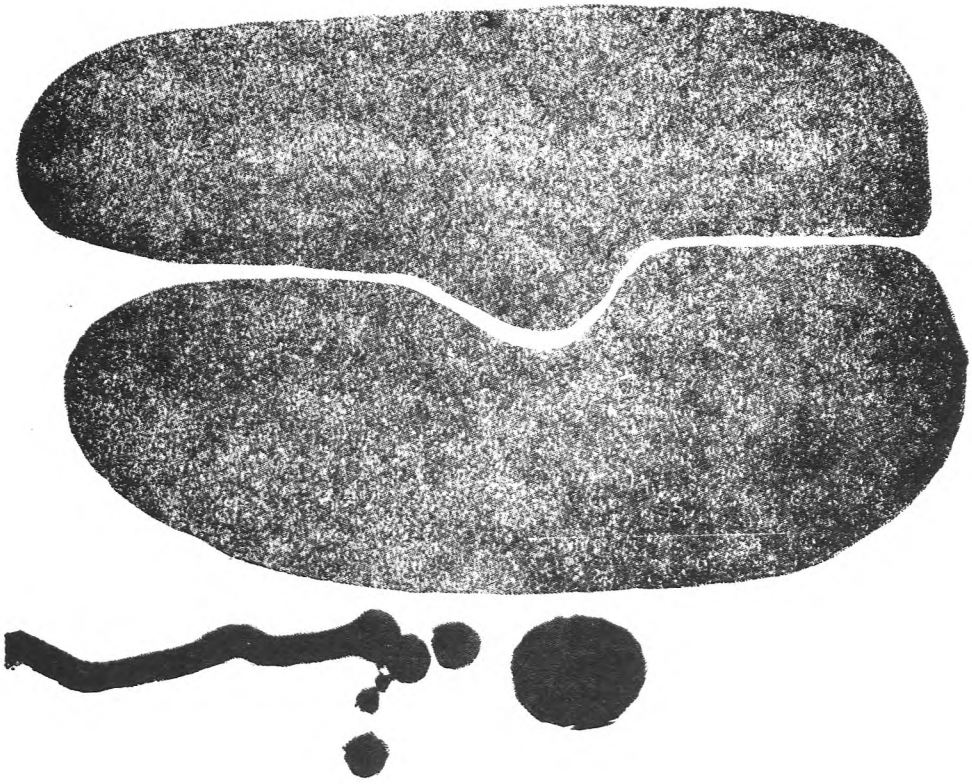
JOURNAL
OF
THE BALINT SOCIETY
1984



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Editor: Dr. Philip Hopkins

Editorial

Balint in Decline

In a recent monthly review of the medical literature for general practitioners, the editor reminded us under the above title[2], that the late Lord Rosenheim considered Michael Balint to be 'a remarkable doctor and psychoanalyst, a man for all time, whose impact on general practice and on the understanding of the doctor/patient relationship has been felt all round the world'.[3]

Yet, we are told, 'Enthusiam for Balint's teachings declined after his death in 1970 . .' so that although, 'Some of the GPs who attended the original Tavistock seminars continued to practice 'whole-patient medicine,' others, while paying lip-service to the concepts, found that attempts to explore the doctor/patient relationship in Balint terms, ' . . . as with so many other psychotherapeutic techniques, made enormous demands on a doctor's time. And some who attempted a Balint approach found the therapeutic rewards of only transient benefit'.

Even if we disregard the last comment about the poor results of the Balint approach by some doctors, since this may say more about those doctors rather than about the method used (just as the results obtained by some surgeons do not detract from the value of surgery when it is skilfully and properly performed), we are still left with some very important questions which demand our very close and serious study.

First, is it really true that there has been a decline of interest by doctors who have qualified since Balint's death?

Our secretary and other members of our Council receive a steady flow of enquiries about Balint-training and the possibility of joining a Balint-group.

In addition, there has been an increasing attendance at our annual Oxford Balint weekends until this year when, for reasons not yet fully understood, we were not granted cover for travelling expenses under Section 63.

But even so, nearly 100 doctors showed their interest and willingness to pay their own expenses to attend the recent Oxford Balint weekend to experience working in Balint-groups.

Many of these doctors were subsequently disappointed to discover that it was difficult to form a Balint-group in their own regions. This, it must be admitted, is a failure of this Society to provide Balint-group-leaders who are prepared to travel regularly to provincial centres, and is in no way related to lack of interest of doctors in Balint-work, and his ideas.

It is all the more important at the present time, especially when it is likely that the Department of Health may soon impose some limitation on the prescribing of many drugs which provide only symptom relief, that our patients should have the opportunity of benefiting from the holistic approach which Balint advocated and encouraged.[4]

Experience of this clinical approach leads to a new dimension in medical practice which is followed by an understanding of the over-all diagnosis of our patients' problems, and a fuller understanding of their true needs.

It is quite clear from the pronouncements and writings of some of those who have mastered the art of using the media for publicity of their activities, that they have not had the advantage of Balint training, in spite of their frequent quotations from Balint's publications.

It may well be that more patients will come to see their need for more effective help than they are receiving, even from those who claim that they are offering a holistic approach, which seems to include referral for various concurrent treatments such as acupuncture, herbalism, meditation, osteopathy, and other such agencies, instead of the more traditional referral to various specialist clinics, physiotherapy, and other hospital based activities.

Public demand for so-called alternative, or complementary methods of treatment will certainly diminish when people become aware that they bring no more relief for the individual underlying needs than does traditional medical care where only the physical signs and symptoms are treated without concern for the underlying emotional, psychological and social factors.

The question, 'Who needs Balint? . . .' asked in the title for the next Balint Prize Essay (see page 31) might be answered by further reflection on what Michael Balint actually said.

Balint did *not* at any time say or write that the doctor is the *most powerful drug used,* but that *the drug most frequently used is the doctor himself.*[1]

This, then, must surely be the role for this Society — to show that there is a need for a growing interest in Balint's ideas, and that there is certainly no decline in the need for their application in our work, just as there is a need to develop further the ways of applying them.

Certainly the attendance and the content of the Sixth International Balint Conference, held recently at Montreux, confirmed that this is so. The papers read by Mrs Enid Balint-Edmonds and by Michael Courtenay at the conference, and reproduced in this issue, as well as the two joint-winning 1984 Balint Society Prize Essays by Stanley Levenstein and Oliver Samuel, who are to be congratulated on their efforts, all support this view.

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The History of Training and Research in Balint-Groups

by Enid Balint-Edmonds, F.R.C.G.P.
Psychoanalyst, London

The aim of Balint-groups has changed very little, if at all, over the last 20 years. Changes, however, have occurred in the techniques which the general practitioners study in the groups, and which I will describe. It is important, at this stage in our work, at this Conference, that I should describe them. Many doctors may be surprised at how *little* our thinking has changed more than at the *way* in which it has changed. I do not think this is due to our inflexibility.

What is general practice like? We all know, but Andrew Elder[4] writes, 'It is a world where the doctor is frequently in the dark, getting glimpses of his patients from time to time, being careful not to find out too much, being content to find out the right distance for the patient and for himself. Sometimes taking the initiative, and sometimes needing to be more restrained and to wait.' If a doctor thinks that this task is one that he would like to undertake, and that it is not too far from his ideas about general practice, a Balint-group should be able to provide the means by which he can learn to do so.

I am assuming, of course, that such a doctor would be well trained and continue to be interested in traditional medicine all of his professional life, because without that none of the ideas I will be talking about have their place in medicine, or can be used reliably.

Although I am not medically qualified, I can only feel the freedom to think about the doctor/patient relationship in the way I do in a group of doctors who value the practice of traditional medicine and feel at home in it. They can then, also gradually feel at home with the less — so far — well-defined aspects of their patients' illnesses and the treatment of them which I will try to describe, and which are at the centre of the research undertaken by the Balint Federation.

Before proceeding, let me tell you briefly how we started, although most of you will have read papers about it and will, therefore, be as aware of the history as I am myself! In 1949 Michael Balint led a group of non-medical professional workers at the Tavistock Clinic — a mixed group started by myself in 1948 with the aim of trying to understand and work with people with marital difficulties. We then decided to start working with general practitioners using the same techniques we had developed during the previous work. At this time, at the beginning of the National Health Service, general practitioners in England were under some strain and many did not seem to get the satisfaction they should from their work. Michael, whose father had been a general practitioner, wanted to find out why this was, and we started what he called then, and what we still call, research-cum-training-seminars for general practitioners. These were held at the Tavistock Clinic where he was a Consultant. I joined him from the start, and for 20 years until he died we worked together in these seminars. The aim is clear from the title: it was to find out what general practice was like, and what was wrong with it, and whether we and other psychoanalysts with our particular way of looking at human relationships and with our inward-looking experience in working with the unconscious mind, could help to throw any light on the subject.

Furthermore, new techniques and methods of working might have to develop; techniques which could be used by general practitioners. We worked in groups of about 8-12 general practitioners, and one or two psychoanalytic leaders, who stayed together for a minimum of two years, meeting once a week for two hours, discussing patients who were currently presenting difficulties, who did not get well as they should and were causing their doctors headaches. The groups studied in detail, without the use of notes, what a general practitioner told the group about a patient with whom he was having difficulty, giving special attention to the relationship between the doctor and his patient, often at one particular consultation. We discussed human relationships: not in general terms, but one particular relationship at one particular time.

Some doctors, having started to think in a different way about their patients and themselves, wanted to go on doing so after the end of the two years. Others had enough after a shorter time. Later, we devised what we called a Mutual Selection Interview so that the leaders of the groups, and the general practitioners who wished to join them, could find out what was on offer. The leader could see if the general practitioners were likely to fit in and be satisfied with the work of the group, and the general practitioner could see what the leader was like and how he spoke about his work, and what he needed. After we started having these interviews there were very few doctors who left before the end of the two-year period, and hardly any who left disappointed soon after the group started[3].

As I have just said, right from the start of our work, we found ourselves studying the relationship between one doctor and one patient at one time. Why was one patient difficult, another not? Our method of work and our research method was stable: it consisted of discussions of a doctor's difficulties with, and his relationship with a patient in a structured setting. With the same leader, the same doctors, in the same place discussing patients over a longish period. Verbatim transcripts were made of each meeting. Some structured information was taken from the scripts by the group itself, at the

following meeting. Headings were devised so that the same data would be followed. We called these headings 'forms'. We still use them, and adapt the headings (i.e. data we wish to observe and follow) as the research develops.

We found the use of the doctor's own notes — the ones he made while seeing his patient, or after he had left — distracting during the discussion itself, and we soon adopted a method based on the method of supervision used by Hungarian psychoanalysts. This was to encourage students to speak freely without notes, contradict themselves if necessary, have second thoughts, remember things they thought they had forgotten; so that a complete picture in which the feelings of the doctor himself emerged about the facts he was reporting. So the actual reports were without notes, i.e. no notes were used while reporting. However, as I have said, at the beginning of each meeting, sometimes we left it for a week or two, the verbatim transcripts were read of the last meeting and 'forms' filled out to guide our thoughts in a particular direction — a direction which was the basis for our current research.

To those who have never worked like this, with an observer leader trained to observe in a particular way; one who can tolerate the absence of a consistent story for a time and *use* the muddle rather than try to discard it, this method may sound very strange and unscientific. It consists, as I have just said, of amassing facts and the feelings about the facts at the same time. Our work is based on the idea that human beings, whether doctors or patients, unconsciously defend themselves against certain thoughts and ideas. They try to get things in order, and this often involves leaving out facts and the feelings about them. The story seems clear, and the doctor when reporting is unaware that it is incorrect. In our kind of discussion and reporting such omissions and falsifications come to light without embarrassment.

A trained observer, possibly a trained psychoanalyst or someone who has worked with one for a long time, is needed to help piece the data together; who has the ability to listen in a certain way. Hunches, fantasies and feelings should be expressed without embarrassment but not treated as sacred; the work of the group and of the doctor in charge of the patient is to see if what is said is true — to examine on what such fantasies and hunches are based — so that the doctor can, if appropriate change his ideas about his patient. This is all done in a stable setting. The methodology does not vary, and each doctor gets accustomed to looking at his, and his colleagues' work with the same strictness and freedom.

We still use the same method, but do we listen in 1984 in a different way for different things? Have we changed? We are, perhaps, even less anxious to make a coherent story, to make 'sense' early on in our work. We still make a working diagnosis (not an overall diagnosis as we used to call it), but we are now more observant of *changes,* however ninute, which take place in the doctor/patient relationship, in the doctor's feelings about his patients, in the patient's complaints and even changes which take place during one consultation. We are particularly careful not to fit new observations into old patterns where they are inappropriate.

Early in our work we sometimes spoke about our ability to train general practitioners to do some form of psychotherapy, and we blamed unsuccessful results on the fact that our doctors did not have much experience in this field. It was assumed then that had the 'psychotherapy' been better, the patient would have been cured. The most common basis of any form of psychotherapy, it was said at the time, is an understanding of the patient's real problems. It was, therefore, thought that had they been understood the patient would have been helped. By 'real problem' was meant the underlying cause of the patient's illness.

However, even as early as 1961 we had an early change in thought — we questioned whether we were right to use the idea of 'diagnosis in depth', or whether we should talk about 'going in deeper with our patients'[2]. We felt that our analyst colleagues would already feel that the various diagnoses in depth that we were reporting were rather superficial when compared with what analysts would accept as deep.

Nevertheless, we decided to stick to the word 'depth' as we felt at that time, that the examinations we were interested in must be oriented so that they should proceed from what the patient tells us towards what lies beneath what he tells us. Depth, therefore, was thought to be taken as denoting the direction and not necessarily the level reached. I now often think it is unnecessary, and can be unhelpful at any given time, to try to discover what a patient thinks is the cause of his present sympton or unhappiness. As I have already said, in general practice the patient's feelings in the present, and the changes in them, seem more important and more reliable.

All our work is based on one human being, a professional, understanding not only intellectually, but in other ways as well; based on traditional medical teaching, and by identification. Intellectual understanding alone, is not enough. To understand, it is necessary to listen to what one does not understand; watch and notice the human being one is talking to, as well as one's self at the same time, and so to be able to identify. It is necessary to notice, and watch changes in one's ways of reacting to the other person.

