest and completed his own psychoanalysis under Sandor Ferenczi, a previous pupil of Sigmund Freud. He also set up in practice as a psychoanalyst and helped to found the Budapest Psychoanalytical Institute in 1926. In that year he is recorded as having given a lecture to a local medical association on psychological problems in general practice. A few years later he was taking seminars for general practitioners, but these had to be given up in the 1930s as a result of the oppressive anti-semitic regime of Horthy when a plain-clothes policeman was directed to attend the seminars and take notes of what was said. As a result of the increasing oppression in Hungary, Balint sought refuge in England. He arrived in Manchester in 1939 where he worked as a psychoanalyst, directed a child guidance clinic, and became an honorary consultant psychiatrist to the Northern Hospital, Manchester. In 1944 he obtained British medical qualifications and in 1945 acquired the degree of MSc.(Manch.) in psychology with a thesis on early infancy. At this time, his wife, Alice, who was also a psychoanalyst, died. His only son, John, was later to become a Professor of Medicine in the Albany Medical School in America. In 1948 Balint moved to London where he was appointed to the Tavistock Clinic staff and became director of another child guidance clinic, and also continued his practice as a psychoanalyst. He held some consultant sessions at the Tavistock Clinic which was then situated in Beaumont Street.

At that time he started to work with Enid Balint in one of the Clinic's projects, the Family Discussion Bureau, now The Institute of Marital Studies, which was a seminar of social workers concerned with marital problems. Several members of the staff of the Clinic, such as Dr Henry V. Dicks, had tried to help the seminar by giving lectures, but with little success. The members of the seminar did not really know what they wanted from a leader until they invited Michael Balint, who was already working at the Clinic, to lead them. Then they realised, as so many doctors who came under Balint's influence later were to realise, that they had found what they had been looking for — a leader with a new technique and a new outlook that had their origins in Hungary. Soon Enid and Michael Balint perfected this new technique for training social workers in their particular field of marital problems.[5] This co-operation led to the even closer one of marriage between the two which took place in January 1953.

But before that. in 1950, Balint had decided to extend his activities to the field of general practice as he had done many years previously in Hungary. He felt that the technique he and Enid had perfected for training social workers could be extended to the broader fields of general practice, and he could improve on the Tavistock Clinic's methods of training general practitioners. The story after that is well known, with its culmination in the publication in 1957 of that classic book *The Doctor, his Patient and the Illness*,[6] which as Dr Tom Main once wrote 'changed for all time the very perspectives of general practice'.[7]

Michael Balint had unbounded energy and was held in high esteem by psychoanalysts and medical psychologists all over the world. He had conducted seminars in most countries in Europe as well as in America, Australia, Israel and Hungary. He was a prolific writer on psychoanalysis and medical psychology with seven books to his credit and well over a hundred papers,[8] and was the Editor of the *Mind and Medicine Monographs*. At the time of his death he was the President of the British Psychoanalytical Society.

John Hunter, who also had his problems of making a successful career and of getting his original ideas accepted by his contemporaries, was born in Scotland, near Glasgow, on 13th February 1728 and died suddenly at the age of 64, from coronary thrombosis just outside the board room at St George's Hospital at Hyde Park Corner on 16th October 1793. Unlike Balint, Hunter showed no academic promise at school though he was interested in natural history. His brilliant brother, William, who was ten years older, was a surgeon and teacher of anatomy in London, and later became the first physician to attend an English queen in childbirth. In 1748, when he was aged 20, John Hunter asked his brother if he could leave Scotland

and assist him in London in the dissecting room of his anatomy school in Covent Garden. Fortunately William agreed and John soon demonstrated his skills in dissection, and later decided to become a surgeon. During the next two years he studied under the great William Cheseldon at Chelsea Hospital, and after the latter's death, under Percival Pott at St Bartholomew's Hospital.

In 1754 he became a surgeon-pupil at St George's Hospital — the hospital in which he was later to serve as a surgeon for 25 years. In 1761 he became an army surgeon to the British Expeditionary Force that captured Belle-Ile, a small island off the French coast. The next year he went with the army to Portugal and when he returned to London he set up practice in 1763. Such was John's industry that while he was in the army he gathered material for his work on gunshot wounds, while at the same time investigated the country's geology, the hearing of fish and the effect of hibernation on a lizard's digestion. On his return to London he moved to a house in Golden Square where he gave courses on the practice and principles of surgery to a few pupils. He was apparently not a good lecturer, but his lectures were much esteemed by his students. At the same time, and doubtless to earn some extra money while building up his practice he cooperated with a fashionable London dentist — an action which today would be comparable with a general practitioner cooperating with an osteopath. As a result of this short association with the dentist John was able to amass enough material to publish a fine treatise on the natural history of human teeth.

In 1767 he was elected to a Fellowship of the Royal Society, while in the following year, when he was aged 40, he was elected one of the surgeons at St George's Hospital. It was not unitl 1771 that he married, choosing as his bride a charming cultured lady, Anne Home, whose lyrics were set to music by Joseph Haydn. By this time Hunter had moved his practice to Jermyn Street and had acquired a country house at Earls Court, where he kept a menagerie and a farm, and where he carried out many of his dissections, and experiments on animals, birds, fish and insects, and on plants and trees. In 1783 he moved his London residence from Jermyn Street to the east side of Leicester Square, where he built his famous museum of comparative anatomy. He had five resident students there and continued to give his lectures and demonstrations on anatomy and other medical subjects. His museum with its countless specimens, some of which had been presented to him, was intended to display the extent and variation in structure of all living creatures from insects to man. Unfortunately much of the museum was destroyed in the last war, but sufficient was saved to form an admirable display which is now housed on the premises of the Royal College of Surgeons in Lincoln's Inn Fields.

