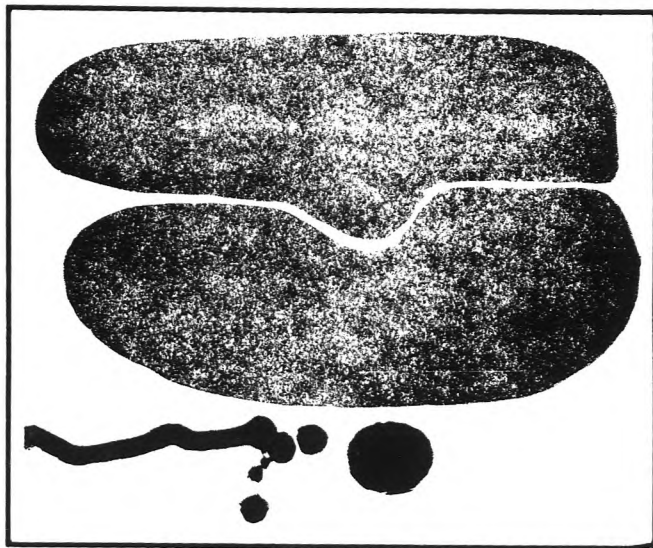


Journal

of the

Balint Society

1989



Vol. 17

JOURNAL OF THE BALINT SOCIETY

Vol. 17, 1989

<i>Contents</i>	<i>Page</i>
<i>Frontpiece</i> : International Balint Federation Prize Essay Award Presentation	2
Editorial	3
Making Sense of Medicine, Michael Balint Memorial Lecture, 1989, Michael Courtenay	5
The Basic Fault and Therapeutic Regression, Harold Stewart	13
What Balint Means to Me, Jack S Norell	20
An Account of the Doctor/Patient Relationship during Medical Training, Mary Keany	24
An Evaluation of Balint-training for Psychiatric Nurses, P I Steinberg and B F Shaw	28
Do We Still Need a Psychoanalyst for a Leader? John Salinsky	33
Reports:	
International Ascona Balint Meeting, 1989	19
International Balint Federation, Paris, 1989	34
The Oxford Balint Weekend, 1988	35
Obituary: David Morris	37
Cyril Gill: An Appreciation	39
Annual General Meeting, 1988:	
Presidential Address	40
Secretarial Report	40
Council of the Balint Society, 1989/90	4
Announcements:	
The Balint Society Prize Essay, 1990	4
Seventh International Balint Conference, in Stockholm	12
Future meetings of the Society	27
Psycho-analysis in Britain Today	32
The Oxford Balint Weekend, 1989	36

Editor: Philip Hopkins
Assisted by Susan M. Hopkins



Photograph by Dr Philip Hopkins

Presentation of the Prize Essay Award for 1989 from the International Balint Federation to Miss Mary Keany, BSc by Dr J S Norell, applauded by President, Dr Erica Jones

For New Readers:

The Balint Society was founded twenty years ago, in 1969, to promote learning, and to continue the research in the understanding of the doctor/patient relationship in general practice, which Michael and Enid Balint started in what have since become known as Balint-groups.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group, and to anyone involved in health-care, established or students and trainees, who are welcome as associate members.

The Society holds regular meetings for discussions about relevant topics, as well as for lectures and demonstration-groups in London. The Oxford Balint Weekend has become a popular annual event, taking place in September at Pembroke College. (page 36) In response to local demand, other similar meetings will be organised from time to time throughout the country.

The Annual General Meeting is held in June each year, and is accompanied by an informal dinner.

The formation of new Balint-groups is under constant review, and the Balint-group Leaders' Workshop continues to meet throughout the year, and is also an excellent forum for Course Organizers for discussion of their work.

The Society is affiliated to the International Balint Federation, which co-ordinates similar activities in other countries, and organizes a bi-annual International Balint Conference. (page 12)

There is an annual Prize Essay of £250.00p (page 4), and the Journal is circulated each year to all members.

Editorial

The Doctor, his Patient — and Time

The situation has altered remarkably since Michael Balint wrote in 1957, 'My diagnosis is that general practice is seriously ill, but the illness is benign and, provided the right therapy is applied, the prognosis is good. Hospital or scientific medicine, however, is not ill, but is hale and hearty, rich in achievements and success . . .'¹

Yet the high cost of funding those achievements and successes, which have brought such fantastic benefits to our patients, has been the very cause of the huge increase in the cost of the National Health Service, leading to the disastrous financial cuts over the last decade or so.

The government have yet to learn and understand that whereas the successful development of new ideas in industry may well lead to increased profits, the reverse is the case when providing a service; that costs money - to provide a good service costs even more money.

As Balint predicted, the prognosis for general practice proved to be good, when the 'right therapy' came in the mid-sixties. This undoubtedly resulted in part from Balint's own growing influence and partly, from the changes associated with the Charter, leading to reduction in the average list-size.

This has made it possible for doctors to spend more time with their patients, with beneficial effects, contrary to the belief held by some who claim that the quality of medical care is not dependent on the duration of the consultation. It could well be that this view has influenced the government's proposed new policy to encourage doctors to increase their list size by changing the basis for their remuneration.