Identification depends more on a willingness, or even a desire to understand, than an ability to sympathise. However, once an observer has identified himself with someone or something, he will find it difficult to feel objectively about that person or thing again. But he must first identify, and then he must withdraw from that identification and become an objective, professional observer again. The identification must have a biphasic structure. In addition, a doctor must be able to respond correctly, without too much delay.

Scientists in other fields describe how difficult, or even impossible, it is to observe anything without influencing the object observed. No two observers will see exactly the same thing. The

value of Balint-groups is to facilitate observations.

Here is a case: it is a follow-up of a woman patient who had been seen and reported to a group almost a year before, soon after her first child was born. The baby, a girl, was suffering from a severe cough. The doctor had the cough 'investigated' but it persisted, and the patient continued to come to see the doctor complaining that she could not stand being kept awake at night any more. She must get back to work because she was not good at being a mother anyway, and she wanted to carry on with her career. Her husband was no help, either.

The group had discussed this case the year before, and had thought the patient was a rather overdominant, masculine woman (although there was no real evidence of her being masculine, other than her not being able to cope with her first child and wanting to go back to work). The working diagnosis was of a dominant woman with a weak husband who was presenting her child with a cough, and who bullied her doctor.

At the follow-up, however, the question of whether the woman was dominant came under review. Could it be taken for granted on the grounds that the doctor fitted in with her requests for frequent examinations of the child, and anyway, the group asked this time, was this diagnosis of any help to the doctor or the patient? Most of the group were doubtful, but did not know where to turn, and then slowly began to look at the interview itself which the doctor was asked to report in greater detail.

The doctor then told us that he thought the patient was very lonely. She had moved quite far from her home when she got married two years before, and the picture of the dominant, unattractive woman disappeared and we seemed to have somebody else as a patient. The doctor began to feel more at ease when he talked about her, and said how lonely it must be for her; how awful it was for her to have a child and to have no one to share it with. He got in touch with feelings in himself, and identified with the patient.

But there had been no biphasic structure in his identification with which the group were able to help him. The patient was then able to feel less alone with her husband, less lonely; let her husband share.

I will give another case to illustrate this point. A doctor reported on the case of an old patient of his, who he had known for several years. At the age of 36, she was dying of cancer, having had all the possible treatments, and she was now so distressed, and so unwilling to go back to hospital that her general practitioner had advised that she be left at home until she died. The hospital had agreed to this.

The doctor, however, then found it was very difficult for him to visit his patient and reported this case to the group because of his difficulty in visiting his dying patient. The group was very subdued, and made all sorts of excuses for the doctor, and could well understand how, because he could do nothing for her, he could not bring himself to visit her; that he was very busy, and so on, and so on.

The case was discussed for quite a long time before someone said he was sure the doctor wanted to visit the patient but was so identified with her he could not face it. The doctor agreed: Yes, he wanted to go but he could not face the way she looked, although when he saw her he did not mind at all. In fact, when he got into her bedroom he was very pleased to sit on her bed and to hold her hand, which she put out towards him when he entered the room. He then saw her as a separate person whom he could be with: relate to. This doctor needed to realise that the patient was a separate person, who did not expect anything of him he could not give, and was glad to have somebody with her who could accept the fact that she was dying, and that she did not look too frightening. There was no need for him to *say* anything special. We will come back to this.

When did we begin to observe the changes in our focus of interest? Changes in the techniques we were trying to devise for general practitioners? It is difficult to say, but a new appraisal started in January 1966, when a research team consisting of ten general practitioners and two, and sometimes three, psychoanalytic leaders met at University College Hospital under the leadership of Michael Balint and myself. The group ended in 1971, a year after Michael died.

A book, based on the research in the group, was published in 1973[1]. The ideas that were structured during these years had already been in the minds of both of us for some time. In his introductory chapter called 'Research and psychotherapy', written just before he died, Michael wrote, 'in spite of all our efforts so far to create a technique suited particularly to the setting of medical practice, the 'long interview' has remained a sort of foreign body in the general practitioner's normal routine.' That is to say, the psychotherapeutic type of interview, though used, was not really suitable. Also, I want to add the kind of diagnoses we were making were too static, not fluid enough.

The new techniques that we were aiming at had to be based on a reliable understanding of the patient's individuality, and particularly of the developing relationship between the patient and the doctor, that is to say on *processes* rather than *states,* and what at one time seemed impossible, the time needed for these techniques had to be compatible with the routine 10-15 minutes that the average patient gets in a medical practice. We encountered severe difficulties in this group, the principal one was, and I again quote from Michael, perhaps caused by the realisation that their old, well-proven methods had to be given up, or at any rate considerably modified, partly because of the new conditions, and partly because we were not sure whether the results in the long run gave the doctor, and therefore the patient, sufficient satisfaction. In the old method which we were giving up, the doctor had responsibility for understanding not only what the patient tried to convey to him, but why the patient had become the way he was; and although he was as interested as we still were to recognise omissions and distortions in the patient's story, his aim then was to solve something which is, after all, the traditional role of the doctor. But in the new technique the therapist's role was to tune in to the patient and to see what it was like both for himself and for the

patient, and what changes occurred and how varied and inconsistent his feelings and the stories that he got were. The need here to identify and then withdraw from the identification is paramount.

The techniques which arose out of these ideas described in 1973 was called the 'Flash', which consisted of a moment of mutual understanding between a doctor and his patient which *was communicated by the doctor to this patient.* It was not an understanding about the patient's past about which the doctor was very likely completely aware, but was usually about something in the patient's current life and which was reflected in the relationship with the doctor for a brief time. These episodes were very hard to follow up reliably, but when they have been followed up changes do seem to persist in the doctor's feelings about the patient, but we have not been able to observe reliably in what way the patient responded to them. It appeared that they were sometimes brushed aside; not referred to again.

Our current research is focused on a technique similar, in some ways, to the flash technique: but different in important ways. As I have made it clear throughout this paper, this time we are concerned with making observations about changes that take place in a doctor's feelings about his patient, and a patient's feelings about his doctor; changes which *are not communicated at the time by the doctor to the patient,* at the time they are noticed. This is crucial. In the 'flash' technique, when a flash occurred the doctor communicated his thoughts and feelings to the patient. Nowadays we prefer to wait and see what happens to a patient when a doctor's feelings change, sometimes suddenly, about him.

Here is a case: A woman in her late sixties, married to a man eight years younger than the patient. This woman had come complaining of depression for many years, for which she had been given pills which she said had always helped her. The doctor changed the medication from time to time, and each time the patient seemed satisfied, although she came back again with the same symptom. One day, however, the patient came as usual — or so it seemed — and the doctor found himself asking her whether there was something that was particularly wrong. The patient said her husband had a mistress, but this kind of thing had happened so often before she did not think it had any particular significance, and she spoke in a way that did not make the doctor feel that she was particularly troubled by it; but at that time the doctor found himself seeing the patient as an old woman with a deaf-aid (which he himself had arranged for her some years previously); a woman who felt that her life was over, with her husband who would never want her any more; that there could be no more sexual relationship between them, and that she was finished.

Actually, it was the doctor who felt all of this, and who reported these feelings at some length to the group. We did not know what the patient felt. In this interview the doctor had not said anything about this to his patient, but he was shocked. He did not suppose that the patient was aware of any of this at the time, but the group felt that probably the patient had felt old and useless many times and that it was the doctor who had only just picked it up. Perhaps the patient felt better because of this. The patient returned after three weeks and said that she was depressed, but for the first time said that the pills were no good and that there was no point in her having any more. She had come because she was going on holiday with her husband, and she wanted to talk to the doctor first about it, but she did not want to use the pills. The patient said she was terrified that she was going to spoil the holiday. Her husband had planned it after giving up his relationship with his girl friend, and this made the patient particularly anxious that she should not spoil it; that the better relationship which seemed to be growing between her and her husband should not be spoiled by her being so awful, and depressed, and useless.

In this interview the patient showed something which could have been caused by the doctor's feelings in the interview before, when *he* had felt despair for her and fear for her future, but had said nothing. We could say that the patient had 'unloaded' her feelings into the doctor and in consequence she had become partially free of them and was able (instead of being passive about them) to become active as if free for the time being and not passively having to accept her fate. If this was so, this was a major change. The idea is that what the doctor 'took in' during that interview and afterwards had enabled the patient to be free enough to take the initiative at the next interview (by not accepting the pills as usual); and also to behave differently, more actively, less like a victim with her husband in the meantime. The doctor, having had insight into the patient's ideas about herself (not about what she was like, but what she *felt* she was like), enabled her to come alive and to rid herself, temporarily at any rate, of her heavy, passive, depression. The doctor had, so to speak, taken in what the patient projected into him and had held on to it for a time; had not immediately handed it back to the patient in the form of an interpretation. At the next interview, however, when she came saying she did not want the pills but did not want to be depressed, he was able to respond appropriately, having by that time got rid of the projection, i.e. of the patient's depression. He did not, of course, at that time, say 'you are an old, deaf, woman and there is no hope for you', but spoke about the holiday and the processes that were going on inside the patient, at that time.

There have been other cases, as I have already shown in this paper, which confirm our ideas about this particular kind of tuning in or, one could talk about it in terms of the doctor's containing a projection from the patient and the effect it has on a patient when the doctor does not communicate, does not interpret, but holds on to feelings which a patient has put into him, and with which for a short time he totally identifies with, but which he is then able to distance himself from. He knows what it is like to be the patient but also is able to see that it is not all the patient has inside him.

The doctor must become aware of the feelings the patient has, and be ready to hear what

the patient says at the next consultation as well as the one in which she projects something in to *him*, or take in other projections. The patient can then become the active one, and this is not deflated by seeing something about himself passively; or, if that is too threatening, to fail to take it seriously at all. The patient can change once the doctor knows what it is like to feel the way she does. She can then tune in to other parts of herself. But she cannot change, sometimes, by being told that she should change, or being told what she is like. She is given the freedom to change in this way.

This brings me back to another reason why we run our groups the way we do; it is so that the doctors in the groups can be active, not passively receptive, either of their own feelings or to what the leader says; so that they can talk freely about their patients and their feelings about them, at one particular moment, in one particular session, bearing in mind that this is almost certain to change; in so doing they can get in touch with feelings in themselves about which they have been unaware, and which may enable them in due course to understand something about their patients which they would not have been able to do had they been out of touch with their own feelings and the seriousness of them.

To take the responsibility for their own feelings and thoughts, to realise how hard it is to observe them reliably, and how easy it is to miss what other people say, are some of the things that doctors in Balint-groups get to know about. Balint-groups allow such processes to occur, allow doctors to realise how hard it is to observe, particularly when the observations are not stable. In this work activity of a special kind is released in the doctors, a kind of psychic activity. Liveliness, not passive acceptance; observations, not instructions.

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Paper read at the Sixth International Balint Conference at Montreux, 1984.

INTERNATIONAL BALINT MEMORIAL CONGRESS: BUDAPEST, HUNGARY

29-31 May 1986

A preliminary announcement has been received, inviting enquiries from all those who might be interested in visiting Michael Balint's birth-place, and to attend a Congress to commemorate his 90th birthday.

The proposed main topics of the Congress are:

1. Balint Memorial Lecture.
2. The management of neurosis in general practice.
3. The treatment of psychosomatic disorders.
4. The Balint-method as a tool for self-education.
5. Work in Balint-groups will also be organised.

Simultaneous translation into English, French, German and Hungarian, is foreseen at the plenary sessions. The group-work will be organised according to different languages.
Accommodation and the Congress-site will be in the Study Centre TOT. H-1121 Budapest, Normafa ut 54., Hungary.

Requests for further detailed information about the Congress should be addressed to the organizers:
MOTESZ Congress Bureau,
H-1361 Budapest,
P.O.B. 32. Hungary.

The Place of Balint-Work in Medicine Looking Back — Looking Forward

by Michael J. F. Courtenay
General Practitioner, London

Just as the patient's motivation is the single most important factor determining the outcome of a brief psychotherapy, so motivation was the essential requirement for the doctors who were attracted to the prospect of Balint-work in the nineteen-fifties. They didn't even know what Balint-work was going to be like, but they knew they needed help desperately. That was the decade when technological medicine was sweeping all before it.

Those of us working outside hospital felt washed up on some desert island. With the very restricted technical resources at our disposal were we even practising medicine? Our patients expected us to do so, while at the same time bringing us syndromes which did not appear in the textbooks of medicine. It was confusing and humiliating. We referred patients to this specialist or that, only to be told we had sent the patient to the wrong specialist or there was 'nothing wrong' with the patient any way. The patients thought differently and continued to complain. Where were we to turn? Suddenly a lifeboat appeared, manned by Michael and Enid Balint. It seemed a rather strange vessel, and it was not clear quite where it was going to sail, but the crew seemed confident and were not patronising towards our plight. We climbed aboard gratefully.

A decade later our women colleagues working in the clinics run by the Family Planning Association to give contraceptive advice were also experiencing difficulties. Women coming to them for contraceptive advice were assuming that they would have some expertise in helping them with sexual problems. The assumption seemed eminently reasonable, but the fact was that medical training at that time virtually ignored sexuality. It was as if the fig leaf on statues had been transferred to the human body.

Our specialist colleagues seemed mostly content with the current medical climate, except some psychiatrists and the occasional paediatrician who felt that technology was not enough.

As the years have passed, the initial motivational impulse has been modified by events. The dissemination of Balint-work ideas in the stream of publications since *The Doctor, His Patient and the Illness*[2], which appeared in 1957 has allowed contact with the work in an intellectual rather than an experiential manner. While there has been a steady stream of new applicants to join Balint-groups on the one hand, on the other hand a much larger number of doctors exists who think they can incorporate the hard won gains of experiential learning by attempting to put into practice what they have read. When this attempt fails they may consider that Balint-work is of no value, not realising that its usefulness depends on yoking together both thought and feeling in the process of training.

Concomitantly the current style of special postgraduate training programmes for general practice in Britain has come about, partly because the Royal College of General Practitioners involved a large number of Balint-trained doctors to set out the goals towards which the future general practitioner should aim, and partly because the doctors appointed to organise the training courses were drawn in large measure from Balint-trained doctors, because of their experience in small-group work. They quickly saw that the re-orientation of the young doctor from work in the hospital setting towards working in general practice might best be achieved by a modification of Balint-work.