John Hunter influenced the outlook on surgery for many decades after his death, as can be seen from the number of his pupils who later became famous surgeons. There were John Abernethy and Sir Astley Cooper of St Bartholomew's, Henry Cline of Guy's, Sir Everard Hume, his brother-in-law, who succeeded him as surgeon at St George's, William Shippen, the founder of the University of Pennsylvania and its first Professor of anatomy and surgery, and Philip Syng Physick, called the father of American surgery, who became the Professor of surgery at Philadelphia. Hunter influenced the lives of other pupils, who did not become surgeons, such as Edward Jenner, who started his career as a general practitioner in Berkeley in Gloucestershire. Jenner became a lifelong friend and supplied Hunter with many specimens. He was a great naturalist and urged on by Hunter in 1787 was the first to describe in detail the method by which the fledgling cuckoo managed to eject the other eggs from the nest in which it was hatched. He was also the founder of the method of vaccination against smallpox, but his work on this subject was not completed until after Hunter's death.[9 10 11 12] Michael Balint has similarly influenced the outlook on general practice, and trained pupils who have already obtained a high reputation amongst their colleagues.

Having outlined the lives of Balint and Hunter and attempted to show how both men had original ideas in medicine and had the capacity to draw together a selected group of pupils to share and further those ideas, it would be interesting to see if they shared anything else in common in spite of the gap of 168 years between their respective births. Balint was mainly concerned with the new approach to non-organic illness, opened up by Freud at the turn of the 19th century with his famous book, *On the Interpretation of Dreams*,[13] and also with the psychoanal-

ytical approach and its application to general medical practice. Had Hunter with all his scientific approach and deductive reasoning anything to say on the mental aspects of illness in the 18th century? It did not take me very long to find out that Hunter had practically discovered the unconscious by dissection!

Hunter gives many illustrations of the effect of the mind on the action of the body, including the shedding of tears, which he wrote, 'arises entirely from the state of the mind, although not so much a compound action as the act in question; for none are so weak in body that they cannot shed tears; it is not so much a compound action of the mind and strength of the body, joined, as the other (sexual) act is; yet if we are afraid of shedding tears, or are desirous of doing it, and that anxiety is kept up through the whole of an affecting scene, we certainly shall not shed tears, or at least not so freely as would have happened from our natural feelings.' This passage it well illustrated in another paper of Hunter's where he wrote that the mind was often in opposition to itself and added, 'I went to see Mrs Siddons acting. I had a full conviction that I should be very much affected; but unfortunately I had not put a handkerchief in my pocket, and the distress I was in for the want of that requisite when one is a-crying, and a kind of fear I should cry, stopped up every tear. I was even ashamed I didn't, nor could not cry.'

Here are Hunter's remarks about the subject of impotence written in 1786, together with a case history which illustrates his devastating logic and his acute awareness of the inner processes of the mind.

In 1786 Hunter wrote a treatise on venereal disease[14] and under a section devoted to the supposed consequences of gonorrhoea wrote a chapter on impotence.

'This complaint', he wrote, 'is by many laid to the charge of Onanism (ie. Masturbation) at an early age; but how far this is just it will in many cases be difficult to determine; for, upon a strict review of this subject, it apppears to be by far too rare to originate from a practice so general.' Hunter goes on to say, 'Nothing hurts the mind of man so much as the *idea* of inability to perform well the duty of the sex' and it is fascinating to see how Hunter qualifies the word 'inability' with the phrase 'the idea of inability'.

He goes on to write on the subject, 'Of impotence depending on the mind'. 'As the parts of generation are not necessarily for the existence or support of the individual, but have a reference to something else, in which the mind has a principal concern, a complete action in those parts cannot take place without a perfect harmony of body and mind; for the mind it subject to a thousand caprices which affect the action of these parts. Copulation is an act of the body, the spring of which is in the mind, but it is not volition; and according to the state of the mind, so is the act performed. To perform this act well, the body should be in health, and the mind should be perfectly confident of the powers of the body; the mind should be in a state entirely disengaged from everything else; it should have no difficulties, no fears, no apprehensions; not even an anxiety to perform the act well . . . Perhaps no function of the machine depends so much upon the state of mind as this.

The will and reasoning factor have nothing to do with this power; they are only employed in the act, so far as voluntary parts are made use of, and if they ever interfere, which they sometimes do, it often produces another state of mind, which destroys that which is proper for the performance of the act; it produces a desire, a wish, a hope, which are all only diffidence and uncertainty, and create in the mind the idea of a possibility of the want of success, which destroys the proper state of mind, or necessary confidence.

There is perhaps no act in which a man feels himself more interested, or is more anxious to perform well, his pride being engaged in some degree . . .

The body is not only rendered incapable of performing this act, by the mind being under the above influence (of pride), but also by the mind being perfectly confident of its power, but conscious of an impropriety in performing it; this, in many cases, produces a state of mind which shall take away all power. The state of a man's mind, respecting his sister, takes away all power. A conscientious man has been known to lose his powers on finding the woman he was going to be connected with unexpectedly a virgin . . .'