Although many of us worked over many years with Michael and Enid Balint in our attempts to find

the best way of utilizing the pathetically few minutes each patient can usually be allowed, some think that spending more time is necessary for many of them.

To paraphrase a well known adage, although preventive measures have their place in medicine, they are not medicine. The real work of a doctor is neither an affair of visiting octogenarians for annual check-up, nor sending for patients to attend for cervical smears or vaccination. The essential unit of medical practice is still the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it.

Today, we must be on our guard to resist any imposed change which will increase the list size, and so reduce the length of time we can allow for each patient's consultation. For that is the road back to the past low standard of medical care.

At the recent 12th WONCA World Conference on Family Medicine, held in Jerusalem, many speakers revealed the results that Balint's influence has had on them. Professor John Howie, from the University of Edinburgh's Department of General Practice, warned, 'If the proposed new contract forces doctors to shorten consultation time, there would be a significant effect on the quality of care. When doctors work fast, they are more likely to prescribe drugs rather than allow sufficient time for the patient to talk . . .'²

A sentiment which no doubt will be shared by most readers of this Journal, although it is worth remembering that Balint said there is nothing wrong in prescribing a drug for a patient, as long as it was not the only treatment that the patient received.

And Time for Congratulations, again . . .

For the second year running, a medical student from Leicester University Medical School, was awarded the first prize by the International Balint Federation.

Congratulations to Miss Mary Keany, BSc, who elected to spend an extra year in her training to study human sexuality in a clinical setting. Her prize-win-

ning essay on the Doctor/Patient Relationship during Medical Training, appears on page 24.

Miss Keany is seen opposite, receiving her prize from Dr. Jack Norell, who also deserves to be congratulated for winning this year's Balint Society's prize for his essay on 'What Balint Means to Me', (page 20).

The Work of Michael Balint

A most interesting and enjoyable Day of Lectures and Discussions about the Work of Michael Balint was given by Members of the British Psycho-Analytical Society, on 5th November 1988. The meeting was well attended at the Institute of Psycho-Analysis.

A goodly number of members of the Balint Society heard Dr Jock Sutherland talk about Michael Balint and the Business of Psycho-Analysis, followed by a description of Michael Balint's Work with General

Practitioners, by Dr Bob Gosling.

Dr Harold Stewart's lecture, The Basic Fault and Therapeutic Regression, is printed on page 13.

1. Balint, M. *The Doctor, his Patient and the Illness*. London: Pitman Medical. 1957.
2. Howie, J G R. The relationship between quantity and quality of care: Some missing links. *The Family Physician*, 1989; 17:1, 37.

The Balint Society Prize Essay, 1990

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme:
Market forces and the doctor/patient relationship.

Essays should be based on the writer's personal experience, and should not have been published previously. Essays should be typed on one side only, with 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.

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

The prizewinner will be announced at the 20th Annual General Meeting in 1990.

Entries must be received by 1st April, 1990 and sent to: Dr. D. Watt, Tollgate Health Centre, 220 Tollgate Rd., London E6 4JS.

The Balint Society

(Founded 1969)

Council 1989/90

President: Dr. Erica Jones

Hon. Secretary: Dr. David Watt
Tollgate Health Centre
220 Tollgate Road
London E6 4JS
Tel: 01-474 5656

Vice-President: Dr. John Salinsky

Hon. Treasurer: Dr. Heather Suckling

Hon. Editor: Dr. Philip Hopkins
249 Haverstock Hill
London NW3 4PS
Tel: 01-794 3759

Members of Council: Dr. Marie Campkin
Dr. Michael Courtenay
Dr. Peter Graham
Dr. Miriam Skelker
Dr. Lenka Speight

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.

Making Sense of Medicine

Michael J. F. Courtenay
Retired General Practitioner

*The Eighth Michael Balint Memorial Lecture,
given on 25th April 1989.*

Anyone who thinks that medicine is easy is a fool. Even in the hospital setting, relating scientific knowledge to patient care is often exceedingly difficult, and most patients in hospital are there after a selection filtering process setting anything and everything the patient brings to the doctor, and anything and everything that the doctor brings to the consultation needs to be understood. It is daunting and exciting. As Balint-work approaches its half-century we are faced with a completely different situation in general practice; on the surface anyway. Gone is the isolation. Gone is the low morale, (leaving the shadow of the white paper aside). Formal training for a career in general practice is statutory. Academic departments of general practice are countrywide. General practice literature is burgeoning. Research is fashionable. It is said that the brightest and best young doctors now aspire to a general practice career rather than specialisation. Where then does the spirit of Balint blow?

Unfortunately it is currently *not* a mighty rushing wind. But it *was* in the nineteen-fifties, when general practitioners were castrated in traditional medical terms, and despised by many specialist colleagues. In that desert were born two forces; the Balint movement and the College (now Royal) of General Practitioners. One deeply committed primarily to human relationships, the other primarily to intellectual excellence. Not, of course, that they are mutually exclusive, just that sometimes they are restless bedfellows. It could be forcefully argued that Balint thinking was a major force in those early years when the College charted the course of training for general practitioners, enshrined in the book *The Future General Practitioner*¹. After all many of the contributory authors had experience in Balint-groups. And the Nuffield Courses for training those who were envisaged to be the educators of the new generation of general practitioners seemed to be seeking to effect changes similar to those aimed at in Balint-groups.