While this approach has been welcomed by a large proportion of those in training, it was difficult to arrange for this training method to be freely chosen, and the lifetime of the group was severely limited, often lasting only a year and never more than three. If the doctor in training found the work useful and congenial, there was the possibility of joining a group after training was completed and I indicated in a paper at the 1978 International Balint Conference that such doctors had developed as much in a year as the doctors who comprised the established seminar which the trainees had joined.[6]

However, those doctors who found Balint-work either too uncomfortable, or thought it was irrelevant their needs tended to reject this approach. These tended to align themselves with the doctors who had sought to use the insights gained by others and described in various publications without appreciating the necessity of experiencing the training process, so that both groups might by considered to have developed antibodies to Balint-work.

Others went along with the principle of the work during their training period, but were left believing that an experience of limited time and intensity had revealed all that Balint-work had to offer and felt no further motivation towards continuing. These doctors might be considered to have been 'immunised' against Balint-training for an unforeseeable period of time.

Furthermore, the academic departments of general practice whose responsibility is primarily to participate in the education of undergraduate students have also involved many Balint-trained doctors. Some students appear sensitised by the exposure to such doctors, but some may react in a

negative way at this early stage. It is too soon to know what effects this may have in the long run.

Perhaps the single most important activity of the British Balint Society is to organise an annual weekend in Oxford where doctors can come and participate in the seminar experience without any prior long-term commitment to join a seminar, and enables them to test their motivation in the context of actual experience of Balint-work.

So much for motivation, except that we still need the motivation of our psychoanalyst colleagues to join us and so form the hybrid activity of Balint-work. How revolutionary was the concept of the Balints' offer to general practitioners nearly thirty-five years ago, and how fortunate that so many of their colleagues joined them. Their offer of a partnership was a tonic in itself. The rewards for those working in a primary care setting are felt by those undergoing training, but the rewards for the psychoanalysts are presumably that their professional expertise is reaching out to a wider public. The dearth of psychoanalysts in Britain and their concentration near London has forced the experiment of using general practitioner leaders, especially in the vocational training programme for general practice. It is likely that they will have acquired enough experience of unconscious processes, that gift from psychoanalysts, to function fairly safely. It is certain that unless our psychoanalyst colleagues who have a concern for primary care continue to help us, Balint-work will perish.

It is interesting to note how the Institute of Psychosexual Medicine has organised the training programme with a two tier system of seminars, the ordinary seminars often led by non-psychoanalysts, while the advanced seminars always have a psychoanalyst leader. At the moment then the work seems to prosper.

What then happens to doctors who elect to undergo Balint-training? The aim, of course, remains 'a limited, though considerable change in the personality of the doctor'.[2] Because it has been generally agreed that a Balint-group should not become a therapeutic group, but should remain a training geared to professional development, the concept that there is a professional ego suitable for training and a personal ego to be left alone has emerged, but we all know that there is really only one ego, capable of object relations in professional and personal roles. This essential unity of the ego often leads to technical problems for the leader. At a meeting of Balint-group leaders in Cambridge in 1984 Van Bork proposed the thesis that the case material presented by individual members of the group may demonstrate a dominant theme, and so reveal that the doctor concerned is in need of personal help. Whether to respond in the group setting or whether the doctor should be invited to see the leader privately to suggest that treatment is necessary may be a difficult decision.

Max Clyne in an address to the Annual Meeting of the Balint Society in 1984 raised the question as to whether Balint-training helps the doctor — is his health improved? does his marriage prosper? If the doctor's personality changes, this must lead to a need to make adjustments in object relations. Whether these will lead to better health of breakdown, to a fuller marital relationship or divorce will depend on individual circumstances. There is also the factor of the extra demands on the time of the doctor which may keep him away from his family longer than previously.

The introduction of a mutual selection interview before a doctor joins a group would seem a sensible and necessary procedure, as this may well show what possible gains and losses an individual may make in the course of training.

The 'apostolic function' is, of course, the professional face of the doctor's ego as he strives to practise medicine, and the realisation of what it is like by each doctor undergoing training is a revelation, both surprising and uncomfortable, but after the experience of Balint-work, what of the 'new apostolic function'? If the training has produced the change aimed at, then it will still be limited, even if considerable. A powerful personality will remain powerful, and may only substitute an evangelical Balint approach towards patients who present in the place of the traditional management previously employed. I recall acting like that myself at one time. If on the other hand it enables the doctor to give of himself more freely, allowing himself to be used (but not abused) by his patients, he will become a more useful doctor for them and possibly even a better spouse or parent! From the patients' point of view it is probably safer to allow them to regulate the dose of the 'drug doctor' rather than to leave it to the doctor himself. He is such an unstandardised drug that poisoning is more than a possibility, though the side-effect of overdependence on the part of the patient must also be guarded against.

Although striving towards perfection may be laudable, the goal of 'the good enough doctor' coined by Professor Lennart Kaije at a meeting of Balint doctors in Umea, Sweden, following the lead of Winnicott's concept of the 'good enough mother' in paediatric practice[11] may be safer and more realistic. Offers may be made to patients and pursued only if accepted. Lack of motivation on the part of patients may be frustrating to the doctor, but this has to be accepted until the time is ripe. The continuing relationship of patient and doctor in the general practice setting is one of its greatest potential assets. We must wait for the patient. But what of him? Is the collusion of anonymity really dead? Do no patients still have thick record files in this enlightened age? Alas, the weight of technological medicine still presses us to focus on the part rather than the whole; partly through the habits acquired during our basic training, and partly because it is superficially easier to study an isolated system rather than a whole person. But in the end only the overall view taken by patient-centred medicine is likely to make sense of the illness for the patient.

The young woman about to be married who develops diabetes will want to understand why she continually drops the test tube in which she is testing the urine for glucose quite as much as how to

manage the illness in terms of diet and insulin dosage. Can we not share our insights with our patients just as the psychoanalysts have shared theirs with us?

What then of the illness? Research in France[1] showed that some Balint-trained doctors identified 'emotional illness' in their patients only marginally more accurately than a control group of untrained doctors. This depressing result is open to several interpretations, but the point I wish to make is that the concept of an 'emotional illness' represents a categorisation of a patient-disturbance in the same terms as a system-disturbance in traditional medicine, so becoming analagous to the model used in technological medicine. Can we get away from the old model? It will be difficult but not impossible. The ways in which technological medicine has been studying the psychosomatic concept has not made the task any easier. Vast schemata involving neuro-logical-endocrinological-immunological mechanisms reveal dimly the shape of the pathways interlinking mind and body, but the danger of the patient disappearing in the mists of molecular biology looms as large as ever.

How can we find our way? The perspectives are now long enough to appraise the grand Balint strategy as it developed over a period of twenty years, and studying this may give us pointers towards the future. It all began with that first great Balint-group in which they struggled with apparently intractable problems, spending hours talking to their patients in trying to find a new way to being a general practitioner. Each patient was seen for something between a half and one hour. At least one of the group held about four sessions a week in the afternoon, devoted to this kind of psychotherapy. It was learned informally, generated by the work in the group, and often remarkably effective in spite of the lack of a theoretical concept, or individual training.

After the basic method of training had been established there came a move to study various facets of practice. Clyne's *Night Calls*[5] demonstrated how regressed doctors, woken from sleep, sought to deal with patients and their relatives whose anxieties had risen to fever pitch during the long hours of darkness, when daylight seemed insupportably distant. Lask's *Asthma*[8] showed that the sterotype of the asthmatic person as a 'demanding baby' applied to less than a third of sufferers, the remainder being so independent that they did not actually mobilise all the help for their condition that was available. Repeat prescriptions[3] were seen to delineate a certain kind of doctor/patient relationship in which the patient needed to keep a certain distance from the doctor, and the other people around them, while the doctors blamed their predecessors for starting to prescribe unsatisfactory drug regimes when in fact they were usually responsible themselves. Dying patients were studied by one group, but mourning for Michael Balint overtook the book which might have emerged.

In the parallel field of psychosexual medicine a start was made with a study of unconsummated marriages. The women doctors in that group managed to convince Michael Balint that doing a vaginal examination while exploring the patient's fantasies was a quicker and more effective treatment than just talking to them. The fact that a psychoanalyst could accept a psychotherapeutic technique which involved touching the patient at the same time is impressive.

Other seminars led by Tom Main explored sexual difficulties in the setting of contraceptive clinics, and proceeded to enquire into frigidity and requests for termination of pregnancy in later groups.

In parallel with that activity, the Balints tested the possibility of those doctors undertaking work with psychosexual problems using a form of focal therapy. This was demonstrably pushing the doctors involved to the limits of safety with regard to psychotherapy and possibly beyond it on occasion. It developed the concept of a formal psychotherapeutic approach capable of being used by doctors in primary health care. The risk to the patient was the possibility of a failed treatment at this level might preclude the patient getting satisfactory treatment at a later date, even in specialist hands. In the event, the results, recorded in *Sexual Discord in Marriage,*[6] were comparable in terms of success rate, judged against specific predictions of intended outcome, as the series reported by Malan,[11]where the treatment was undertaken by trained psychotherapists. Malan had suggested two factors, other than the patient's motivation, which were paramount in predicting a successful outcome; they were enthusiasm in the therapist and the handling of the negative transference during the treatment. While the enthusiasm of the primary care therapists was not in question, those working in general practice experienced a difficult technical problem in that at the end of a treatment the patient would usually remain a potential patient, where the effect of working through the negative transference might remain to disturb the relationship. Alternatively if this was not done thoroughly, an overdependent patient might develop.

Even at the level of the ordinary general practitioner group, there is a danger that a patient can fare badly. I remember the remarks of two American psychotherapists attending a leaders' workshop studying the transcript of a group-meeting, when they felt that a particular patient was getting treatment that fell short of a professional standard, talking from the standpoint of a trained psychotherapist. The truth of this must be seen in the context of the dilemma experienced by the Balint-trained general practitioner who may see twenty patients in one session, offer Balint-work to two or three, and feel guilty about not doing so to three or four more, also with an apparently equal need.

Perhaps that was why the Balints turned their attention to examine the 'ordinary consultation' in general practice. This was the seminar which led to the production of *Six Minutes for the Patient*[4]. The difficulty in that study was, I think, due to the fact that the general practitioners involved felt ashamed

of how little they were doing for some of their patients, and were wary of exposing themselves. I speak for myself anyway. When we were finally challenged to do so, we were surprised how much valuable work could be done with the patient in a short time on occasion. In retrospect, I sometimes wonder whether the concept of 'the flash' was not counter-productive in that it introduced an overdramatised, almost miraculous dimension into what was just the day-to-day work of the doctor. I may be speaking out of turn as more work on the concept was done in a group of which I was not a member, but which has not yet published its findings.

So if we survey the direction of this grand strategy and look to where it points us, what do we find? I think it points to our work with each and every patient, and it points to doctors who have undergone even more change. Researchers in Scotland, far from the field of Balint-work,[10] have shown that for every patient who comes to see a general practitioner, there is another person in the community for whose health care he is responsible, who has similar symptoms but who does *not* consult the doctor. And the difference between the two groups is, in terms of their object relations, one being relatively unsatisfactory, and the other satisfactory. This indicated that *every* patient who consults a general practitioner has a problem potentially amenable to Balint-work. It may be only minor, but the dimension is always there. It does not mean that every cough and cold requires fifty minutes of the doctor's time, but perhaps rather a deeper enquiry into that old Balint-work question: 'Why has this patient come *now?*'

On the part of the doctor this requires an openess, a free-floating attention that may be difficult to achieve. Perhaps the defences of the doctors need to be better understood, but if that were so, can it still be done in the context of the Balint-group as we know it? Or would it inevitably shift towards a therapeutic group? Perhaps this enquiry has to be undertaken by a group of doctors well experienced in Balint-work who really are brave enough to display the courage of their stupidity. I think their courage is needed.

Michael Balint once said that he had begun the enquiry into the way general practitioners worked with the assumption that they always did the best possible for all their patients, and he had found it was not so. That is a terrible indictment and I am afraid it is true. It is also a reminder that we doctors are, like our patients, frail human beings. Can we not go forward giving each other all the help we can?

Paper read at the Sixth International Balint Conference at Montreux, 1984.

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The Sixth International Balint Conference in Montreux, 1984

The Sixth International Balint Conference was held at Montreux on the 11th. to 13th. October, 1984.

The main themes of the conference were the 'Development and Change in Doctors during Balint-Group Training', and 'Current Research and Research in the Future.'

There was a good attendance of some two hundred people, doctors and others interested in such work.

In the opening session, Dr. Trenkel (Switzerland) gave an excellent paper concerning the 'Small but significant change in the doctor's personality . . .' He described the ideal change as a move towards honesty, simple perception and communication.

This has links with childhood thought, retreating from science and method, and the limitation of verbal communication. If the doctor steps back into himself and into his own fantasies, it helps the patient to do the same.

The relationship of doctor and patient may allow many levels of work (verbal, non-verbal, somatisation of fantasies, relationship ideas, etc.) without the doctor dominating the interview with his own ideas.

There were many interesting ideas in this paper, which must have been as difficult to translate in the lecture-room as it is for me to describe now from my jottings. I look forward to the opportunity of reading it.

On the second day, devoted to reasearch now and in the future, Enid Balint-Edmonds (Great Britain) described the current ideas here since the 'flash'-group. The flash involved overt sharing of the change that occurred in the doctor/patient relationship, but we have been looking at the interview in general practice and trying to define other, perhaps more common moments of change in the relationship which are not necessarily shared, but which allow doctor and patient to re-tune to one another.

Enid described a case-history where a doctor suddenly saw an annoying old lady as pathetic and sad. He was able to stand back from this feeling without verbalising it, or allowing the new feeling about her to dominate.

The process of identification between doctor and patient involved a desire to understand, together with constant re-tuning, rather than an ability to sympathise. I am looking forward to reading this paper in our Journal. (See page 3).

Dr. Berton (France) described the difficulties that Michael and Enid had in their choice of a model for research into general practice. The attempt to medicalise the psychoanalytic model produced such ideas as, 'overall diagnosis', 'doctor as drug', 'apostolic function', 'focal problems', and so on.

He spoke also about the difficulties of the gulf between the open-ended psychoanalytic process and a selected piece of focal therapy which could be assessed. Like Enid and Dr. Trenkel, Dr. Berton also seemed to be reaching for new understandings of the processes in general practice. (In Dr. Trenkel's absence, his paper was read by Dr. Gelly).