Hunter, having pointed out the necessity of having the mind independent respecting the sexual act to achieve potency, goes on to say that the only way to distinguish real impotence from apparent impotence is to 'examine into the state of mind respecting this act. So trifling often is the circumstance

which shall produce this inability depending on the mind, that the very desire to please shall have that effect, as in making the woman the sole object to be gratified.' Hunter concludes by saying, 'Cases of this kind we see every day, one of which I will relate, as an illustration of this subject, and also of the method of cure.

A gentleman told me that he had lost his virility. After above an hour's investigation of the case, I made out the following facts. That he had, at unnecessary times, strong erections, which showed that he had naturally this power; that the erections were accompanied with desire, which are all the natural powers wanted; but that *there was still a defect somewhere, which I supposed to be from the mind.* I inquired if all women were alike to him; his answer was, no; some women he could have connection with as well as ever. This brought the defect, whatever it was, into a small compass, and it appeared there was but one woman that produced this inability, and that it arose from a desire to perform that act with this woman well, which desire produced in the mind a doubt, or fear of the want of success, which was the cause of the inability of performing the act. *As this arose entirely from the state of mind,* produced by a particular circumstance, *the mind was to be applied to for the cure;* and I told him that he might be cured if he could perfectly rely on his own power of self-denial.

When I explained what I meant; he told me that he could depend upon every act of his will, or resolution; I then told him, if he had a perfect confidence in himself in that respect, that he was to go to bed with this woman, but first promise to himself that he would not have any connection with her for six nights, let his inclinations and powers be what they would, which he engaged to do, and also to let me know the result. About a fortnight after he told me that this resolution had produced such a total alteration in the state of his mind that the power soon took place; for instead of going to bed with the fear of inability, he went with fears that he should be possessed with too much desire, too much power, so as to become uneasy to him, which really happened; for he would have been happy to have shortened the time; and when he had once broke the spell, the mind and powers went on together, and his mind never returned to its former state.'[15]

It is a remarkable fact that Hunter was just as interested in a morning consultation with a patient complaining of impotence as he was in an evening session in his garden at Earls Court studying the copulation habits of the dragon-fly. 'On August 18th 1778 at eight o'clock in the evening', Hunter wrote, "I saw the dragon-fly flying about, making short turns, which were performed very quick. I also observed gnats flying; and what took my attention most, was his making up to a gnat, and then the gnat was seen no more; therefore I conjectured he was feeding upon them. I caught him and opened him the next morning, and could observe in the stomach the scales of some insects. Hunter goes on to describe in detail the alimentary tract and generative organs of the dragon-fly, and then gives a full account of how copulation takes place in October. 'The attitude of the dragon-fly in this act', wrote Hunter, 'is very singular. The penis is about the middle of the body of the male, and the vagina of the female at the extremity of the abdomen; and during the act, the male embraces the head of the female with the forceps at the end of the tail. The female is now in a circular position; the male therefore, has his head and wings at liberty and manages the flight'.[15]

It would seem from these glimpses of the lives of Balint and Hunter that they had much in common. Though their appearance was quite different — Balint with his patriarchal smile and unlined relaxed face; Hunter with his piercing eyes, more rugged look, and his passions ready to burst at any moment. Their characters showed many similar features. For instance, Dr Main said in his memorial address at Balint's funeral, 'the way Balint's remarkable gifts were combined made him so admirable, so endearing, so rare and unforgettable a man.' He said too that Michael had a 'huge zest for life', that he 'had an insatiable curiosity; all his life he was eager to know, to search and to learn, to entertain new ideas and test them and to seek new truths and to place them among the old,' that 'he was impatient with platitude and scornful of the meretricious', that 'he had an astonishing originality of thought . . . he would take nothing for granted . . . he thought out everything afresh and regularly offered brilliant view-points or new syntheses of accepted observations or gave things a new twist in acts of creative vision. Inevitably some household gods were broken and Michael was seen by some as an errent nonconformist'.[7]

It is remarkable that every word I have just quoted from Dr Main's memorial address on Balint could equally well have been said of John Hunter at his funeral in 1793.

Edward Jenner used to refer to John Hunter as 'the dear man', and I should like to conclude by saying that I am very glad to have had the privilege of paying a tribute in this Society to the great John Hunter in this 250th anniversary of his birth, and also of paying a further tribute to 'our dear man', Michael Balint.

REFERENCES

1. Stewart, E. F. G. (1969) The Hunterian Society. *The Practitioner,* **202**, 572.
2. Hopkins, Philip (1972) Recorded interview. *Patient-centred Medicine,* p.316 Regional Doctor Publications, London.
3. Main, T. F. (1972) *Psychiatry in Medicine,* **3**, 403
4. *The Times* (1971) Obituary. 5th January.
5. Family Discussion Bureau. (1955) *Social Casework in Marital Problems.* Introduction by J. D. Sutherland. Tavistock Publications, London.
6. Balint, M. (1957) *The Doctor, his Patient and the Illness.* Pitman Medical Publishing Company, London.
7. Main, T. F. (1971) *The British Psychoanalytic Society and the Institute of Psychoanalysis, Scientific Bulletin,* **53**, 21.
8. *Journal of the Balint Society (1975)* **4**, 13.
9. Paget, Stephen (1897) *John Hunter.* T. Fisher Unwin, London.
10. Dobson, Jessie (1969) *John Hunter.* Livingstone, Edinburgh and London.
11. Gray, E. A. (1952) *Portrait of a Surgeon.* Robert Hale, London.
12. Pasmore, Stephen (1979). John Hunter in Kensington. *Transactions of the Hunterian Society.*
13. Freud, S. (1920) *The Interpretation of Dreams.*
14. Hunter, John (1835) A Treatise on Venereal Disease in *The Works of John Hunter,* Ed. Palmer, J. F. Vol. 2 p.304. Longman, London.
15. Owen, R. (1861) Ed. John Hunter's Essay and Observations on Natural History. Longman, London. Vol. 1, p.98.