What then are these changes? Surely the provision of skills appropriate to the setting. I agree with Gosling² that the considerable though limited change in personality in Balint-group members is a by-product of the learning of new skills. The problems arise when considering which skills are deemed most useful, or even essential, and the means by which they are best acquired. We are already deep into what learning is all about. The relevance of the psychoanalytical terms of reference associated with Balint-work (in distinction to any specific theoretical issues), is the commitment to a lifelong quest for growth and development. While the College commitment to continuing medical education is undoubted, the nature of such education still appears to be a kind of menu, from which general practitioners choose which dishes they prefer. That is not to say their

choice is always for *nouvelle cuisine*, sometimes it is for rice pudding because it is good for them. The menu is wide ranging, eclectic, and will certainly include interactional elements such as consultation skills (now usually built into Vocational Training for General Practice), and such approaches as Transactional Analysis. Balint-work may be seen to be just one dish among many, and therefore assumed to carry roughly the same weight as the other dishes on the menu.

An illustration of this was provided by the sad experience of French Balint group-leaders in Paris, where the medical school offered them a slot in a part of the undergraduate curriculum. About nine disciplines were each allotted some sessions. The other things on offer were such topics as 'renal medicine', 'asthma', 'hypertension' and so on. The students who opted for a taste of Balint-work attended a couple of sessions and then declared that it was very interesting, but now they knew what it was about, they must go and learn about something else. Tasting all the dishes on offer, but not having a meal.

My contention is that Balint-work is a quite different kind of learning. But because it is not recognised as such it is often ignored and even denigrated. How much of this arises from an old hostility by medical academia towards psychoanalysis, how much an emergence of old resistances to acknowledging the power and ubiquity of unconscious processes I can only speculate.

Whatever the truth is, it is very difficult to convince anyone who has not experienced the benefits accruing from Balint-work, that putting such work in one pan of the scales and the multifarious fragments of general practice research in the other could possibly achieve anything like a balance. A further problem often arises because some rather diluted Balint-work experience has become incorporated into much Vocational Training, sometimes resulting in feelings similar to those experienced by the French medical students. What, then, are the real differences, if any, between the Balint-work approach and that of academic general practice?

In Balint-work the focus is on the doctor as a person, relating to the patient as a person in distress, with the emphasis on the interaction rather than the story; while the academic approach rests on the story and the context; the data which can be collected by the doctor from the patient and those around him. Pelligrino³ considers that no unitary explanation or logical method can encompass the several different *reasoning* modes and several kinds of evidence acceptable in answering the different kinds of questions the clinician must answer. But after this statement about the intellectual approach to medicine, he continues to put the doctor/patient encounter in perspective: The end of the medical encounter . . .

is restoration and healing . . . not diagnosis, not scientific truth, testing an hypothesis or evaluating a treatment . . .

So the concern for the patient as an individual is not in doubt in the intellectual approach to making sense of medicine.

Moreover, during the nineteen-eighties outstanding academic general practitioners have been restless in searching for sense in medicine. Howie⁴ states that we must recognise that the cellular style of general practice research can be expected to have only a modest part to play in helping our science forward. He reminds us that Kuhn⁵ argues that the time to rethink the appropriateness of a framework is when it becomes progressively less able to answer the questions asked of it.

McWhinney⁶ also reminds us that Kuhn began by challenging the view that science develops by the accumulation of individual discoveries and inventions. 'The formation of a scientific discipline begins with the acceptance of its first paradigm'. The earlier stages in the history of a science are marked by many competing schools of thought. During this phase observations are made and facts gathered, but in the absence of a paradigm there is no organising principle to indicate to the observer how the facts relate to each other (the so-called pre-paradigm phase). Although this early fact-gathering has been essential to the origin of many sciences, the result is usually, in Kuhn's words, 'a morass'. 'No natural history', he says, 'can be interpreted in the absence of at least some implicit body of intertwined theoretical and methodological belief that permits selection, evaluation and criticism'.

McWhinney recounts how Kuhn thinks a change of paradigm occurs. The process begins when normal science encounters anomalies. At first these are ignored, or perhaps not even perceived. Eventually, however, the anomalies become too obvious to be ignored and a state of crisis ensues. Anomalies become critical when they cast doubt on the fit between paradigm and nature. The state of crisis is a period of intellectual ferment and debate about fundamentals. Eventually a new paradigm is introduced to compete with the old. A period of conflict ensues . . . The change from an old to a new paradigm is revolutionary rather than cumulative . . . Proponents of a new paradigm often arise from the periphery of the discipline or from outside it altogether . . . The fit between nature and the old paradigm may persist under limited conditions . . . The new paradigm can therefore be viewed as enfolding, rather than replacing, the old one.