Dr. Doktor (Holland) took a more practical view of problems concerning what sort of doctors wish to join a Balint-group, and what changes could be observed in those who stayed the course, and in those who dropped out.

On the last day, under the title of 'The Place of Balint-Work in Medicine', Dr. Sapir reminded us of various other polarities in our work. The illness is not to be ignored in its effect on the patient, who sees the doctor as someone who can relate to his illness; while the doctor sees himself (if at all) in quite a different light, and reacts to the patient from his own inner tensions.

Michael Courtenay (Great Britain) gave a paper describing the developments in Britain concerning training and research. As this excellent paper will be published in our Journal, I will not discuss it here (page 8).

Dr. Stanley Levenstein (South Africa) described the situation, and the history of the development of Balint-groups in South Africa.

There were two demonstration-groups; one French, led by Dr. Guyotat, and the other, German, led by Dr. Stucke. The very difficult conditions of a demonstration-group made these less than perfect but they both followed traditional lines.

The closing session started with a talk on student-training, by Professor Luban-Plozza (Switzerland), and then proceeded to a general discussion which seemed to fragment into detail and strands of thought. Perhaps that is as it should be.

The form of the conference was excellent, with brief discussions after the papers in the large group (never very coherent because of the tension in such a meeting), followed by small-group meetings in the different languages, which were free to do as they wished. The English-speaking group worked well.

There were also round-table discussions in the main hall, which is a rather better form of discussion than a free-for-all.

The conference seemed to go well, with most of the delegates very much on the same wave-length. However, the sad note is that the Dutch now feel that they have 'moved on' from Balint-groups, and are withdrawing from the Federation. I attended their demonstration meeting where we were invited to draw our relationship with a difficult patient in pictures. I found this an interesting way of gathering my feelings about the case, and the subsequent discussion was quite helpful, but not, I think, as helpful as a real group discussion would have been.

At the end of the conference, Dr. Pierre Bernachon (France) resigned as President of the International Federation, and we thanked him warmly for his excellent work over the years. Dr. Jacques Dufey (Switzerland) is the new President.

CYRIL GILL

'Six Minutes . . .'*

by Stanley Levenstein
General Practitioner, Capetown, South Africa

I was not going to attempt this essay. I found the topic depressing, and it was only after trying to understand why this was so that I felt inclined to put pen to paper.

What then, do I think, was my depression about? To begin with, I was beset with my huge sense of anti-climax which gradually set in after reading 'Six Minutes . . .'[1] about 10 years ago. I firmly believed that I was going to flash all (or nearly all) my patients to salvation from all their problems and miseries, but my subsequent experience was to be very different.

At first, I denied my sense of failure, then I became angry — angry with the book and its authors, angry with my patients, angry with the 'system' (after all this is 1984!) and, although I did not recognise it, angry with myself. My feelings of guilt and inadequacy, which I also did not recognise, came to be experienced as a kind of apathy ('there's not much one can do, so there's no point in trying *too* hard'). I thought I had resolved most of these negative and inappropriate feelings until I realised how I felt about writing on this subject.

Perhaps deep down I still feel a bit let down by those intrepid pioneers who co-authorised *Six Minutes for the Patient*. My thoughts go back to a paper delivered at the 1978 International Balint Congress entitled 'What ever happened to the flash?'[3] I also remember my sense of eager anticipation at the prospect of a 'flashback' group at the same congress, only to find that the session turned out to be no more than just that. Now six years after that congress, I am still waiting for some new breakthrough, some new guidance which will re-kindle my apostolic zeal.

It is the word 'guidance' which betrays me. What I have always wanted, and still want, is for some guru-like figure(s) to 'show me the way'. Yes, it is the 'perpetuation of the teacher-pupil relationship' with me as pupil, plain and unadulterated! I have always fought this phenomenon tooth and nail, but perhaps I protested too much. Behind it all was a belief, a conviction, that the psychoanalysts really *do* know all there is to know and that they can teach us how to do it. This belief, in spite of the Balints'[3] sincere protestations to the contrary, caused me to *expect* them to show me what to do.

It also caused me to expect my patients to get better, because I believed, equally erroneously, that psychoanalysts always cured their patients. Thus, all goodness was projected on to psychoanalysts and psychotherapists. It was only after a later phase of projecting all *badness* on to them that I was able to develop a realistic attitude of genuine, non-idealised, respect for them. The problem of *time* in relation to consultations with a general practitioner is usually discussed mainly in terms of the doctor's *workload*. In my view it is not sufficiently recognised that the general practitioner's real point of reference for his comparison is the amount of time the psychoanalyst spends with his patients! This comparison, however inappropriate, gives rise to feelings of helplessness and inadequacy 'I'm only a G.P.'

What has helped me see things in clearer perspective is the realisation that even if *I* sometimes forget that I am a general practitioner, and not a psychoanalyst, my patients never do! If they wanted therapy they would ask for a therapist, and occasionally they do. What exactly they *do* want from me is often unclear to one or both of us, but I see it as my task to get as close as possible to finding out. What I can do about it, if I do find out, in six, sixteen or even sixty minutes, if that were routinely possible, will always be an extremely difficult question to answer and implement.

Why so difficult? To a large extent because, and here I am not being angry or paranoid towards my patients, many or most patients do not want to get better in the way we may consider desirable. They do not want their defences tampered with, or to have too many of their inner difficulties exposed. Perhaps the operative words are 'too many' — it is a matter of allowing the patient to give us a little bit and then trying to give a little bit ourselves. I am still trying to learn to be as satisfied with this situation as I think many of my patients are.

Here are a few of my recent little bits:

1) Mr N (45), complained of feeling very tired 'for no reason'. Everything at home was fine and he didn't want a

*Balint Society Prize Essay, 1984.

certificate for work. His current form of employment was as a supervisor where he was doing 'two people's work'. In spite of the demands of his job he never complained and always tried to please his superiors. 'I even have bad dreams about my work', he said. In these dreams he was always doing something wrong there.

A short discussion followed, in which he told me that he had not seen his father till he was seven years old, because he was away in the second world war. He said sadly that his father did not regard him as a son, and was not warm towards him. I said 'and you tried hard to be a good son to him?' He nodded. I said 'and you're doing the same thing now at work'. A silence. A raised eyebrow. Then, 'maybe!'

2) Mrs G, who always smiles a lot, brought her 5-year-old son to see me, saying that he was hyper-active and she had difficulty controlling him. She denied that there were any domestic tensions that the child may be reacting to, but agreed to come to see me the next day on her own.

   On this occasion, the smiles vanished and she wept openly. She complained bitterly about her husband who was no help at all in the house, and said it was 'like father, like son'.

   She then told me about her unhappy childhood as a result of her alcoholic father who used to maltreat her mother terribly. When I asked what her mother did about it, she replied 'nothing'. I said 'seems like it's like mother, like daughter too'.

   At her next visit we discussed her fear of her own violence. She told me that as a child she had chased her brother around the house with knives, and that she had felt like choking both her sons when they were babies. She also often felt like attacking her husband. We spoke about her difficulty distinguishing between actions and fantasies and about her guilt about her aggressive feelings. She recognised that her fear of destroying people was effectively paralysing her, and depriving her children (and her husband!) of much-needed limit-setting.

3) It is not often that I can report a flash with a 3-year-old: Mrs C came in with Alan (3) who, she said, had a cold. She then proceeded to ask me about the feeding of her new-born baby who had a low birth-weight and was not sucking properly. At this point, Alan began making peculiar sounds and movements with his mouth. His mother turned to him and said, 'What's that?' After a pause, I said 'We are talking about breast-feeding'. At this mother smiled, half-amused, half-enlightened, but I shall never forget Alan's re-action: he gazed at me intently with a look of wondrous amazement for about thirty seconds. It was an extraordinary experience for both of us.

4) A flash of a negative-kind occurred with Mr V. He is one of Aaron Lask's archetypal 'hands off my asthma' asthmatics.[6] Repeated attempts to engage him therapeutically had failed, even on the purely physical level, and seemed to have aroused some resentment in him.

   On this occasion he came in wheezing very badly but said he didn't want any medication and almost refused to receive an injection of aminophyllin. He only wanted a sick certificate for two days, he said. This time, instead of my customary 'I'd like to see you again . . .', I said 'When would you like to see me again?' He smiled and said 'We'll see what happens'. We both laughed.

This last case illustrates my problem well, i.e. even if we flash like a discotheque, what are we *doing* for our patients? Will Mr N exhaust himself less trying to please his bosses. Was his 'maybe' yet another attempt to please an authority figure? and will Mrs G learn to be more assertive? She certainly agreed when I said 'It's easier said than done'. Still, the fact is that some patients do learn to cope with life better, and I am sure that at least in some cases the general practitioner's interventions must have had something to do with it.

I think that a good deal often depends on the timing of a therapeutic approach, i.e. there seem to be certain times when patients are more amenable to change. One such time, in my opinion, is the neo-natal period. So often marital and sexual problems appear to date from this time and later become much more refractory to treatment. Often these women present frequently to their doctors with (through) their babies, and usually can be worked with then, even if not always very successfully. A recent example may be worth reporting, though I hasten to

add that it represents a 'difficult case' and not one of the more easily treatable ones:

5) Joy, (17) came to see me with her mother, to whom she is very close, requesting a pregnancy test, which was positive. Mother was upset and angry saying 'I've got nothing against your having sex, I told you, but I told you to use contraceptives'. Joy, however, was overjoyed, saying that she and Michael were madly in love and would soon marry, which they did with mother's and (alcoholic) father's approval. Mother very quickly decided that the pregnancy was not such a bad thing after all.

Soon after the baby's birth, Joy presented a baby she was not coping with. Her tears were mixed with anger at a husband who, she said, was not supporting her. Next day I saw the husband who, if anything, was more depressed than she was, and complained that his wife was being very nasty to him. His own father had died a year previously and he was very close to his mother who pampered him. After brief discussion, he appeared to realise that his wife's 'nastiness' was due more to her emotional difficulties, related to her feelings of inadequacy as a mother, than to a rejection of him *per se*. It was later possible to convey the same awareness to his wife. Two weeks later, she came in smiling and said 'everything's fine, thanks to you!'

Unfortunately, the story does not end there. A few weeks later she brought her baby in again and said he was quite restless, was not sleeping very well, etc. Physical examination was completely negative and I asked if she thought he might be reacting to any tensions at home. She then launched into a tirade against her husband, saying that he was drinking excessively, and criticising her constantly, comparing her unfavourably with his own mother. She said she felt much more relaxed in her own mother's home and was thinking of staying there during the week and going back to her husband at the weekends. She also said she wanted to go to cinemas and have fun while her husband wanted to stay at home all the time.

I pointed out that it seemed very hard for her to have to assume the roles of wife and mother at an age where she would like to be free and enjoying herself. Also, that it appeared that she and her husband expected from each other what they felt they were getting from their mothers, and they were turning increasingly to their mothers for support instead of to each other.

Of course this woman was also turning to her general practitioner. In fact, at our last meeting, she said, 'I talk more to you than to my mother. She just tells me to stop worrying'. Will this help her and/or her baby and/or her marriage? Only time will tell, and even then one will not know what part other, unknown factors have played in determining the outcome. Nevertheless, I feel I can reasonably claim that things would probably have been much worse, at least for her and her baby, had it not been for my efforts.

There are other life-situations where I feel the general practitioner is well-placed to make favourable therapeutic interventions. One of these is bereavement, where I believe the doctor can reduce the incidence of mental and physical illness at such times. And it is not only bereaved people who have a greater risk and incidence of physical illness. General practitioners can give over-conscientious workers 'permission' to work less hard in certain cases, thus rendering it unnecessary for them to find an 'illness solution'. To me the whole area of stress-related illness is one of the most interesting and promising fields of enquiry in general practice. I do not think we have begun to explore its potentialities fully. It is remarkable that patients seem to have less difficulty than doctors accepting that mother's going to work and being separated from baby may have 'lowered his resistance' to infection and that it may be more than co-incidence that little Johnny developed an ear infection a few days after father was called away for military service. It seems to me to be a worthwhile apostolic function to pursue these aspects with patients, which can give them a justifiable sense of having greater control over their own health.

It will be seen that from a rather sombre start, I have reached the very ambitious position of claiming to be able to influence my patients' attitude to health and illness to the point of materially improving their physical and mental well-being. I will readily admit that I am still a long way from achieving this goal to anything like the extent I would like.

What is still missing? Greater sensitivity, perceptiveness, empathy and self-understanding? Undoubtedly. Technique? In *Six Minutes for the Patient,* Philip Hopkins writes: 'The question is: Is there any technique? Can we devise a technique that would be helpful to get one more step further, and

the next step will be done in two months time, or two weeks, when the patient turns up again'.[2]

To my mind, that question is still as relevant as it was when it was posed a decade ago. The great pianist Artur Rubinstein once said that the trouble with Mozart was that it was too easy for beginners to play and too difficult for grown-ups! Much the same could be said of general practice. To develop a relationship that is accepting but not collusive, to 'tune-in' but not be intrusive, to judge to a nicety the optimal use of one's insights and one's self — this is the job description of a saint!

Speaking of saints makes me think of a teacher-pupil relationship of a different kind, i.e. my admiration for the powers of the medicine-man of old, or shaman. It is postulated that they work by making direct contact with the patient's unconscious thereby circumventing the patient's defences, which remain intact. Is there someone who will help us to learn more about this, or are things already too complicated as it is?

Complicated, certainly, and difficult. But this makes our work the more stimulating, challenging, and, at least at times, rewarding. It could be that the sterling work done by the early Balint-groups and the 'Six Minutes' doctors took the Balint movement as far as it was ready to go for many years, in the same way as we sometimes take our patients as far, or further than they are, or possibly ever will be, ready to go. It is easy for me to blame the Balint movement for not going further than it has but how much further have I, with all my Balint training been ready to go? At times I have been amazed at what doctors in Balint-groups have failed to notice about patients or general practitioners.

It is only recently that I have realised that it is not so much what they cannot see as what they do not *want* to see! Here certain people will argue that this highlights the need for doctors to find out more about themselves, either by a different kind of Balint training, or by personal therapy or analysis. But the fact is that even if this argument were to be accepted as being valid, even fewer doctors than the handful who are willing to work in Balint-groups, would agree to it.