The Balint Society Prize Essay

The Council of the Balint Society will award a prize of £250.00 for the best essay submitted on how Balint training has affected medical practice. The first prize-winner will be announced at the twelfth Annual General Meeting in June 1981. Entries should be submitted by 15th April 1981. Details are obtainable from:

Dr Cyril Gill, Hon. Secretary,

11, Briardale Gardens, London, NW3 4PS.

From the Annual General Meeting held on 14th June, 1979

Secretary's Report

The membership of the society has been pruned of a few non-attenders, but is still rising.

We have obtained a list of attenders at the Tavistock groups during the past 10 years, and will be circulating them. There is also publicity about the society and its activities appearing shortly in the magazine *General Practitioner*.

Following the last two autumn meetings at Oxford, we are arranging a weekend at Reading on September 14th-16th. The Oxford attenders have been contacted, and advertisements placed in journals to attract a wider public than trainers and course organisers and their trainees, who accounted for most of the Oxford attenders. Reading is cheap and accessible, though support is slow at the moment.

This season's meetings included 'Symptom Roulette', a case history by Aaron Lask. An attempt to look at the assessment of general practitioners' work, in a paper by Tunnadine and Veira Bailey, and thirdly a symposium on student teaching, with contributions from Chris Donovan and Conrad Harris. As usual the society is best when discussing cases, such as Aaron's paper, and not so good on theoretical discussion. We know what good doctoring is, but cannot define it.

The student teaching discussion brought out the difficulties of the right dose of Balint ideas for students, and the difficult borderland between teaching and therapy which a student group or discussion involves, since it is easy to forget how immature some students are.

I have copies of criticisms of the London conference from our European colleagues, available for anyone who is interested.

The workshop for group leaders has 18 members, and anyone leading a group is welcome to join. The form is for a group meeting to be tape recorded, transcribed, and circulated to all workshop members before the next meeting. This can cost about £30 nowadays, and we are asking the society to sanction payment of these costs from society funds.

The International Balint Federation has been reconstituted following the London conference, with the following structure:—

Enid Balint-Edmonds, President of Honour

Pierre Bernachon, President

3 Vice Presidents, a Swiss, a German, and a British representative. Max Clyne has been proposed by your council and has accepted the British post.

Roger Van Laethem is to be Secretary General.

The next international conference will be in Cologne, 2nd-5th October 1980.

Cyril Gill

New Balint Centre at Ascona

The Community of Ascona, always sympathetic and interested in previous Balint conferences, has now generously made it possible, with the cooperation of the Ascona Library, to establish a Balint Centre to meet the needs of international Balint conferences, and for the exchange of ideas.

Principally students and doctors will be able to use the new Centre, which, in spite of its modest size, can make books, excerpts and programmes concerning Balint work as well as the aspects of psychological education available to them.

Those who wish to use these facilities for study or research purposes should send in their requirements in writing. The corresponding material will be made available free of charge, partly in the form of photocopies. Only postal expense will be charged.

The Centre, for its part, will be grateful to receive any form of pertinent material, which will enrich the Centre's documentation and bibliography, gradually expand and diversify it, thus serving all who will use it.

The documentation centre will be guided by a scientific council, presided over by Enid Balint-Edmonds, London; at present the secretariat is in the hands of Boris Luban-Plozza.

Book Reviews

Unwanted pregnancy — accident or illness? David Tunnadine and Roger Green. Oxford University Press. 1978. (£8.00)

This book grew out of a Research Seminar led by Dr Michael Balint until his death in 1970 and then by Dr Dorothea Ball, until 1973. Good use is made by the authors of their understanding of the doctor/patient relationship in each case.

In all, 147 cases of women requesting termination of pregnancy were investigated, and certain characteristics found to be common among them. The descriptions of 42 of these presentations with the comments on the eleven doctors presenting them (under pseudonyms of course) form the most valuable part of the book, and certainly they make compulsive reading.

From this material and the theory of the split in personality by Winnicott in 1965 and Laing in 1970, an interesting scheme has been developed. This encompasses the woman's worldly self and her personal self, and the degree of split between them, which represents the failure of communication between the two selves. True maturity being when the two selves are truly mixed and interdependent.

The theory put forward may not fit all patients as well as it does in those women presented, but the wealth of material and the surprising information in some of the many excellent tables makes it valuable reading for all general practitioners, and anyone else who must concern themselves with women seeking termination of a pregnancy.

ANDREW ELDER

The Human Face of Medicine
Edited by Philip Hopkins. Pitman Medical. 298 pages. 1979. (£12.95)

This is a collection of forty papers delivered at the Fourth International Balint Conference (London) in September 1978. It is therefore a varied offering, and mostly it is still from those who developed their interest in the earliest and personal Balint-inspired days.

It is well edited and clearly presented, both of which are all the more praiseworthy considering the speed of its appearance, only five months after the conference took place.

The paper which include case descriptions, whether of patients (Gill) or doctors (Ehebald) stand out from the page in a book where the live material of the conference, groups and discussion, has not been included.