McWhinney views medicine as in a such a state of crisis; the loss of confidence, the questioning of fundamentals; the widespread interest in the philosophy of medicine. He asks what part family medicine is playing in all this. Will the result of the crisis be a change in paradigm and, if so, what will the new paradigm be like? He thinks we can already see its main features. The new paradigm will pay more attention to health. It will retain, for practical purposes, the concept of disease categories, but will pay more attention to illnesses which do not fall into these categories. It will focus on the person and his or her environment and relationships as strong determinants of health and disease. *It will elevate the*

doctor/patient relationship to its rightful place at the centre of medicine.' (My italics).

Could then the Balint concept of the doctor/patient relationship be the crucial factor in effecting the paradigm change which is so clearly necessary to the future of general practice? It would enfold traditional medicine, not replace it, satisfying both Balint's and Kuhn's visions. And if so, then it would be clear that the weight carried by Balint work is more than enough to tip the scales.

For however much psychological and social factors are considered, the traditional intellectual activity is based on the *doctor's* capacity to get information and then proceed to problem-solving. It is essentially a doctor-centred activity, having to cope with the severely limited capacity of short-term memory to store, handle and manipulate information per unit time. That is why working with the doctor/patient relationship is so much more economical. The present pressure on the decision making capacity of the doctor is immense. Decision making is looked on as a cognitive skill, nevertheless Fox⁷ accepts that subconscious methods of using knowledge may dominate decision behaviour. And even the more conscious decisions are based on knowledge which has been built up over the years.

Barrows and Tamblyn⁸ assert that medicine's knowledge base is what separates it from all other professions. High value is placed upon it in training, it is what is tested in the final examination. Carlton⁹ considers that it determines how doctors view data and the value they put upon 'correctness' and certainty and control. This is the traditional approach in Balint terms, and was never denigrated by Michael Balint, who considered it as the treasure house of medicine.

But turning back to psychoanalysis, *it* is never contemptuous, it too is in the business of the use of knowledge, indeed its main product is the knowledge of people, and that knowledge is the analyst's vaccination against being overwhelmed by other people's distress, allowing the analyst to remain with the patient. So it is a different dimension of knowledge, dealing with the theory of the person and the personal bond. However, the Balints always discouraged psychoanalytical theorising in the seminars. They were intent on trying to discern what went on in general practice, identifying the relational content of the general practitioner's work, and considering how psychoanalysts might help the doctors to understand it. The Balints seemed to appreciate that their specialised knowledge would be useless if just declared in an *ex cathedra* manner, and relied on peer interaction to enable the doctors to discover what they could do more than they did already. The whole venture of training-cum-research was set against the background of a special stream of feeling emanating from Michael Balint towards general practitioners, perhaps based on his relationship with his own general practitioner father; comprising a certain indulgence not normally characteristic of his relationship to colleagues; coupled with a conviction that general practitioners were as tough as leather. This set the scene for the Balints to work *with* general practitioners sincerely as true colleagues. Notably they gave encouragement to the doctors to present cases without

Journal of Balint Society

using notes, with the psychoanalysts' message that unrehearsed thinking could be valuable, analogous to the free association technique used in psychoanalytic treatment.

The recognition by peers in the Balint-group of repetitive interpersonal problems between doctor and patient is important for the doctor's work, though explicit revelation of the significance to the doctor as a person has been strongly discouraged. The groups are educational rather than therapeutic, though precisely where personal development lies along this spectrum is difficult to define. All true education must be concerned with personal development, as objective knowledge must be constantly informed by personal knowledge. Current positive criticism of the traditional Balint approach centres round this point. Many doctors, including those involved with so-called holistic medicine, feel that the need for the treatment of doctors should be explicitly accepted. Balint-training seeks to promote the acquisition of skills in working with the doctor/patient relationship in everyday general practice, which will lead to a considerable though limited change of personality if these skills are acquired. A therapeutic group would focus on the members' personal difficulties in private areas of life. It may be that in the course of the life of a Balint-group it will become clear to the leaders that a doctor is in need of personal therapy, and this would be addressed outside the context of the group.

However, there might be general agreement that many doctors have personal problems which may interfere with effective patient care. Perhaps the key rests in the sphere of motivation. Doctors must initially be free to choose training or treatment. The real problem is that so few doctors seem to have motivation in either direction. It seems to boil down to the fact that we Balintians cannot understand why others are satisfied by their work, and *vice versa*. Returning to Balint work, the training is above all an experiential learning process, combining an interaction between thought and feeling, thoughts leading to feelings and feelings giving rise to further thoughts about the significance of the feelings in the context of relating to a patient. Doctors, in this way, can actually change, professionally and personally! Perhaps we should see the problem in Winnicott's terms; in which case the Balint group will seek to produce a 'good enough doctor'.

Can this happen as a result of a purely intellectual process of learning? Yes, I think it can, but with a reservation. Unless cognitive reception of a piece of information, or conclusion from a piece of research triggers a positive affective response in the reader, no lasting lesson will be learned.

For example, take the problem of treatment for upper respiratory infection in children, one of the most common conditions encountered in the general practitioner's surgery. Buchem et al¹⁰ compared the treatment of acute otitis media by surgery (myringotomy), antibiotics or analgesia alone. They made a good case, based on outcome measures, that the prescription of strong analgesics was as good as either of the other two active interventions. Yet when a group of experienced general practitioners was asked how this research finding had altered their management of the condition, almost all admitted that

they continued to prescribe antibiotics in most cases. In discussing why, various factors emerged: memories of the older doctors of acute mastoiditis necessitating destructive surgery, wishing to spare colleagues being called out again at the weekend, or some important social occasion occurring in the patient's family in the immediate future. Affect was tending to override the intellectual judgement.