This immmediately brings to mind our long-standing grievance against the medical schools for over-emphasising the organic aspects of medical training at the expense of whole-patient care. It should be remembered that while our complaints are fully justified, it remains true that the medical schools reflect the prejudices and reactionary attitudes of the societies of which they are a part, and are to some extent the *result* of the public's approach to health care rather than the cause of it.

Thus, we arrive at a need for a fundamental change in society before we can hope to see a fundamental change in patient-care. John Berger reaches the same conclusion in his excellent book *A Fortunate Man — the story of a country doctor* when he says, '. . . our present society wastes, and by the slow draining process of enforced hypocrisy, empties most of the lives which it does not destroy . . .' I know that as a general practitioner, a mere individual, I cannot effect radical changes in the nature of society, and that my task is to treat individual patients and their families.

However, society is composed of individuals, and one individual can influence others who can influence others . . . But the process tends to be slow, just as change in patients tends to be slow, and maybe we Balint doctors need to accept that we are ahead of our times and concentrate on consolidating and disseminating what we have learned at least as much as on trying to become more 'space-age' in our knowledge and insights. This is not intended as an excuse for complacency nor as a dampener on the spirit of scientific enquiry, but it is a plea for us not to lose sight of our social-educational goals while we are searching for newer and deeper understandings.

So maybe I have several future roles as a 'Six-minute' doctor — as healer, as researcher, and as a force for progress and enlightenment in an increasingly alienating and de-humanising society. Quite an undertaking for someone who is only a general practitioner!

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"A Candle for St. Agnes"*

by Oliver W. Samuel

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When Mr and Mrs Brown moved into the bungalow in the next street and came to register as patients, they looked just an ordinary middle-aged couple. They were in their mid-forties, although she looked rather older. Her hair was sharply home-permed in a severely practical style and she wore an intermediate tweed skirt and a high-necked blouse with long sleeves which, it later emerged, concealed the cross-hatched scars of several suicide attempts. Mr Brown was a local government officer and had recently changed jobs to an executive post at the town hall. Mrs Brown suffered from period troubles and, it soon emerged, was a depressed, obsessional and anxious person.

At the time I had been in single-handed general practice for three years and had been attending a Balint-group at the Tavistock Clinic for almost two years. These seminars were advertised as designed for the study of psychological problems in general practice and were led by a psychoanalyst working at the Clinic. I had gone there to try to learn how to cope with those of my patients who seemed to want to come to see me but for whom I found my previous training and experience unhelpful.

In our group we were encouraged to take on patients for regular hour-long interviews to explore their problems in depth and in so doing to try to learn some practical psychotherapeutic skills. At the meetings we would report on the progress of our cases and enjoy the advice and support of other group members and of the group leader as we struggled with out patients' distress and our own feelings of inadequacy.

When Mrs Brown started coming to see me, I had several 'long-interview' patients attending, but it never seemed to be in any way appropriate to offer her a protracted consultation. She seemed to be much too disturbed for such an approach and, in truth, I felt frightened for her.

The first crisis came about six months after they moved in. I was called to the house as Mrs Brown felt unable to leave it. Her obsessional rituals with the taps and light switches had rapidly increased so that she could only just make it to the corner shop before she had to scurry home. She was actively hallucinating the scolding voice of her harridan mother and felt that she was being driven to seek appropriate punishment and might well try to kill herself. All this had cascaded out once I asked her worried husband to allow me to see her alone. Compulsory admission to hospital was arranged at once and she was given a course of electro-convulsive therapy and drugs.

When she was better she came to the surgery and thanked me for asking her husband to leave the room. 'He must never know about the voices, they would frighten him.' I suggested that she should come and see me when she needed, implying that I, at least, was not frightened to hear about the voices. This was the start of our work together, for ever since that important accepting interview, Mrs Brown has come to see me whenever she has wanted to tell me about her feelings. She never stays longer than ten minutes and often it is for much less than that. My role has almost always been passive and accepting of whatever she tells me, although she has been prescribed tranquillisers and antidepressant drugs as well and, occasionally, I try to show her that I can understand how she is feeling.

I learned that she was the youngest of three children and that her parents had really wanted another boy. She had married late, a couple of years after her mother had died. Children were out of the question, despite her devoted Catholicism, but I never learned precisely how she avoided this issue. At first she came to see me once a fortnight and often protested how overwhelmingly grateful she was for my treatment, much to my puzzlement for usually I remained silent throughout.

She also spent much time in the Church, lighting candles and praying to the appropriate saints. The local priest clearly took a great deal of her burden, for when he suffered ill-health I noticed that Mrs Brown came more often to the Surgery. Yet, clearly, our roles were different for there were some matters that she told me about that she did not tell the priest. For example her husband needed her to help act out some sexual fetishism and although she was very willing it evoked a cascade of scolding from her mother's voice.

I tentatively suggested that this might perhaps be because she had dared to allow herself to enjoy

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*Balint Society Prize Essay, 1984.

being married and noted that she did not reject the idea that she needed her voices to make her feel bad and guilty about such feelings. By acknowledging how guilty she needed to feel but not rejecting anything she ever told me, she gradually seemed to grow able to tolerate and be aware of some of her own emotional reactions and to cope with some of the irrational feelings. Although the Church offered her absolution after appropriate penances and both drugs and medical acceptance were constantly available, neither lasted long enough as we moved on to the next crisis.

Over the next years she experienced the menopause and, after much distress, grew to accept being childless. Her husband had seemed to be a rather shadowy figure, but he now had some medical problems of his own. He developed a duodenal ulcer and had an operation. He became very concerned about their financial situation, in view of his impending retirement and inadequate pension arrangements. Money obsessed his thoughts and Mrs Brown shared his fears. The brief interviews with her continued, although their content has changed greatly over the years.

The focus has moved away from the psychotic paranoid hallucinations, through a severe depression that followed the menopause to a situation in which she was now far more concerned with caring for and coping with her husband and his problems than her own. She used great patience and toleration with him and then came and used time at the Surgery to regurgitate at me some of the feelings of irritation and despair he gave her. She still feels that she has to protect him from learning how awful her feelings are, but has learned to use my help in containing them. In recent years too, her sense of humour has occasionally emerged so that she can even joke about the ridiculous way she manages her emotional confusion.

What then of the doctoring? At first, she became dangerously ill and had to be sent compulsorily to hospital; a most inauspicious start to a therapeutic doctor/patient relationship. Then, when she came home she was felt to be too difficult to treat by the raw and tentatively developing psychotherapeutic skills of an enthusiastic but inexperienced young practitioner. However her need to be accepted for herself somehow struck a chord and so brief interviews, whenever she wanted them, became the accepted mode of treatment. Although she frightened me, I was trapped by her gratitude into going on seeing her without any hope of curing her. Having lost some of my excessive therapeutic optimism, I learned to accept whatever she wanted to tell me and that she would use the Church, the priest, her husband or me to help her as she felt best.

I came off the mountain and learned some therapeutic humility from her and was rewarded over the years by learning to respect her resilience and appreciate her steady achievements. Although at first I dreaded seeing her notes on my desk, I see her now as a welcome friend in the morning surgery. She has reduced the frequency of her visits now that she has matured into being able to take a motherly interest in coping with her ageing husband. She still comes in every three or four months for a five minute chat and to collect a prescription. She still takes her tranquillisers, manipulating the dose in accordance with her needs, as we have agreed that she should do. Although she still seems to be a rather dowdy person she is much more alive and active. The Church takes much of her attention as does the Women's Institute and they both make a useful break from the task of coping with her ailing spouse.

Being a family doctor is a very privileged role which allows one to know and work with some patients over very many years. With Mrs Brown I had to establish a *modus vivendi* in our relationship so that she could be coped with within the practice. The patient had to feel tolerated and accepted whenever she chose to come and almost regardless of what awful tale of distress she had to relate. I suffered with her as she shared part of her terrors and fears with me. I granted no absolution, just as my ecclesiastical co-therapist offered no cure.

With time, things changed and in retrospect I think of our relationship as having three phases. At first I felt terrified of what madness she would tell me next; of her guilt, of her obsessions and of the voices that haunted her. After a time we moved into a long, fairly unproductive but not too worrying phase. She learned with me that her dread that the house would subside (it did), that the gas would leak, that her husband would lose his job and all the other panics were manifestations of her basic insecurity and were made more frightening by her depressed mood. I learned to stay silent and tolerate five minutes of catharsis and to give her some pills that would tide her over till she came again. In the last five years however, we have moved on to accept that her concerns are largely focussed on her husband, whom she mothers effectively as he becomes infirm, despite her own anxieties. The phobias are almost gone (except for train journeys) and she only rearely hears the voices. She now plays a sociable role in the community and in the Church, and attends the Surgery much less often. I feel that she has at last grown up and is far less dependant on me. Indeed it is her husband who now relies on her for support and reassurance and on me for medical management.

What has been achieved in all those brief consultations over such a long time? No flashes of instant insight have illuminated the path. Such understanding as has been achieved has been won by steady attrition rather than inspiration. The focus of all our meetings has been firmly anchored in the

present situation in which she found herself, so there are large areas of Mrs Brown's life about which I still know absolutely nothing; her childhood, the relationship she had with her father, whether she was ever happy at home and many other relevant matters. Having eschewed the role of psychotherapist, I also avoided being a detective and allowed my patient to tell me what she wanted me to know, rather than search to satisfy my curiosity.

After many years, my patient has now come through a desperately unhappy time to the calmer waters of maturity. She owes this achievement largely to her own inner resilience, aided by her marriage and the episodic support both of her priest and her doctor, whose assistance has flickered briefly but usefully whenever she has called either of us to help; and of course she also still lights an occasional candle to St. Agnes. Mrs Brown needed an intimate but limited, controlled and tolerable relationship with her physician so the unspoken contract for 'subtherapeutic' doctoring began and has continued for more than twenty years. During this time she has grown through major life crises without breaking down and has matured at last into an ordinary member of the community while I have grown less ambitious but much more skilled in helping her.

As general practitioners we see many patients each day, so the model of hour-long interviews used in formal psychotherapy has a very limited place in our normal working. Balint-training, though firmly based in psychotherapy, translates well into the limited times available for interviews within general practice. The case reported in this paper shows one way that very brief encounters were used over a long time to help a very sick patient. The lessons learned in the course of participating in a Balint-group profoundly influenced the doctor's approach and enabled him to develop a new dimension of tolerance for the patient and her problems.

Although at first the aim of Balint-training was to teach psychotherapy to family doctors, this objective changed in the early years to a much broader one. It is to develop appropriate skills to enable general practitioners to treat an extended range of patients needing help. The 'limited but definite change of personality' described by Michael Balint that occurs as a result of training may involve a lower of defences that might otherwise lead the doctor to reject involvement with certain patients. It seems likely that a Balint-trained doctor will perceive and respond to his patients in a way that is profoundly affected by the training, for the group-discussion of only specially selected patients resonates in the doctor's management of all his cases. Even patients seen for minor ailments have the possibility of being listened to and offered some extra understanding that might not have been otherwise there.

It is not the length of the interview that seems important, nor even the length of the relationship between the doctor and patient. It is the ability and skill of the doctor to be able to feel which of the patients needs special help and understanding and to create the right atmosphere in which an effective relationship can develop between him and his patient. This can be within the context of an interview that last either six minutes or sixty, for time is far less important than emotional temperature and making available the skills of perception and empathy. The general practice setting brings a wide range of potential patients to the doctor. Balint-training extends a general practitioner's therapeutic potential and allows him to risk trying to help people who otherwise might not be reached.

What then happened with the case reported in this paper? At first my patient's needs were desperate and she seemed far too ill to risk being offered unskilled psychotherapy while the hospital service could only offer in-patient care or monthly out-patient attendances. My membership of a Balint-group had had a valuable effect however. I learned to tolerate depression and anger and was able to cope with the idea that even mad patients needed to be accepted and listened to. The apostlic zeal with which I had tried to convert my patients into a preconceived mode of how patients ought to respond to the doctor had been powerfully modified by the group experience and my tolerance of how different patients might need to use my skills in unexpected ways had been considerably widened. Having acknowledged that Mrs Brown was too difficult for psychotherapy, I felt relieved of the burden of having to try to cure her. I felt able to work, not as a psychiatrist manqué, but as a family doctor, who sees patients for brief interviews whenever they choose to come to the Surgery, aiming to befriend and understand, rather than to solve them. In this paper I have tried to show how, in this case, it seemed to help.

Some Thoughts about the Relationship between Psychoanalysis and General Practice*

by John Denford

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When I first thought about the title of this lecture, I was confused by the many different directions a discussion might follow. I could have explored the consequences of our both working in such long-term relationships with patients, and how everything a general practitioner does however physical a medical act, is ultimately a communication within a relationship, neglect of which will so often interfere with or nullify completely the doctor's intention.

I also thought that the interface between our two disciplines represents the traditional and largely illusory boundary between mind and body in medicine as in philosophy. I thought of general practice and psychoanalysis as being like two medical media of life, like the sea and the land, and I had a number of interesting thoughts about standing on the seashore and feeling the mystery that is in the one for someone in the other, and of the connection — that psychoanalysis is a development of some major elements of general practice — rather as land life has developed out of sea life and still has the traces of that earlier life in its structures. And so on.

The subject I was given is a very large one, and I can hope to cover only a very small part of it in an hour or so. Because I was a general practitioner myself for a couple of years before I became a psychoanalyst, it is a subject with personal meanings for me. It sets me thinking about why I did things, and myself then and now. Inevitably, what follows reflects some of the things I believe psychoanalysis has done for the general practitioner in me, for which I am grateful.

General practice is one of a number of working situations in medicine where one has to hold considerable direct responsibility alone. Like the psychoanalyst, the general practitioner is on his own in clinical situations in ways that occur much less often in hospitals, and often for relatively long periods of time. He is in direct touch with matters of life and death for individuals like himself, matters that are peculiarly powerful in evoking uncertainty and fear in everyone. The general practitioner is the one who must take responsibility and contain such feelings by the use of his knowledge and emotional steadiness. Because he is relatively isolated there is a danger of loneliness as well, and consequent distortions of his behaviour which will lessen his effectiveness.