The furthest distances from centre are found in a paper urging us into family therapy (Levenstein) and rewriting Balint to become 'The Doctor, the Family, and the Illness'. Is it not surprising that there has not been more work along these lines? A linguistic approach (Lenga and Gutwinski) charting changes in language, the move from 'one feels' to 'I feel', in the presenting doctor. And furthest, a Dutch group (van Weel) experimenting with short blasts of relaxation-cum-therapy groups.

The mainstream ranges through scientific theory (Barnett's excellent reply to Sowerby), some pretty arid stretches of theory-cum-jargon, 'the function of the trained doctor becomes that of the laisser-faire of spontaneous curative dynamics' (Faure), working with medical students, and some interesting work on assessing trainees.

What of overall themes? I was left with two — one old, one new. First the constant concern with the series of relationships that lie at the heart of our work — psychoanalysis and medicine, group leader and group member, psychoanalyst leader and general practitioner leader — leading to considering the integration (or not) of Balint trained doctors in general. What do they become? How best can (and how well do) the insights and new models get integrated into the doctor's everyday medical practice?

Secondly there is the serious question, posed in a way by the conference itself, or certainly by the paucity of the British attendance at it, that the Balints' work is everywhere read and quoted, but there are few new groups. Does 'the Balint myth function as a defence against the work of the groups themselves' as Guyotat suggests? What can be done?

Even good books (and certainly conferences) are no substitute for the work itself.

ANDREW ELDER

Recognizing Crisis in the Family: Two Case Reports

by ROGER SHORE* and KENNETH GRAUER**

Formerly Family Practice Residents, St. Margaret's Memorial Hospital, Pittsburgh, Pennsylvania.

Patients who complain of somatic symptoms but who have no readily defineable lesions are a continual source of difficulty and frustration for physicians. Despite the multiple laboratory examinations and numerous consultations with specialists, many of these patients never receive a definitive diagnosis. Instead, they receive a diagnosis that is so general as to be nearly useless in the care of the patient, eg. 'fibromyositis', 'atypical chest pain', 'severe tension headaches', etc.

What is perhaps even more unfortunate than the lack of a well-defined 'lesion' is the fact that despite the use of multiple drug therapies (eg. anti-spasmodics, anti-emetics, anti-anxiety agents — indeed drugs that are 'anti-everything'), and despite the use of physical therapy, braces, corticosteroids, and even surgery, the patient with these complaints often continues to suffer.

Physicians have chosen a number of terms to describe some of these patients such as 'crocks' or 'turkeys' (and other terms less complimentary). It often appears that no one or no form of treatment can help these patients, who often respond to this lack of help from physicians by going to another and still another physician until the patient has seen numerous doctors, each of whom may make a different but likewise vague diagnosis until the patient has multiple diagnostic 'labels' but no relief from his symptoms. The term 'nomad' has been used to describe this type of patient who wanders from physician to physician looking for a 'cure' but never finding it. First used by Michael Balint who studied many of these patients, it aptly describes the almost endless and sometimes hopeless search for help that these patients sometimes undertake.

Balint, after following some of these patients for several years, reached the conclusion that, despite the multiple symptomatologies in these patients, the common site of 'the lesion' was in the whole person.[1] Despite the general sounding nature of 'whole person pathology', this conclusion has profound implications for diagnosis and treatment. Indeed, it says that the lesion is not to be localized by x-rays, radio-isotope scans or blood tests but rather is a 'functional' one for which the treatment is, at present, poorly defined. One of Balint's rather surprising findings was that psychiatrists did not often see these patients with somatic complaints and, when they did, usually had very little to contribute to their care. In addition, often feeling the problem is 'in their body', the patient often refuses to see the psychiatrist. To manage these patients is difficult, Balint concludes in his book, *The Doctor, his Patient, and the Illness.* He states that the physician best suited to study this poorly understood, poorly diagnosed, poorly treated but not small group of patients is the primary care physician.

The above conclusion is not surprising in view of the fact that the primary care physician is the one who best understands the whole person and thus should best be suited to understand how pathology can arise in this area and how it can manifest itself in the patient.

Since the total person and his/her environment is the source of the lesion, it is not surprising that the pathophysiologies are as varied as is the human condition. This paper is an attempt to describe only one small subset of that population of patients where the lesion may be said to reside in the whole person and who presents to the physician with bodily complaints. Its purpose is not to describe the therapy of all of these patients nor even to describe all of their symptoma-

* Dr Roger Shore, MD, is now a family physician in practice in Pittsburgh, Pennsylvania.

** Dr Kenneth Grauer, MD, is now a family physician in Ft. Lauderdale, Florida.

tologies, but rather it is to suggest an approach to such patients by use of one subgroup, and to suggest that some of the classical diagnostic and therapeutic approaches to 'medical patients' may not be useful in their diagnosis and management.

CASE HISTORIES

Mrs A. is a 43-year-old white married female with a four week history of progressively increasing headaches, photophobia, tinnitus, forgetfulness, weakness and staggering. She states that approximately four weeks prior to admission she fell, striking the back of her head, resulting in unconsciousness for an undetermined amount of time. About two weeks after this incident she began to vomit several times a day, culminating in her visit to the Family Health Centre, where she was assessed.

Mrs A. has a long history of headaches but there is no past history of seizures, stroke, diplopia, blurred vision, or other neurological symptoms. Review of Systems was otherwise negative.