Yet more cogent arguments against a change of practice were not mobilised. The Dutch doctors prescribed an analgesic which would have been thought dangerous in this country, and was administered by suppository. They also considered admission to hospital for pain control in otitis media justifiable. The adverse effects on the child of using suppositories or hospital admission were not explicitly discussed by any of the experienced general practitioners. In another study, Bain and Sales¹¹ showed that more children of mothers on psychotropic medication were referred to ear, nose and throat surgeons than was the case with mothers not taking such drugs. This research suggested that the referral process was partly determined by the emotional problems of the mothers, but this had somehow not been fully faced by the referrers. What had been done for the disturbed mothers apart from psychotropic medication was not dealt with in the research.

In a tribute to the surgeons involved that a smaller proportion of the children of mothers on psychotropics were recommended surgery, compared to the controls. But there was no evidence of the use of the doctor/mother relationship by the referring doctors of a kind that was likely to lead to a good referral, even in traditional terms.

In contrast, being in a Balint-group might achieve a change in the doctor which could lead to more sensible referral rates because the relational issues become recognised by patient and doctor. If this is true for traditional type presentations, what of inchoate presentations by patients in the surgery which produce little to bite on in traditional terms? This is the very stuff of what the Balints called 'unorganised illness'. As about half of the cases a general practitioner sees are likely to be of this kind, it is in this area where Balint work *par excellence* informs general practice medicine and seeks to make sense of it.

Initially the aim of the work seemed to be to encourage something of a formal psychotherapeutic approach towards a selected number of patients, but this gave place eventually to something rather different. The Balints came to see that the introduction of psychotherapeutic long interviews was a foreign body in the mainstream of general practice work, the additional time required necessitating choosing some patients for special attention, and thereby creating tensions in the doctor who knew that many patients were not getting the attention they appeared to need. This led to a change of aim, to understand important interactions with all patients presenting. Ironically this was accepted with great difficulty by the doctors who had got used to the earlier mode of work. Indeed those who had developed their psychotherapeutic skills furthest were naturally the most resistant. However, I believe that this resistance was not entirely misplaced, in that many patients do require at least one long

interview before mutual understanding can be reached.

Sadly perhaps, in this day and age, the myth that the general practitioner knows a lot about his patients because of a long and continuous relationship over years needs to be reviewed, especially in inner city practice, with high rates of population change. The mobility of both population and doctors in recent years means that a large proportion of patients will be comparative strangers. Realisation of this often leads to the conclusion that even if a patient has been in the practice for quite a long time, the doctor's knowledge about that patient may be exceedingly tenuous, and often the product of observation and deduction untested by the patient's own perceptions. Patients tell their doctors only as much as they think the doctor needs to know, so that it is only in times of crisis that a deeper understanding of the patient may develop because of the latter's need for help.

For instance a man who developed bone secondaries. Although his pain was well relieved by judicious use of radiotherapy, he was well aware that he had not long to live. He had been the main support of his chronically ill wife, and had always paid scant attention to his own complaint over the years that he had been a patient. So it was only when death was staring him in the face that he began to talk and present himself as a person to his doctor. He had been brought up in the Baltic States before World War II, and his home had been in the battlefield between the Nazis and the Soviets. He had managed to survive, but told a harrowing tale of returning to his burning native city, searching in vain for his relations, who disappeared for ever as far as he was concerned. His subsequent escape to the West, and eventual arrival in England, where he worked hard to establish his own small business, and eventually marry a widowed Englishwoman with children. Then he had to shoulder the responsibility for looking after her in her state of chronic disability. And now he was going to leave her due to circumstances beyond his control. To meet his need to reveal himself as a person, and to establish his worth as a human-being, and share his grief at impending separation, extra time was required, and this seemed a paramount obligation on the doctor's part in the course of his terminal care.

A more cheerful scenario is someone with a sexual problem. A man complaining of premature ejaculation needed time to talk about his sexual development, and his relationships, past and present. Even if he was to be treated with a behavioural method, this would have required time with him and his partner initially. If on the other hand a psychotherapeutic approach emerged as appropriate, then further long interviews would be necessary. Such a patient who, during the initial interview, showed an impatient attitude towards gratification of any kind, typified by his relation to the doctor in wanting instant relief, suggested that his symptom was related to this rather than sensory hypersensitivity. An interpretation in that direction was readily accepted and worked with, so that half a dozen sessions were enough to relieve his symptom. His case could not, in my view, have been adequately dealt with in short sessions.