Some ability to be alone is necessary to do all work, indeed to live normally as an adult. The need increases the more responsibility one is obliged to accept and the longer one must hold it. D. W. Winnicott[1] taught that this capacity depends on a sufficient early experience of 'good enough' parental care for their presences, particularly that of mother, to have been so incorporated in the individual's mental structures that they have become secure parts of his self. Winnicott asserted that an ability to be alone depends on the presence of those significant others but in a mental way, so that psychologically the individual who has developed adequately in this respect has a sense of inner accompaniment. He can be alone in a social way because psychologically he is never alone.

Winnicott's conclusion is that an ability to function as an independent human being depends on the successful internalisation of reasonable first relationships. For any mature individual there have been numerous relationships after the early ones with parents, that modify, sustain and reinforce them. If subsequent ones are sufficiently negative they may damage what was originally a reasonable confidence and integrity. The original capacity obviously has a major part in determining whether the individual can use all later relationships positively.

In this matter of spending much of one's professional working time alone with patients, the general practitioner and the psychonanalyst have much in common. Each has to depend mostly on his own personal resources to supply whatever needs the patient has, for considerable periods of time. Each has to face the patient and cope with him alone. This sort of responsibility can be lessened by various aids. The doctor can turn to his instruments, call for tests, ask for advice, look up his books, and temporise in various ways. Similar mechanisms exist in psychoanalysis. The analyst can write up his sessions, think about them, discuss them with colleagues. But for each there is a considerable amount of patient need that must be supplied on the spot whether the needs are psychologically or physically urgent. Except in the most extreme emergencies (which can also occur in psychoanalysis) physical urgencies are always compounded with the psychological one.

Both analyst and general practitioner are required to supply needs entirely from their own resources, needs that are psychological in nature,

*Paper presented at a meeting of the Balint Society on 10 May 1983.

whether in the form of direct responses to the patient communications, or both directly and indirectly in the way the doctor meets physical needs. All this is to say what an essential item in the general practitioner's and psychoanalyst's professional equipment is his personality, its integration, flexibility, inventiveness, imaginativeness, sensitivity, and so on.

Psychoanalysts have developed the concept of transference. This is the understanding that whenever anyone makes a relationship with another person, elements in his feelings and perceptions that were first learned in his earliest relationships are activated. The process is unconscious. Psychoanalysts use the concept to understand the distortions of perception and feeling that occur in all relationships, but are particularly marked in neurotic and psychotic people. In ordinary people the same kind of influences occur though the distortions are not usually sufficiently extreme to attract attention. Transference implies that no one can make a significant relationship with another person without bringing to life the events of his former personal relationships, right back to the first and most fateful ones.

Psychoanalysts would understand that this is indeed a work of unconscious re-creation in that the formation of a new link in the outside world allows also the re-creation there of elements of the first significant links with others that then match the inner psychological presences which we carry about with us permanently. The ideas and feelings that are projected onto the other person and re-experienced in the course of the relating are re-embodiments of the original. It seems obvious that in this way the making of a relationship with a real present other person is going to reinforce strongly the sense of already existing inner held or remembered elements of presences, to amplify their convincingness by providing external representations of them, and by proving the person's ability to recreate them virtually at will given the opportunity. The development of a significant relationship between doctor and patient, and psychoanalyst and patient can be expected to reinforce strongly the integration and cohesion of the former's state of mind in each case, and since as I have said that of mind is an essential tool in his effective functioning, to support strongly his work and efficiency.

But then, if the doctor is to use his patient in a human way to help him with his being alone and so become more useful to him, what is the nature of the relationship the doctor should have with his patient? Psychoanalysts talk confidently of 'making a relationship with a patient' because they have the nature and limits of this very clearly defined. Like general practitioners, they meet their patients frequently and over long periods, but in interviews whose timing and location are clearly defined and consistently kept. They keep the circumstances as stable as possible, do not touch the patient, communicate with him as far as possible only in words, avoid giving advice, avoid seeing him elsewhere or having social connections with him, try to limit the amount of personal information about themselves available to a patient, avoid communications that would have a personal or ordinary social significance, confine their discussions to the patient's material keeping themselves out of it, etc. They adhere to a very clearly defined professional role, so it is not difficult to see where the professional line is being drawn.

In contrast, the doctor is required to draw the line between professional and social over a far more complex, uncontrollable and unpredictable set of circumstances. He has the same intentions as the psychoanalyst, to preserve his professional distance even though he comes into intimate physical and mental contact with the patient. The nature of the intimacy is determined by the intentions of each party, each has a mental set that results in the communication of certain signals and precludes others. The patient communicates a clinical need which in itself has a restricted and restrictive effect; by its being clinical it excludes by implication communication for other purposes, and it has the effect of restricting the responses of the doctor to clinical ones. In turn *his* responses being clinical communicate an equivalent set of ideas to the patient and reinforce his set. By these means an alliance is created to which both parties contribute and in which each focuses on a restricted set of preoccupations and of which all events within the exchange are preceived and integrated in a particular way, are all referred to that mutually agreed idea.

Medical practice makes great use of this phenomenon. It enables doctors to sustain calm objective attention and to act coolly and with precision in circumstances that would be seriously disruptive of attention and emotional control in ordinary social observers. It allows patients themselves to borrow calmness and strength from the doctor's presence. Doctors can pursue with a serious and unquestioned clinical intention enquiries which would be considered offensive or intolerable in ordinary social circumstances. Doctors and patients can sustain themselves calmly and innocently in activities which would be experienced as highly emotionally charged, embarrassing, shameful or compromising in other circumstances.

Psychoanalysts are in no doubt about these uses and advantages, but they say there are also dangers, and think of these in the light of their conviction that there are unconscious mental events as well as conscious intended ones and that a situation can be held outside awareness and yet be significant. I think that the conventional alliance I have described is a mechanism to hold outside awareness all those elements in the relationship between doctor and patient that would otherwise interfere with its primary clinical purposes. The better trained and more experienced the doctor is, the further from awareness these ordinary social thoughts may be kept.

What is excluded from awareness is anything that is incompatible with the clinical set and

intention. The more at variance with that convention, the further it is removed or the more is the thought denied. But in the professional situation as in others where one person is required to take responsibility for another (as also in being a parent or in teaching), there is a need to be aware of as many elements as possible that are relevant to the situation, especially when anything is wrong.

An essential ingredient in any technical manoeuvre is control. Mental elements that are literally outside awareness are beyond intentional control. Psychoanalysts would maintain that though the professional person should set aside his ordinary social feelings and responses, he should not lose sight of them. They say he needs to recognise their presence and nature so that he can subject them to the same control in the service of his professional aim as he does with his strictly professional technical capacity.

In fact psychoanalysts have discovered that in their own work these very social and personal responses should be viewed as part of their technical equipment as well, though of a different order. by exploring the idea of counter-transference, psychoanalysts have found that not only do they have their own ordinary expected feelings but that they are subject to the same distortions, though to a less degree, as are those of their patients, and attending to them greatly augments sensitivity to, and understanding of what is occurring in the patient's mind, or is even essential to its efficiency. They use their personal responses as fine sensors of the patient's personality, in as objective a clinical way as they can achieve. There is in this idea of the clinical use of personal responses a model of objectification of oneself for professional purposes that is central to my theme.

The doctor is required to be both subjective and objective — to retain his capacities to respond as an ordinary person, but also to make himself aware of what they are so that he can begin the process of objectification that will eventually allow him to use those responses for therapeutic purposes. What children require of their parents serves as an illuminating parallel to what I have described between doctors and their patients. As children develop and mature, they acquire characteristics — physical, intellectual, social and sexual, etc., which have the same significance for their parents as they would have for any other person, and which therefore would tend to evoke appropriate reactions from those parents were their responses not countered by considerations arising from the fact that they *are* the parents and the children need a parental, not a peer response. The parent is required to perceive correctly and adequately and so value and properly respect, the particular characteristic that is appearing in the child. For example, fathers and mothers have to perceive their daughters' and sons' sexuality, have to perceive it pretty accurately and realistically if they are to convey to the child now becoming no longer a child, such messages as will help him to her to continue to mature in a socially appropriate way. Of course it is not only parents who need to do this but their responses have major consequences because of the authority and intimacy of the relationship. The same applies to the maturing of other cardinal characteristics.

It is all part of the continuing socialising process in societies whereby immature individuals become mature by absorbing the culture filtered through the medium of their families. The parent in these circumstances is required to do the same complex thing as the doctor — to be aware and sensitive and accurate, and yet to inhibit. He turns his response which would otherwise be direct and unmodified into a form that expresses his care and concern and sense of being responsible for the other, without losing a proper sense of the awareness that originally began his response. Indeed it is probably the original energy of those responses, whether of delight or pleasure or satisfaction or admiration that makes his concern and care so strong when it is redirected by his wish and need to inhibit his involuntary responses. Of course I know that such responses can become exaggerated and distorted or even perverted, but the process I am describing is a normal one and is negotiated successfully by most parents and children.

I am not only describing a process of objectification of a doctor's feelings and responses to others, but implying the need for proper recognition of and respect for subjective experiences in relation to his patients. I am saying: they are legitimate and inevitable, and potentially useful in a number of ways if their existence is acknowledged and given attention. They are useful in enhancing the doctor's technical effectiveness in his medical work with patients; in making him effective and potentially therapeutic in his interpersonal work with patients, without which he would be relatively helpless and working blindly or according to rules of thumb and not according to an accurate dynamic gauge of the patient's feelings and thoughts; but also of considerable importance in helping the development and maturing of the doctor's own personality, from which many benefits may accrue.

Personality development and maturing occurs mainly as a result of continuing meaningful interaction with others. By 'meaningful' I understand experience that is fully attended to, adequately perceived and thought about, and that is fully felt. (These elements are necessary for experiences in treatment to achieve personality changes.) I am of course describing an ideal. Virtually everyone defends himself against the full effects of experience not just in the ordinary rational way of not bending to every wind that blows, but maintaining his own position, resisting ideas that do not accord with his previous experience, etc. That is normal. It would be impossible to maintain a stable social position without doing so. But in addition virtually everyone protects himself from the effects of experience beyond what is reasonable and necessary, and does so by using mechanisms of denial, some form or other of shutting off analogues to the method of exclusion from consciousness mentioned earlier, as being used by a professional person taking a

traditional conventional attitude to the interpersonal aspects of his work.

I believe that this interpersonal world of medical work with patients is potentially a very large source of emotional experience to further the maturing of the doctor's personality, and that if he shuts himself off from its full force he is depriving himself of experience which will not only enlarge his mind but increase his effectiveness as a clinician and augment the pleasure he has in his work and in his life generally.

The traditional attitude of doctor to patient tends to be paternalistic, as with the parallel relationships between parents and children, and between teachers and students. The traditional attitude minimizes the personal significance of the interaction in an important but subtle way, diminishes it, so that there is a danger that it will be discounted either by the doctor or patient, parent or child, teacher to student. The relationship will remain static — in some sort of emotional limbo, and neither party develop as a result of it, and the possible contribution such relationship development could make to its primary and apparent purpose will be lost or lessened, or perverted when there is idealization.

The alternative which I am suggesting allows not only an increased efficiency in the interaction, but also provides the subject partner, the patient, child or student, with the possibility of a different experience that is mainly the result of being more directly in touch with the feelings and thoughts of the person in the 'applied to' established (parent, teacher, doctor) position.

These ideas lead one to think of the personal life and development of the doctor in clinical work. There is a traditional idea of the family doctor as a most significant figure, of probity, responsibility, compassion and wisdom. There is also in the tradition the expectation that these attributes should exist in such forms in the doctor that they are available to and practically useful to his patients. I think such attributes may not be so available and useful if the doctor occupies a position — the result of his attitudes to patients — which is apart, superior, emotionally aloof or reserved. If that is the case these fine characteristics in the doctor are viewed in a rather idealistic way by his patients, who will go elsewhere for the warmth they also need. Traditional views emphasize the way the good mature doctor can serve his patients, but I am also concerned with his need to serve himself as well. If the doctor does not develop emotionally, his patients will suffer.

It is important to remember what powerful forces operating in medical situations tend to push both patients and doctors toward an idealistic and unreal state of affairs in their attitudes to each other. Patients are often afraid of what is wrong and fearful that it may not be treatable. They *want* the doctor to know everything, they *want* to believe him to be infallible and omnipotent, because then they can hand over to him completely and not worry any more. In its extreme form of course this is a childish state, and its acceptance by a doctor the reflection of an equivalent survival in him. (There is also a negative version of this which makes the doctor know nothing, and is just as disruptive, though not dangerous because it is so obvious.) In lesser forms idealization is common and grades down into an element (respect for the authority of the doctor's skill) that is useful and even essential in successful transactions, but beyond a certain degree it has significant disturbing effects on the connection between doctor and patient. The patient idealizes the doctor, the doctor accepts it and is in danger of settling into assumptions about his own powers and ideas that are unquestioning and complacent on his part, and unquestioned and admiring on the patient's.

The practical and intellectual currents in a doctor's life all make contributions to his maturing identity. Obviously different aspects of his personality are apparent to the different groups of people who know him — patients, colleagues, friends, family and finally himself. The extent to which all these different elements are consistent with one another though different, the extent to which they form a coherent whole, is a measure of the extent to which the doctor has matured as an integrated personality. The extent to which others' opinions tally with one's own view and knowledge of oneself is a measure of one's realism. Too great a discrepancy between the two (some at least is inevitable), besides being a form of failure of integration, is an indication of the state of affairs in which our own views of ourselves have lost touch with how others perceive and judge us, a measure of the degree to which our ideas and actions have come to be determined by our own thoughts, are inward referring, and have become less useful in our dealings with others. The superficial sign of this is pomposity.

By pomposity I mean that state of mind that is self-satisfied, shows in unreally inflated thoughts and more or less stereotyped responses — thinking, feeling, talking and acting, and is essentially disconnected from the real world of others, and relatively impervious to influence from it. I am less concerned with its irritating social effects than with its being the outward sign of a degree of cessation of personal development in relation to work, and disappearance of liveliness and pleasure in work which is serious. It implies some sort of premature failure of thinking and feeling.

Pomposity is the social sign of a person having stopped thinking to his full capacity. It *may* be a character trait of laziness, the most economical way to be — living without new thought, thinking on the basis of worked out and finalised ideas — but may have developed as a defensive state by which the individual has come to protect himself against effort, criticism, the demands and needs of others, and anything difficult or new that will require creative thought and new solutions, because he has become afraid of these things and lost his confidence in being able to do them, or because he has lost his conviction that they are efforts worth making.