Past medical history revealed a hysterectomy performed in 1974 for unclear reasons. There was a history of rheumatoid arthritis but no joint deformities or other objective criteria had been fulfilled. There was a history of multiple drug 'allergies', all of which were manifested as nausea. In 1975 the patient had been to at least three physicians for right upper quadrant pain ultimately resulting in a cholecystectomy. Six weeks after the operation she was again seen in the Emergency Department for right upper quadrant pain. Multiple admissions had been for such diagnoses as 'incisional pain', 'possible gastroenteritis', and 'acute anxiety reaction'.

Family and social history revealed a married woman with four children, aged 23, 19, 17, and 14. All are alive and well except for the youngest, Billy, a boy with mild cerebral palsy. Being very concerned about her son, Mrs A. readily told the physician that approximately one week prior to *her* fall, Billy had sustained a skull fracture while riding his bicycle.

Billy had originally been in a school for handicapped children until, despite the reluctance of his mother, the teachers had decided to place him in a regular school. Mrs A. stated she had feared he would not cope well with the new educational demands and, indeed, throughout the last year he had been having difficulty with the schoolwork and with social interactions with his peers.

Physical examination revealed a well-developed woman sitting upright with expressionless facies but complaining of intense headaches. When asked where the pain was, she placed both hands on top of her head.

General physical examination was negative except for the scars related to the cholecystectomy and hysterectomy. Neurological examination disclosed an ataxic gait in which the patient fell to the left but permitted her to turn her body smoothly. There was generalized weakness. Sensory examination showed pinprick sensation was diminished in no specific dermatomal pattern. Reflexes were symmetrical. Cranial nerve testing revealed photophobia and bilaterally blurred vision. Neurological examination was otherwise within normal limits.

Although it was initially felt necessary to rule out a subdural haematoma, brain scan, skull films, and routine lab tests were normal. An EEG showed nonspecific abnormalities. A neurosurgical consultant felt the most likely diagnosis was a conversion reaction, much to the dismay of the primary care physician.

During her hospitalization, the patient began to discuss some of her feelings about her son's recent injury. In particular, she disclosed the fact that she had blamed herself for the fall, as she had thought Billy would be with other children when, in fact, he rode his bike alone. (Billy had sustained a skull fracture but no neurological sequelae from the fall.)

When the patient requested an explanation for her symptoms, she was told she had no skull fracture and no tumour but that she had a combination of factors at work, including reactive headaches that were exacerbated by social factors beyond her control — much as the patient who blushes cannot control his/her response to the environment.

As the patient and her physician talked during her hospitalization, her headaches began to diminish in intensity and her photosensitivity lessened as well. She was discharged and, when seen several days later, was complaining even less of headaches. At this time the patient was able to smile and generally appeared less depressed.

Mrs B. is a 45-year-old white married female with the chief complaint of left buttock pain of three years duration, radiating into the entire left side of her body and into the left occipital area of the skull. She describes it as if 'there were a line drawn

down the centre of me, dividing me in half'. The pain is intermittent, worsened by sitting, and associated with a 'pulsation' of the entire left side of her body. Mrs B also complains of dizziness which has been diagnosed in the past as Meniere's Syndrome.

Although the pain began three years prior to admission, she relates the pain to a minor car accident in 1967. She says she soon forgot about the accident since her son was killed two days later in a tragic hunting accident in which his brother shot him.

The patient presented at this hospital on the rheumatology service to which she had been referred by a friend. She was admitted for full investigations for her symptoms despite having been to multiple physicians in the past, including at least one neurologist, two orthopaedic surgeons, one otologist, and one chiropractor. Although the otologist had labelled her dizziness as Meniere's Syndrome, he, like the preceding physicians, had been unable to provide the patient with 'the reason for my symptoms'. Despite a brace prescribed by an orthopaedist and despite temporary modest relief by the chiropractor, the patient continued to complain of her symptoms at the time of admission.

The symptoms had become so severe that three years ago the patient had given up her own business as a beauty shop owner. Having also given up her position as an active sportswoman, she found herself limited by the pain in the activities she could engage in with her family. So restrictive was the pain that her daughter had to help her do her housework.

Past medical history revealed that a dilatation and curettage had been performed in May, 1976 (her symptoms were exacerbated by menses). The following studies had been done in 1976 for no obvious reasons and were reported as normal: sigmoidscopy, intravenous pyelogram and barium enema.

Family and social history disclosed that the patient had four children, the eldest of whom, a 16-year-old son, had been shot to death by his 15-year-old brother in 1967 when a gun misfired. Mrs B. states that it 'shook up everyone', especially the younger son (whom they immediately took to a psychiatrist), and the patient's father who had been with the boys at the time. According to the patient, her father has 'never got over the incident and has an anxious condition'.

Mrs B. described the deceased son as a very good boy who always did everything his parents and teachers wanted. In the course of several discussions with the resident physician, she said that one to two months before his death he remarked to his mother on at least one occasion that he was 'afraid to die' and 'not ready to die'. On the day he left to go on the hunting trip he milled around the kitchen according to his mother, seemingly very nervous.

The other children (aged now 24, 21, 10) are alive and well except for the elder daughter who has Farfan's Syndrome.

Review of systems was unremarkable other than as described above.

Physical examination revealed an alert, pleasant, cooperative but slightly withdrawn woman with a flat affect who complained intermittently of severe left buttock pain.

There was no evidence of hallucinations, delusions, or paranoid thoughts. There were no neurological abnormalities. A neurological consultant agreed there was no evidence of organic dysfunction but arranged brain scan, EEG and skull x-rays to be done. All were within normal limits. Lumbosacral spine x-rays revealed minimal degenerative changes consistent with her age.