But I should now like to return to the run of the mill type of consultation, which lasts up to ten minutes. On the face of it this is not a long time, but

research in an academic department of general practice, by Morell et al.¹⁷ has demonstrated that even the increase of available time from 7½ minutes to 10 minutes allowed greater depth in the consultation. This has recently been supported by Howie et al.¹³

In the Balint-work described in *Six Minutes for the Patient*¹⁴ arising from the last of the groups jointly led by the Balints, 'sought to make some advance in approaching many problems, among them those connected with the dangers of a too dependent doctor/patient relationship'. As Michael Balint wrote in the opening chapter of the book, 'Because every therapy is based on an interplay between patient and doctor, it cannot be really understood if one restricts one's observations either to the one or the other: the therapy happens not in the patient nor in the doctor but between the two of them'. The change involved a shift from the established method of Balint-work characterised as that of the 'great detective'.

As Michael Balint continued, 'The doctor using the (old) technique 'listened' most intently, observed everything carefully, and, if necessary examined conscientiously every area which, in his opinion, might be involved in the patient's problems'. This description would equally well apply to the form of clinical reasoning advocated by an academic approach to work in general practice, as Balint noted. As he wrote, 'These traditional functions assure the doctor of a safe feeling of superiority: it is he who knows more, to whom the patient turns with hope and trust, and who can prove by the success of his diagnostic skills that the trust in his superior knowledge and skills was justified. Looking at the diagnostic period from this angle, every turned up stone yielding a clue is a most rewarding and reassuring experience to both partners in the doctor/patient relationship'.

This will appear as rather a rosy picture of the feelings of ordinary general practitioners in a setting where time is short and uncertainty long! That group sought ways in which the doctor could 'tune in' to the patient's communication more exactly. On occasion this was amazingly successful, but such success was unlikely to be achieved in each and every patient. However, some broader gains resulted from the new approach. Michael Balint again, 'It allowed the patient to use the doctor in his own way, while at the same time it allowed the doctor freedom to be used, that is to give himself, without anxiety that his patients will abuse his time. It also gave a freedom to the doctor to make his own observations; but imposed a discipline on the doctor during the brief interviews to observe both the patient and his own thoughts and feelings'.

On the face of things the cost of this would be an increase in the intensity of the contact. While this sounds threatening, in practice such intensity can be achieved by a form of free-floating attention which is not more stressful than the usual mental set that general practitioners bring to consultations, and can be less. Doing becomes less important than being. The problem is that it is hard for the doctor to change his method of working. We are so trained to take control, that anything else proves difficult.

I well remember an exercise I undertook in trying to allow patients more space in the interview. I attempted to greet the patient cheerily and then shut

up. In order to keep myself silent I sat the medical student who was sitting in on the surgery so that he could kick the back of my leg if I rambled on. My impression was that the patients were able to tell me why they had come in record time; but at the price of having a very sore leg!

If in Enid Balint's words in the same book, the doctor is freed from the primary task of trying to discover *why* the patient talks, thinks, feels and behaves in the way he does: the patient in due course may provide the answers to why; the doctor's task is primarily to observe a very small sample of *how* the patient talks, thinks and behaves, and *why* this causes him pain; *what* he is like and what he seeks in an obscure and confused way to share with his doctor; what really makes him want the doctor's attention? She adds that this aspect of the work has nothing to do with solving problems or averting crises.

This is in contrast with moves in current general practice thinking, greatly encouraged by the Royal College, in two main areas. One is the encouragement of counsellors in the practice setting, the other is the emphasis on preventive medicine. With regard to the first, Gosling et al² suggest that we doctors are captured by the system, we feel that talk is somehow not a proper part of medicine, and that doctors should delegate a talking role to others. This seems to be tied up with a confusion between aims to provide treatment or to provide an opportunity for personal growth. One is proper and the other not. This I believe is an abdication from the unique position in which a general practitioner finds himself, of being able to move across any theoretical boundary between mind and body in his clinical work, instantly, soundlessly; and, be it said, logically, in that mind-body dualism is hardly tenable in this day and age.

The other move towards preventive medicine is essentially laudable, but I cannot help thinking that it is also a move towards an assertion of control, an unwelcome return to the status of the 'superior doctor'. My reason for this feeling is that effective preventive medicine is in practical terms largely beyond our reach. Holland¹⁵ reminded us of Wilson and Jungner's criteria for useful preventive procedures. He goes on to say in the general practice setting this activity depends on the advice to individuals by individuals, and that doctors are not trained in skills to effect changes in behaviour. Only in such fields as immunisation against communicable disease, especially poliomyelitis, are the means and benefits clear cut.

But the National Audit Office¹⁶ has castigated the profession for not adequately addressing itself to the prevention of coronary heart disease, but such an approach inevitably leads to questions about patients' life-styles. This raises contentious issues. Morell¹⁷ considers that good quality general practitioner care does not demand, 'responsibility for the control of people's behaviour, be this concerned with excessive eating, smoking, sexual promiscuity or drug-taking. These are the responsibilities of society at large, and to impose such a responsibility on the general practitioner is to condone the medicalisation of social behaviour, warned against by Ivan Illich.'

Does anyone in Britain not know that smoking is injurious to health? Yet I have seen a cardiologist furtively light a cigarette. Poor man, he was under great
Vol. 17, 1989

strain with hospital management problems, and this reveals why the general practitioner may find these behaviours very much his business in some cases. But, in general it is likely to be a challenge to the patient's autonomy, and an open invitation to doctor-dependence.