It is obvious that I could be talking about

signs of anxiety or depression or both in the doctor that would indicate his having more or less lost hope or given up in some general way. The problem is a complex one with many possible contributory factors from other areas of life besides the professional one. I am concerned here to try to define the meaning of such a disturbance primarily in relation to work. What can depression and anxiety in the doctor signify regarding his work?

Most psychological theories of causes of depressive states emphasize that the person is trying to cope with feelings about some variety of loss, either by trying to prevent himself feeling them, or on the other hand by properly grieving about it. The first way tries to maintain an unreal state of affairs, that the loss has not occurred. The second faces the reality and tries to come to terms with it by feeling its consequences. The first necessitates some degree of shutting oneself off from reality, the second is essentially a social process: one grieves with others, but denies reality in some form of isolation.

A further theory recognises that grieving (or mourning) is an essentially reparative activity; something that is felt to be lost or broken is being healed or repaired in some way, and that grieving in later life unconsciously repeats the more or less successful reparation that has taken place in respect of the inevitable losses of earlier life. Furthermore, it is assumed that the success or otherwise of those earlier grievings depended on the individual having been able to find the warmth and love and other human resources necessary for him to be able to come to terms with the disappointments and losses involved in growing up and accepting the realities of the world, in the closest relationships available to him — effectively those of his family. I have said that for the practising doctor an important part of the resources of affection and support available to him are in his patients, and it is my contention that he needs to find ways of keeping them available.

I have so far made no attempt to define the ways in which clinical work faces the doctor with experiences of loss. There are the obvious examples of patients who do not respond to treatment, or for whom all one's efforts can achieve little, and those who will die. All cause painful feelings in the doctor, all can challenge his belief in himself and his techniques and those of medicine generally. Also obvious are the disillusionments that come from working conditions that are bad, and economic factors that over-crowd surgeries and reduce the standards of practice. There are selfishness, aggressiveness, ingratitude and arrogance in some patients, and generally the sheer weight of human misery of which the working doctor sees so much. All these things exert their constant pressure, but I have an idea that they are easier to cope with because they are apparent, and so mobilise the doctor's spirit and resistance and make it easier for him to feel separate from them or defiant of them.

I think it possible that it is the less dramatic and subtler elements in his patients' lives that wear him down in his own — the slow losses of ageing — both the physical deterioration and the dissipation of relationships, and the ways that the meanings and significances of life are slowly eroded by the passage of time, by the loss of youthful energies, by repetition and monotony, and the turning of activities that were once exciting novelties into familiar routines. Life requires from all of us increasing efforts to sustain our conviction that the living of it is worthwhile.

An important antidote to these developments is to be open to the thoughts and activities, the energy and ferment of people who are in a normal alive state. For the practising doctor a major part if not the great majority of this influence will come from his patients if he will allow it, just as change and maturing continues indefinitely to be possible for teachers and parents if they can keep themselves open and responsive to the influence of their students and children.

The act of relating successfully with another has a fundamental reparative significance — for the reasons detailed earlier. For the doctor who is struggling with a sense of loss in his life, as for anyone else, the psychoanalyst has one basic recipe for relief: to repair his relationships and discover or re-discover in them the feelings and reassurance that have the opposite meaning and will act as a real counter to his depression.

Any doctor who does not stop his ears to this 'slow sad music of humanity' has to be pretty steady and tough to maintain his own position and sustain his courage in face of all the battering he is given. He can choose to be somewhat less alone in his position, better able to tolerate these if he can consistently in his own mind and in his actions and attitudes reduce his sense of being apart, allow those connections which are compatible with his professional function, 'join' his patients both practically and symbolically. I contend that a doctor who keeps himself in that position sustains an active, responsive, dynamic system in himself, and such a system is more flexible and resilient than one that has become static and rigid.

As well as being supported in his work and feelings from beyond himself, he is reinforcing and renewing that state of affairs by which his own secure personality structures were originally built up. He is also spared the unnecessary additional effort that is required to maintain a position of separation and superiority that becomes increasingly artificial with time. Instead he can devote that energy and attention to protecting himself in his continuing professional function in the different and closer circumstances to which he has trusted himself (what I am describing is an active increased trust on the doctor's part, and there will be those patients who will attempt to abuse or exploit it). To counter such influences the doctor needs to understand his patients in all the ways that Balint groups explore.

In this different way the doctor can be seen to be maintaining those relationships on real human and professional grounds, more accurately and appropriately than he would if he stayed in the traditional more distant position. It may be more difficult to do, more time consuming, but it is more

accurate, more humane, better medicine and offers the additional therapeutic possibility that the way is then open for real human influence of an integrative kind, not idealising, to occur in both directions between doctor and patient.

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Book Review

The Making of Love By Prudence Tunnadine.
1983. Jonathan Cape, London. (Pp. 222. £8.95p.)

Prudence Tunnadine, is a gynaecologist who is particularly concerned with exploring and dealing with the psychosexual problems found in women attending Family Planning Clinics, or their own doctors for contraceptive advice. She is, of course, a member of the Balint Society.

For some years, Dr Tunnadine has been the Director of Training of the nationwide Institute of Psychosexual Medicine which has provided training for over 1300 doctors, with the acknowledged help from Dr Tom Main who formed a group under the auspices of the Family Planning Association when the one started by Michael Balint came to an end.

In the first place Balint was invited to help a group of doctors to study their work in this field in order to find ways of improving their techniques for dealing with their patients' problems. Something of the remarkable success achieved as a result of nearly twenty-five years of the wonderful work that has followed, is to be found in this book.

The book has nothing to do with sexual performance, but is a study of human sexuality and its difficulties. Prudence Tunnadine reveals her great concern for her patients and their feelings as well as their physical problems. She describes a great deal of what she has learned from over twenty years of her own experience, as well as from the enormous amount drawn from the accounts of hundreds of other doctors in the training-cum-research seminars of the Institute of Psychosexual Medicine.

In Part One, *Getting Started,* we meet some of the many patients whose stories are told throughout the book. We learn of their problems, how they arose and how they were dealt with — and the results.

The infinite variety of 'fantasies', or day-dreams as Prudence calls them, and 'phantasies' which she regards as being more unconscious images, are explored, and the reader can begin to learn how to deal with them by following how they were dealt with by someone whose caring humanity and sensitivity comes through so vividly.

In Part Two, *Expressing our Needs,* we are led easily into the difficult realm of the 'language barrier', and the intimate problems associated with 'letting go'. Of course, the patients described are not only women, but because the sexual partners are invited to accompany the presenting patients, the sexual difficulties experienced by men are also described.

The wide range of psychosexual problems with all their difficulties are covered. In Part Three, *Slings and Arrows,* attention is paid to those, both young and old, whose sexual lives have been happily established, but have later gone wrong.

Many other topics apart from contraception and psychosexual problems, such as fertility and parenting are also discussed; and so also are the effects of abortion, hysterectomy and the menopause described, with appropriate clinical stories. I am happy to say that we do not read any case-histories in this delightful book.

Doctors will recognise some of the problems they see every day in their consulting rooms, and they can only benefit from such sensitive, and at times humorous, writing. Patients too may well find something about their own problems reflected from the pages as they read, and from that a beginning of a better understanding of their own disturbed feelings and conflicts about the making of love.

I wondered whether perhaps Prudence should give way to the temptation she resisted to include a simple Index in the second edition, as it would add to the usefulness of this enchanting and most readable book.

PHILIP HOPKINS

Balint-Training: Does it help the patient or does it only make the doctor feel better?*

by John Salinsky,

General Practitioner, London

In the early 1950's General Practice in Britain was in a state of depression. The National Health Service had recently started and general practitioners had lost their connection with hospitals. They had plenty of patients but few of them seemed to be seriously ill and many general practitioners were unsure what their patients really wanted from them. They had been trained and well-trained to diagnose acute appendicitis, to treat cardiac failure and to deliver a baby. They were much less sure of themselves when presented with a patient who had recurrent abdominal pain but a normal barium meal. Or a lady who was always tired but never anaemic. They found it difficult to cope with a patient who came every week with a different complaint. They found it difficult to cope with a patient who made them feel angry, and many patients did. They wanted to treat patients with proper diseases like the ones in hospital; but most of their time was spent with these others who were so frustrating.

Then along came a Hungarian psychoanalyst called Michael Balint. His father had been a family doctor and he was actually interested in what general practitioners were doing. Furthermore, he had a lot of respect for their work and in particular the way they were able to get to know their patients over a period of many years.

Balint and his wife Enid, also a psychoanalyst, started a series of seminars in London for general practitioners who were interested in psychological aspects of their patients and their problems. This led to the world famous book *The Doctor, his Patient and the Illness,*[1] in which he described the way the seminars operated and some of the conclusions they reached about the doctor/patient relationship in general practice.

What were the aims of these seminars? The first aim was to encourage the doctor to listen to the patient instead of using the traditional style of history-taking which is more like an interrogation or even an inquisition. At first this extra listening was done by making a special appointment for a long interview outside normal surgery hours. More recently Balint groups have preferred to deal with what the patient has to say in the course of an ordinary consultation. This style of working has been described in the book called 'Six Minutes for the Patient'[2]. Whatever the time available the doctor tries to see the patient as a human being rather than a collection of symptoms; he tries to become more sensitive to the patient's feelings and to hear what it is he is trying to say.

At the same time he becomes more aware of his own feelings; especially those feelings aroused in him by the patient: feelings such as sadness or anger, or feelings of identification. When he presents the patient to the group the other members of the group are also made aware of the doctor's feelings about the patient and may point out things to him that he has been unable to see himself. As a result of this process, each member of the group is able to learn something about why he always has difficulties with certain kinds of patients. Balint thought that participation in such a group for several years could lead to a change in the doctor's personality which he described as 'considerable but limited'.[1] By this I think he meant that the change was limited to his work with his patients, but 'considerable' enough to have a substantial and beneficial effect.

The group-leader's role in all this is quite a difficult one. He is not there to give a lecture, nor to tell the doctors how to treat their patients. He has to encourage them to think and feel for themselves, but to keep the focus of the group's attention on the doctor/patient relationship.

A Balint-group does not provide therapy for the doctors, although some may feel that this is what they want.

Nor is it a method of teaching family doctors how to do psychotherapy. Its purpose has more to do with the doctor's use of himself as an instrument of therapy. Balint pointed out that doctors knew all about the pharmacology of the tablets they prescribed, but they knew very little about how to prescribe a suitable dose of themselves. In other words they needed to realise that their own relationship with the patient and the patient's feelings about the doctor are tremendously important and should never be underestimated.

So much for the changes in the doctor. But what sort of changes did the pioneer Balint doctors hope for in their patients as a consequence of this intensive and time-consuming training?

First of all, it is clear that they expected that all those physical symptoms with no diagnosis: the headaches, the dizziness, the 'feeling tired all the time', the abdominal pains with normal radiology,

* A paper presented to the Icelandic College of Family Practitioners on 27 September, 1984.

would simply melt away. We have many patients like this in Britain, and I would guess that in Iceland you also have one or two. The expectation was that in response to the doctor's new abilities, these patients would reveal the psychological problems which were the root cause of all their puzzling symptoms. As a result of discussing their feelings with the doctor it was hoped that these psychological problems — perhaps a difficulty in relating to authority figures stemming from the Oedipus complex, or a psychosexual difficulty which also had its roots in infancy — might be resolved. Certainly the early students of the Balint movement talked a good deal in these psychoanalytical terms, although Balint himself did not.

It was further hoped that as a result of all this problem solving there would be a great saving of the time spent on 'Chronic Attenders' — the patients who haunt our surgeries — never 'really' ill and never getting better. It was thought that the investment of time in the long interviews would pay off, and the patients would go away — only returning if they had something unavoidable such as an acute appendix. *Finally, the drug bill would be reduced.* All those tonics, vitamins, analgesics, cough mixtures and sedatives would be unnecessary once the doctor had learned to prescribe himself.

That was the picture painted for me at a Conference on Psychological Medicine in General Practice which I attended in London in 1959. I was only a first-year medical student, but I was inspired to read the book and subsequently to join a Balint-group. After 10 years in various Balint-groups, I am now in a position to tell you how far this picture measures up to reality. I can only refer to my personal experience as there are no published papers comparing the practices of Balint-trained doctors with those of their colleagues.

Let me first consider whether it is possible to cure people of their psychosomatic symptoms. I think that this does happen, but not very often and usually in the younger patients whose symptoms are not so firmly established. A good example is a patient of mine called Frances, aged 25, who came to me with a history of perpetual tiredness, sore throats and abdominal pains for a year. She was very intelligent and attributed her symptoms to a viral infection, something like mononucleosis, which she wanted me to investigate. Instead of doing that I invited her to tell me about her personal life.

I found out that her father had died suddenly when she was 9 and as a result of his death, her mother was plunged into a depressive illness which needed treatment in hospital. Frances was cared for by a succession of aunts before returning to her mother a year later. Now she still lives with her mother, but her father is never mentioned. While at University she had a love affair with one of her lecturers — a man old enough to be her father. The affair ended when he went back to his wife, and my patient's 'virus infection' started.

After two or three discussions about all this, the 'virus infection' disappeared and has not been heard of since. Frances still finds life quite difficult, but does not like to feel too dependent on anyone. In fact, after a few months she decided that she was getting too dependent on me and was going to spend the time on skiing lessons instead. This was probably very sensible and I am going to claim her as a success.

Now, to be fair, I will record one of my failures. In my first year as a family doctor, I was asked to take on a lady called Ellen whose previous doctor had refused to go on treating her because she repeatedly called him to see her at home at times when he preferred to be at home in bed or with his family. Being young and optimistic, I saw this difficult old lady as a challenge and decided to visit her of my own free will to find out all about her. I found that she had a constant shakiness of the legs which prevented her from walking without a frame, although thorough examination had revealed no trace of Parkinson's disease or anything else for that matter. Her other leading symptom was vaginal soreness which could not be relieved by any medication.

She also told me about her childhood and about her two marriages. Her first husband had deserted her for another woman about which she still felt bitter. He subsequently developed diabetes and became blind, which she saw as a divine punishment for his wickedness. Her second husband, in contrast, was a perfect gentleman. Unfortunately he developed chronic bronchitis and she had nursed him until he died of respiratory failure.