The patient's symptoms persisted throughout hospitalization and, despite a programme of physical therapy, upon discharge there was no improvement. The staff physician's last statement to the patient upon discharge was, 'All the tests are negative, and emotions can sometimes cause these problems'. Mrs B was scheduled to be seen in the office in two months.

DISCUSSION

It was clear in talking with these patients that their symptoms were not only severe in quality but were also relatively incapacitating in these otherwise healthy women. Similarly, it should be obvious that it is impossible to say with 100% certainty exactly what is the pathogenesis of these symptoms.

Although no aetiological mechanisms can be proven, it will be argued that the general clinical setting, the additional statements made by the patients, and the outcomes in both cases all point to the same basic aetiology suggested below.

It is the feeling of many psychiatrists, paediatricians, and family physicians that parents (especially mothers) are prone to feel responsible for the illnesses that befall their children. How many times has a physician heard a mother of a deformed child ask,

'Was there something I could have done that might have caused this?'. As Lewis Holmes, a paediatric geneticist, has put it, '(with respect to congenital malformations) since the family history is usually negative, the parents often blame themselves and assume that environmental factors caused the malformation. Mothers often report that this opinion is encouraged by their having seen the well intended publicity summarized in the phrase, 'Be good to your baby before it is born'.'[2]

More subtly, much of a parent's apprehension about a child's illness stems from a fantasy that 'if only I hadn't taken that pill or hadn't taken the baby outside, etc., the illness would not have occurred'.

This propensity of parents to possess guilt for their child's illness is of unclear aetiology; furthermore, patients vary in their level of expression of this guilt just as physicians vary in their levels of awareness of it.

In the first case the similarity between the patient's symptoms and her child's illness was striking — one week after the child sustained a skull fracture the mother developed severe headaches, photophobia, weakness, and other symptoms that she said were due to a fall no one else had witnessed. The symptoms were so impressive and suggestive of 'organic' disease (eg. subdural haematoma) that an urgent neurosurgical consultation was obtained. To the bewilderment of the family physician, the surgeon felt the diagnosis was 'non-organic'.

Mrs A. talked readily of her extreme concern for her handicapped son and of her ambivalence about sending him into the social situation in which he now found himself. Having been reluctant to send him to the regular school, she was obviously greatly pained to see the ridicule and teasing his peers began to shower upon him.

In talking with her physician she gradually disclosed the feeling that she felt responsible for her son's fall, as she had thought Billy would be with other children but he had instead ridden his bicycle alone. Already feeling guilty because of his school situation, she responded to the accident as if it were 'the straw that broke the camel's back', and her guilt increased. Via a mechnism no one understands, she now began to experience physical symptoms. Once she could express her guilt to her physician she no longer had to 'bear the burden' of that guilt alone but had now found another human being to help her. Anyone who has ever experienced guilt knows the importance of sharing that burden. It was as though she no longer had to punish herself with all the suffering for her supposed irresponsibility in caring for her son. To live a more pain-free life now became possible, and the patient's symptoms began to abate.

In reviewing the patient's past records, it was apparent that she had been given numerous 'non-organic' diagnoses; eg. her medical records revealed 'incisional pain' (with a well healed incision), 'possible gastroenteritis pancreatitis' (actually persistent right upper quadrant pain *before* and *after* cholecystectomy), 'rheumatoid arthritis' (but no apparent objective documentation). 'Allergies' to multiple drugs were said to exist but the reaction was always nausea (ie. 'they made her sick').

In summary, then, she was a woman who had had many complaints that were inconsistent with 'textbook' symptoms of disease. Nonetheless, she had been given diagnoses which were, unfortunately, very poorly documented. Persisting in her 'doctor shopping' she had in the past finally found a surgeon who was willing to 'cut out her pain'. Not surprisingly, the right upper quadrant pain recurred after cholecystectomy. In short, it is suggested that the headaches and other symptoms of the present admission were not the first ones that had arisen in the 'whole person'. Although the symptoms had migrated to joints (?arthritis), to stomach (?nausea with all drugs), to abdomen (?incisional pain), to head (?subdural haematoma), the 'lesion' remained in the person as a whole. It was, as it were, the same disorder with multiple manifestations.

In the second case the aetiology of symptoms is more subtle. At first glance several facts in the history are incongruous. For example, although she says the pain is connected with a car accident in 1967, she says the pain actually began six years later when there was no obvious precipitating event. Also bizarre are the events prior to her son's death, eg. he had talked of his approaching death (she says) and he left the house reluctantly on the eve of the disaster (as if he had an ominous feeling).

The above facts taken alone, the conclusion might be reached that the patient is a poor historian. However, viewed from the fact that the patient is well educated and oriented and considered in the light of the first case, one can consider all of these statements as

distortions of a very emotion-laden past that has been 'rearranged' by an ego attempting to preserve itself. For example, it is suggested that the premonitions of the boy's death are representative of the fantasy that his death was actually forewarned to his mother. This further implies it might have been averted had these 'leads' been followed and had his mother stopped him from going on the trip.

When Mrs B. was asked what was occurring in her life at the time the pain really began (ie. three years prior to admission), instead of saying she fell or in some other way traumatized her body, she began to talk about her children. It was December, the same time of year in which her son was killed, and serious events were occurring with her other children. Her living son had just left home to go to college, and her daughter contracted infectious mononucleosis ultimately requiring admission to hospital.