There is also the question of the use of time. If general practitioners need to spend more time with patients to allow work with the doctor/patient relationship, this must be made from somewhere. For instance, will doing minor surgery consume time that might be better spent in our key role? What is it that general practitioners can do *which no other doctor can?* What sort of doctor is most useful to patients?

When I entered general practice with woefully inadequate postgraduate training, and tried to apply what medicine I had learned, I very soon felt out of my depth. It seemed that my knowledge and skills just did not meet the needs of a large proportion of the patients who came to see me. Every so often a recognisable condition loomed out of the mist and was latched on with enthusiasm. A spinal cord tumour, a case of lead-poisoning, tuberculous meningitis. Once when I had just returned from holiday I found myself testing the first patient's urine for glucose and thinking as I did so, 'if there is no glucose in this urine I have no idea what is wrong with the patient, and will have to begin the whole consultation all over again'. In the event there was glycosuria but this demonstrated the sort of condition reflexes built up by my training. Useful, but in a minority of cases.

But for the greater part of the time, I could not understand the reality behind my patients' complaints. I searched high and low for answers. Eminent physicians, one of them an erstwhile mentor of mine, wrote in *The Lancet*¹⁸ that picking up the big diagnoses was the proper role of the general practitioner, and that any other was of no importance. I was certain that they did not know what they were talking about with regard to general practice. After all they practised medicine in hospital, the medicine they had taught me, and I knew that was not an adequate response to what my patients were seeking. Anyway if what they advocated was accepted, most general practitioners would die of boredom in between seeing what the specialists considered illnesses. This had already led to the phenomenon of doctors complaining that patients overwhelmed them with trivia. But beyond that lowest common factor was the gnawing certainty that there must be something to explain why so many people came complaining in a way which did not seem to be explained by the traditional medicine of the time.

With delicious irony, I was admitted under the care of my erstwhile mentor suffering from epididymitis, and spent three days in hospital reading *The Doctor, his Patient and the Illness*. They did not wish to discharge me in spite of negative investigations, but after I had read the book I felt that I had found what I had been seeking, and was eager to return to work. I immediately applied to join a group, and after an astonishing interview with Michael Balint, commenced one that autumn.

This very personal account would carry little weight if it were not for the fact that in running a half-day release course as a course-organiser for a

vocational training scheme I noticed year by year that the problems faced by the trainees in starting work in the general practice setting seemed to echo those which I had encountered, even though they had had substantially more postgraduate training than I had undergone. This led me eventually, with Enid Balint's help, to introduce a group-experience for the trainees. I am on record¹⁹ about the achievements of some of those trainees when they had gone on to join an established group of general practitioners. While those results were gratifying, I am left with some nagging doubts as to whether in some cases it prevents doctors from obtaining a good experience of Balint-work, but I see no alternative to making the offer of what I believe is the crucial need for Balint-insights into general practice.

One has to face the fact that not all doctors are likely to be convinced. Balint et al²⁰ suggested that only about 50% of doctors might be accessible but in reality less than 1% seem interested. As I have already implied, it must be that the majority of doctors are satisfied with the way they practise, or that they are so immersed in the day-to-day pressures of clinical work, that they have no time to stand back and ask themselves whether what they are doing makes sense. They get sucked onto a treadmill which they cannot get off. But it is no help just to drag them off.

A colleague of mine practising in a country town told me that a single-handed doctor there had a myocardial infarct, and when he returned to work his colleagues asked him how they could help. He replied that he had got so bogged down with about three hundred of his patients, that he had become unable to cope. They offered to take on this three hundred, split between several practices. At the end of a year, the single-handed doctor confessed that he had accumulated another three hundred difficult patients! Incidentally, very few of the original three hundred patients who had been distributed round the other practices in the town had caused problems for their new doctors.

The doctor in distress obviously had problems in relating to certain kinds of people, but would seem to have been wrestling with their apparently intractable problems, rather than understanding what it was in the doctor/patient relationship which produced the difficulties, and which might have been used in the interest of the patients. This does not necessarily mean that he was a less caring doctor than his colleagues in the town; it may well have been that he tried so hard that the patients became dependent, while the others took a less involved role, and so kept their professional distance greater.

In parenthesis, one of the saddest professional writings I have read recently was a Personal View,²¹ in which the author felt that compassion for the suffering as a prime motive for becoming a doctor was likely to rebound to the patients' disadvantage. He had been happiest when he had just left medical school.

As far as I know, none of the country-town doctor's supportive colleagues were Balint-trained, and the story illustrates the fact that the doctor/patient interaction in Balint-terms is largely ignored in this country. In other countries too, of course.