As she told me this sad story, her limbs trembled and even her voice trembled. I felt sure that I had the key to her inexplicable symptoms. It seemed to me that I had only to explain them to her and she would get better. I was wrong. In spite of all my efforts to link her feelings with her physical disabilities, she remained unconvinced, and the shaking continued as usual. All the same she was grateful for my interest and I offered to visit her once a month. This at least had the desirable effect of preventing any of those so-called emergency visits which had finally exhausted the patience of her previous doctor.

Have I managed to save myself any time? Not really, because although she rarely calls me out at night I probably spent much more time with her during the day than her previous doctor did.

In fact my experience in general is that once I start to get interested in a patient I end up seeing more of him rather than less, unless the problem is a very simple one.

Do I save the National Health Service any money by prescribing myself instead of a tranquilliser? I probably prescribe less than I would otherwise. Again this mainly applies to the younger patients. The older people are too firmly attached to their medicines and are reluctant to give them up. They don't do much good, but they don't do much harm either.

Ironically, a large scale increase in prescribing the doctor instead of the tranquilliser would not be cost effective. Diazepam is cheap and a doctor's time is expensive. However, we could well argue that it is much better for the patient to have a

doctor who will take time to listen; even if it makes the doctor's day a little longer. Michael Balint quotes in the *Doctor, his Patient and the Illness*[1] one of his early disciples who said he would always be grateful to Balint for teaching him to listen to his patients. 'But', he added 'sometimes — at the end of a long day — I wish that you hadn't.'

To sum up, my conclusion so far seems to be that as a result of my Balint-training I spend longer with my psychologically disturbed patients but I still prescribe drugs for them and, with the exception of a few of the younger ones, they don't get better.

Is there a more effective way of dealing with emotional problems in general practice? There has been a lot of interest in Britain in the last few years in the idea of employing a counsellor or a clinical psychologist in the practice; it is argued that these people are more highly trained in psychotherapy and would be able to devote more time than the poor overworked doctor to some of these problem patients.

Some practices have started this sort of service and there have been some enthusiastic reports such as that of Brook and Temperly[4] and more recently from Ives[6]. Patients in the latter study were shown to be well satisfied with their treatment from the psychologist and in the next six months they needed fewer drugs and fewer contacts with their doctors.

On the other hand where an attempt has been made to carry out a controlled trial the results have not been encouraging. Earll and Kincey[5] reported that although their patients were highly satisfied with their treatment by a psychologist, a comparison with a control group seven months later showed no significant difference in any of the outcome measures used. Another interesting paper, this time from Australia, by two psychiatrists, Brodaty and Andrews.[3] They selected from three practices the patients who registered the highest scores in the General Health Questionnaire and other scales indicating neurotic symptoms. These patients were divided into three groups. One group had eight weekly half-hour sessions with a psychotherapist, the second had eight sessions of the same length with a general practitioner and those in the third group had nothing at all. When assessed directly after treatment and again after a year it was found that patients in all three groups had improved significantly — but there was no difference between them.

Now these studies are very fascinating, but it seems to me that something very important about the nature of family practice is missing. All the studies ignore the fact that the relationship between a family doctor and his patient is an extended one which may go on for many years. Often doctor and patient will grow old together. During the span of such a long relationship some patients will need the doctor only occasionally. Others will see quite a lot of him because of chronic problems; physical ones like arthritis or emotional ones — more likely a mixture of both. These are problems which by their nature are not easily cured.

Now we can all accept and live with a patient with a physical disorder such as multiple sclerosis or arthritis which is not going to get better. So long as our patient is a 'good' patient who says 'thank you doctor' and does not make a fuss. On the other hand, the idea of a patient with a personality which is not going to change can be intolerable for us. We feel that such a patient could easily get better and lose his psychosomatic symptoms if only he really wanted to. These are the people who dismayed Balint's original doctors. They are unlikely to be cured but they can, certainly, in my opinion, be helped. On the other hand if would be exceedingly difficult to demonstrate objectively what difference, if any, a Balint-trained doctor had made to their lives.

Can we see any way in which the patient is likely to benefit? My title suggests that the Balint-trained doctor feels happier for his training and as a result of the way he practices. Why should this be so if he is not getting many cures and he still has to see the same patients with the same complaints over and over again?

I think the answer is that he has discovered that people are more interesting than diseases. Their lives are interesting and so are their feelings. The doctor has also become a little more interested in his own feelings, especially those aroused by the patient. If a patient makes him feel angry, instead of shouting at her, he is a little more likely to say to himself: 'What's going on here? What am I getting upset about?' He may even be able to share his conclusion with the patient so that they can both understand it.

Let me remind you of my second case history — the lady I have called Ellen — who made her first doctor so angry with her panic calls that he struck her off his list of patients. You will remember that my original plan was to discover the mental processes which had resulted in her physical shaking and inability to walk. I think I must have seen her as a hysterical lady of Vienna and myself as the young Professor Freud. That was actually ten years ago when she was 69 and I was 32. Now I am 42 and she is 79. It is not surprising that she still shakes a lot and is unable to walk without a frame, and still has episodes of vaginal soreness.

During the last ten years I have visited her regularly once a month. I stay about fifteen minutes and she gives me a comfortable armchair so it is not too painful. What do we talk about? Well she generally starts off by complaining bitterly about how it is not getting any better, in fact it is getting worse. Indeed things did get worse because she began to lose her vision and is now partially blind, due to retinal degeneration which of course the ophthalmologists were unable to reverse. She was fairly bitter and angry about that, but I have learned just to listen and to share some of the frustration and bitterness. I can also see that she has a good deal of fear about ending up blind and helpless and lonely.

Now it is not so easy to be a listening doctor. One's first reaction to this sort of complaining is

acute discomfort and irritation. Why can she not shut up? It's not my fault after all, she must know by now I cannot do anything. One feels the need to stop the flow by *doing* something: prescribing a new drug, or arranging another useless referral to another specialist. Gradually I have discovered that if I just listen, after a while she relaxes and says, 'How are you doctor? How are your children getting on?' After about fifteen minutes I write her prescription and it is goodbye till the next time.

That gives an idea of the kind of work that I do, I think largely as a result of my Balint-training. Of course I do not see all my patients as often as I see Ellen — not even all my difficult patients.

Most of them come to see me, not by regular appointment, but when they feel they need me. But even with irregular contacts, or contacts only at times of crisis, it is possible to build up a relationship with a patient or a family which becomes richer as the years go by. Richer because it stores up all the experiences which doctor and patient have gone through together.

Now this kind of extended relationship has always been a feature of general practice, particularly in country districts where the doctor tends to stay around and there probably are not any other doctors for the patients to go to anyway. It tends to disappear when the patient sees a different doctor every time. In Britain the extended relationship was encouraged by the National Health Service which insisted that the patients were to register with a particular practice through which all treatment would be received and all referrals channelled.

Michael Balint did not invent the doctor/patient relationship. It was something he found alive and well in general practice at a time when general practice seemed to have lost faith in itself. His great contribution was to point out to us doctors how important the doctor/patient relationship is, and to help us to make better use of it.

How does all this help the patient? That was my starting point and I can imagine that a potential patient might now be asking: How *is* all this going to help *me?* Suppose I register with one of these Balint-trained doctors — what sort of deal am I going to get? Will he be able to do anything for *Me?*

We will suppose that this gentleman (he had better be a man because I have given examples only of women patients so far) we will suppose this man has aches and pains of various kinds and difficulty with micturition (although his prostate is normal) and episodes of breathlessness, despite a normal chest X-ray, peak flow, etc. Already he is beginning to resemble one of my own patients and probably one of yours too; one day we may even be like this ourselves so let us not feel too superior.

What can I tell him about this doctor he is about to consult? I shall say first of all that he is a doctor who will try to take your feelings seriously. He will always pay attention to what you want to tell him and will try to understand how it feels to be in your shoes. He will also understand how important a person he is in your life and be aware that this is a big responsibility.

Sometimes he will tell you what he thinks your feelings mean, and why you feel the way you do. This may make sense or it may not. It may change your life or it may not. Looking at you I would say, probably not. I cannot promise that he will cure you of what is troubling you now, but if you ever get anything that needs an emergency operation, he will make sure that you get it as well as any other doctor. He may not save your life but he will not desert you when you are dying. 'Well', says the patient, 'I would really prefer a doctor who could cure me, but if that is not possible this doctor will certainly do to go on with.'

I would like to finish by telling a little story for which I am indebted to a colleague in the Balint Society, Dr. James Carne. He told me of a patient, an old lady, who transferred to his practice after the death of her previous doctor. She had many aches and pains and other confusing symptoms which resisted all Dr Carne's therapeutic efforts. To make matters worse she continually told him about the other doctor, now dead, how brilliant he was, what he used to say and so forth. 'What a wonderful man he was' she would say. The new doctor found all this rather irritating, and observed that the old lady seemed to be just as sick as ever, despite the attention of his brilliant predecessor. So he interrupted her flow of praise and said: 'Yes, yes, but could he do anything for you?'

'Not a thing. Not a thing,' replied the old lady. 'But what a wonderful man!'

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Balint Weekend at Oxford 14th-16th September, 1984

The numbers at Oxford this year were roughly halved because of the drastic reduction of Section 63 funds, but considering that many young doctors were prepared to pay £40 to come, the attendance was remarkably good. It had the side effect of making the whole weekend more manageable. For instance the 'fishbowl' on Friday evening had the ratio of about four spectators to one group-member instead of nine to one as has been the case in previous years. This meant that the amount of frustration in the spectators was noticeably less than that previously experienced. Jack Norell and Antonia Shooter led the 'fishbowl-group' well, although there was a little unfinished business with one case.

There were only five working groups for the rest of the weekend, with two co-leaders apiece. There were, of course, quite a number of veterans scattered more or less evenly among the groups who were neither in a leadership nor a beginner's role, but who contributed substantially to the excellent working of the groups. It never ceases to amaze me how quickly these *ad hoc* groups settle down to work so quickly and so well. In the space of a weekend the group-members have already been able to weld themselves into what a casual visitor would consider to be an ongoing Balint-group. In our group at least there was a welcome shortage of pregnant nuns, and I think that was a general impression given by the other group-leaders.

We old lags received a notable bouquet as well as a brickbat. The same participant congratulated us on the fact that we treated the newcomers as equals, unlike many old-timers in other settings (and this was a happy confirmation that we are carrying the Balint banner correctly after nearly thirty-five years), but on the other hand, we were upbraided for placing constraints on what was discussed in the groups. This referred specifically to events in the group led by Erica Jones and myself, in which we headed off attempts to delve too deeply (in our opinion) into the private transference area of one doctor, and on another occasion to restrict a discussion about one member's partners when this led away from a consideration of the doctor/patient relationship.

I have to confess that Erica and I are unrepentant, and it will be up to those who come after us to justify developments in the directions suggested. However, friendly constructive debate must always be welcome in our Society, and in my opinion the Oxford weekend must remain what is probably the single most important activity of the Balint Society.

MIKE COURTENAY

Residential Balint Weekend at Pembroke College, Oxford

From 6 p.m. Friday, September 27th to 1 p.m. Sunday, September 29th, 1985

General practitioners, both principals and trainees, are invited to sample the experience of attending a Balint-group for a weekend. There will be opportunities to discuss the experience, and also the problems of learning and teaching in small groups.

Further details are available from the Secretary:

Dr Peter Graham,
149 Altmore Avenue,
London. E.6

The Balint Society Prize Essay, 1986

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme 'Who needs Balint? . . .'

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 two copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.
Length of essay is not critical.
Entry is open to all, except for members of the Balint Society Council.
Where clinical histories are included, the identity of the patients should be suitably concealed.
All references should conform to the usual practice in medical journals.
Essays should be signed with a *nom de plume,* and should be accompanied by a sealed envelope containing the writer's identity.
The judges will consist of the Balint Society Council and their decision is final.
All entries will be considered for publication in the Journal of the Balint Society.
The prizewinner will be announced at the 16th Annual General Meeting in 1986.

Entries must be received by 1st April, 1986, and sent to:

Dr. P. Graham,
149 Altmore Avenue,
London, E.6.

Please advertise this amongst your colleagues.

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 Dr. Philip Hopkins.

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

Extract from the Rules of the Society

Membership of the Society
Membership of the Society shall consist of Ordinary, Honorary and Associate Members.

(i) **Ordinary Membership.** Ordinary Membership shall be open to registered Medical Practitioners who have taken part in Balint-type seminars for not less than two years and who are preferably in General Medical Practice. The names of the first Ordinary Members of the Society (for the purpose of this clause describes as 'Foundation Members') are set out in the Schedule hereto. The Foundation Members prior to the first meeting of the Society have taken the following action:—

(a) Elected a President, a Vice-President, an Honorary Secretary, an Honorary Treasurer an Honorary Editor and two other members of the Society, who together form the first Council of the Society.

(b) Approved a list of persons as Ordinary Members of the Society.

(c) Approved a list of persons as Honorary Members of the Society.

Subsequent candidates for Ordinary Membership shall be proposed by an Ordinary Member of the Society and shall have previously attended at least one meeting of the Society as a guest. The proposer shall submit the candidate's name and qualification for Ordinary Membership in writing to the Hon. Secretary two months before the next General Meeting. Nominations for Ordinary Membership will first be considered by the Council and submitted by them for election at the next General Meeting.

(ii) **Honorary Membership.** Persons considered to be of outstanding merit by the Society shall be eligible for Honorary Membership. Subsequent nominations for Honorary Membership shall be proposed by the Council who will submit names for election at the Annual General Meeting.

(iii) **Associate Membership.** Associate Members shall be persons not possessing the necessary qualifications for election as Ordinary or Honorary Members. They shall have all the privileges of other members, but may not have voting rights.

All candidates for Membership of the Society, after election, shall receive a letter of invitation to join the Society. Membership, except in the case of Honorary Members, shall then take effect on payment of the Society's subscription.

Election shall become void in default of payment of subscription within three months. Ordinary Membership shall automatically lapse when no single attendance at an Ordinary Meeting is recorded throughout the twelve months following the Annual General Meeting or when the subscription has not been paid within three months of the Annual General Meeting unless the Council shall have accepted mitigating reasons.

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

Produced by Haverstock Publications, 249 Haverstock Hill, London, for the Balint Society.

Printed by The Galloway Gazette Ltd., 71 Victoria Street, Newton Stewart, DG8 6PS.