Such a reaction occurring at the same time of year as the original emotional turmoil has been termed an 'anniversary reaction'. It is particularly significant that her pain began just as both children were being 'taken away' from her, one by college and another by a hospital (just as the first son had been taken away by death).

Still another piece of data supporting the suggested aetiology of symptoms derives from the old adage, 'If one listens to the patient, the patient will tell one the diagnosis'. Hence, one day the patient asked the physician, 'Do you think my nerves might be causing these symptoms?'. When the reply came, 'That could possibly contribute to the problem', the patient responded: 'I can sort of see that with my dizziness — I get dizzy when I feel cornered. But *not* my pain'. (In fact, her dizziness had first occurred while her daughter was being threatened by hospitalization; the patient became dizzy while standing in the hospital chapel.)

Another piece of data suggesting guilt on the patient's part was the relation of a mystical-sounding experience in which on the day after her son's death she saw the words 'her-to' appear on the floor. It seems not unreasonable to suggest they may symbolize 'her — *too*', a phrase loaded with the potential for 'pointing the finger' at someone (not surprisingly, a female).

The basic resistance to a functional aetiology of her symptoms (as shown in the above comment, 'But not my pain',) persisted throughout her hospital course. When told by the staff physician, 'All of your tests are negative, and nerves can sometimes cause these symptoms', her reply was, 'You only say that because the tests are negative'. This was particularly frustrating to the resident physician who had repeatedly told the patient he expected the studies to be normal. This clinging to 'a cause for my symptoms' as coming from a test of the body instead of from feelings is perceived as a major stumbling block to her gaining insight into the situation as presented.

It should be mentioned that, unlike the first case, no allusion was ever made as to who might have been 'responsible' for the accident involving the child. It can only be conjectured how the outcome might have been altered had the patient been able to say, 'I felt responsible in some way for his death' (as in the first case). Unfortunately, the patient has been lost to follow-up; yet she continues her search for help as a 'nomad', having visited a chiropractor after discharge from our institution. When last heard from she had achieved no relief of her symptoms.

SUMMARY AND CONCLUSIONS

In primary care medicine many patients present to the physician with somatic symptoms that may be similar to but are somehow different from 'textbook diseases'. In general these patients have normal physical examinations and normal laboratory studies. Although these patients are often given 'diagnostic labels' these are seldom definitive or helpful in the care of these patients. This paper discusses a small subset of that population and suggests a mechanism through which pathology in the whole person might manifest itself through physical complaints.

Two case histories are presented in which the presenting somatic symptoms and physical findings are very unusual for 'known' diseases. The laboratory findings are within normal limits in each case. Data that the patient provides is presented to suggest that the pain derives from feelings rather than from structural changes in the body. In the first case a striking similarity between a son's injury and a mother's symptoms culminates in the patient's disclosure of guilt over her son's injury. Significantly, her symptoms then begin to diminish in severity.

In the second case, a more complex one, an intelligent, educated woman presents data in a manner that implies but never says precisely that the patient may feel the accident

befalling her son was preventable. Although her perception of the past is distorted and her guilt irrational (as is most guilt), her sincerity and severity of symptoms are unequivocal. Despite reassurance and symptomatic therapy she fails to improve; she also fails to express any open reservations (as the first patient did) about what she did or how 'things might have been different'. It is suggested that this might be explained at least in part by viewing her as possessing tremendous guilt over her son's death. To the best of our knowledge she feels she has to bear the burden of this guilt alone; further, it is suggested that her symptoms are a symbolic punishment for this 'misdeed' (as perceived by her). Her symptoms persist, a definitive therapy is unknown, and her prognosis must remain guarded at present.

As Balint cogently argues in his book, *The Doctor, his Patient, and the Illness,* much research remains to be done on patients whose lesions reside in the whole person. The pathophysiology of symptoms, the clues to diagnosis, the therapy, and the natural history of this group of illnesses remain imprecisely defined. It is a funamental point that the physician most able to understand these problems is the physician who knows best the 'whole person' (ie. the primary care physician). Only through more research will it be learned how truly to help these patients; at the beginning, many patients are reluctant to *talk,* which would seem to be the necessary method of therapy. Until the patient is ready or until more is known about these entities, the family physician must be patient, continue to listen to the patient, and, most importantly, maintain contact with the patient. This means a ready cure may often be impossible; how to bring about relief of symptoms is problematic and is a question demanding more research.

Finally, in the second case multiple laboratory diagnostic tools were employed by the physician in an attempt to diagnose symptoms very atypical for 'structural disease'. When the tests were normal and the physician concluded that feelings might be the problem, this diagnosis of functional illness by 'elimination by appropriate physical examination' was rejected by the patient. Instead, she continued to cling to the idea that 'the reason for my symptoms' might be found on an x-ray, a scan, or a blood test. In fact, it seemed that the use of laboratory tests had become an *excuse* for her unwillingness to talk. Could these tests have been avoided she may have been less resistant to further discussions of her feelings. The possible ways of avoiding this conflict between talking over feelings and finding the answers with laboratory tests can only be determined through more work in this area.

(The authors wish to express appreciation to Dr Marjorie Tavelaras and Dr Paul Scott who helped greatly in the understanding of these patients.)

REFERENCES

1. Balint, M. (1957). *The Doctor, his Patient and the Illness.* Pitman Medical Publishing Company, London.
2. Holmes, L. (1976). Current Concepts: Congenital Malformations. *New England J. Med.,* **295**, 206.

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

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

Manuscripts and communications for publication in the Journal should be forwarded to the Editor.

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