A Swiss medical student came to me for an attachment just before his final examinations. He had

lost his way, and wondered if he even wanted to become a doctor after all. Happily the experience of observing an approach using the doctor/patient relationship tool confirmed his vocation in a new direction. But this leads me to another point. When in most general practice literature the doctor/patient relationship is said to be 'good', I suspect that this means that both patients and doctor are reasonably happy in their interaction, but whether it is *useful* is quite another matter. In general medical parlance a good doctor/patient relationship is just a personal emotional meter-reading, or at best a good climate for communication, not a tool for understanding the patient, or the doctor come to that. But it really is a field in which skill may be exercised to bring benefit to the patient. This is exemplified in the old Balint adage that any emotion the doctor feels during the consultation may be a symptom of the patient. Most doctors seem to be unable to accept that the relationship between doctor and patient is a crucial part of the work, and that continual sweetness and light in such a relationship may be immaterial or downright harmful to the patient's interest. The essential thing is for the doctor to observe continually what is going on between his patient and himself, and to use that as part of the clinical activity.

Having retired from clinical practice nearly a year ago, it is a unique and fleeting opportunity to look back over the experience of the doctor/patient relationship. The process of retirement has been immensely interesting in that regard, it is fascinating to observe which of one's patients come to say goodbye. The ghastly facet is that these are probably those who have remained dependent! The ones that have regained their independence and have forgotten the doctor's part in it are the real successes.

Take the case of someone who became a patient through a psychiatrist (who did not know me), and proved to be very challenging. Mrs A., in her forties, was the wife of a doctor, and I became involved when the psychiatrist treating her at the time insisted that a doctor other than her husband should be in charge of her case. She had been suffering from persistent pain, which a number of specialists had been unable to diagnose, and had become dependent on opiates and barbiturates prescribed by her husband. On weaning her from those over a period of time, it became clear that it was likely that she did have an organic element for her pain, and this was relieved by surgery. By this time her husband had moved out of the matrimonial home, sub-letting part of it, although it was structurally in a deteriorating condition. This produced a fighting reaction in my patient, although now living alone, except for her dog, and surviving on social security and the statutory services. She felt she was too weak to go out of the house on her own, and was in constant conflict with the sub-tenant, her home-help and social worker, and various solicitors who she engaged to try to gain possession of the house and deal with the divorce proceedings. Her loneliness and distress were obvious underneath her paranoid attitude to most of the world. Her behaviour was very demanding, so that she rapidly exhausted the patience of everyone with which she came into contact.

I determined that I should offer to visit her once a week for twenty minutes, to allow her to discharge

the pus of her hatred about everyone else. I adopted a strictly non-activist role, prescribing as little as possible (at one stage I discovered she was not taking most of what I had prescribed anyway), and undertaking any small service which seemed not unreasonable, such as communicating with home-help organisers and lawyers, but refusing demands which appeared unreasonable. I sought to provide a basic amount of reality-testing for her in her difficult life circumstances, which had partly led to her current situation and attitude to the world. I would do anything that was not contrary to my perception of reality. For instance, one evening she rang me in tears to say that her dog had died, so I found myself burying the dog in her garden by torchlight. This seemed a perfectly natural part of my work in the circumstances.

It grew quite naturally out of the situation in which I was the only non-enemy in her life. She went through great vicissitudes, and even landed up in gaol for contempt of court on one occasion, where I visited her. I obtained help through the Official Solicitor and purged her contempt. After this she was becoming increasingly independent, managed to gain ownership of the house, and pay the mortgage interest with the help of social security, and began to go out on her own. So that after some years she became a patient who used to consult me at the surgery in the ordinary way, and only presenting relatively serious illness. So my work with her, conceived in a situation where she was abandoned by her family and friends, and indeed not encouraging any positive relationship, was just to be there with her, recognising her anger, but speaking my mind when I felt she departed from reality, always willing to assist when it seemed appropriate. I am convinced that the emotional equilibrium necessary to sustain the relationship arose out of my new understanding of the possibilities in general practice gained in a Balint-group; never ignoring the traditional medical role on the one hand, while using the relating process of the individual concerned. Before such experience I am convinced I should have rejected her like everyone else.

But several sorts of pitfall surround this endeavour. The price of effectiveness is continual observation of oneself in the process of relating. One has to be on guard against *hubris*. Another patient, Mrs B., also became my patient at the request of a psychiatrist, who was treating her husband. She was a man-eater, and I found myself having a long-interview at six o'clock in the morning at her house. That made me realise the position, my wife having already made the correct diagnosis some time before, and I was rescued by a colleague who sectioned her when he was called when I was off duty. It was a lucky escape.

A similar danger is not to recognise when one fails repeatedly to make a useful relationship. Family C, in which the parents persistently denied the importance of anything emotional, in spite of many

attempted interpretations, should have been asked to find another doctor. It would have been better for both family and doctor if this had been done, and my failure to do so must be put down to regrettable professional pride.

It is also possible to be too clever by half. I once said to a woman who was presenting her children for something, that it seemed that she felt she was an inadequate mother. She seemed to let this pass, concluding the consultation soon after. Much later she told me that my remark had been such a bullseye that she had frozen up completely; and this I had failed to observe.

On the other hand, happily, even one's apostolic function can occasionally be useful, such as in the case of the patient who receives things from one, of which one is unaware at the time. A woman came to say goodbye to me and thanked me for the help I had given in changing her life. I had no memory of such a miraculous intervention. When I first knew her she was living with a man in what seemed to be a profoundly unhappy relationship, making her ill. She had then, from my point of view, suddenly left him, married an entirely different character, had three children and hardly ever came to consult me. When I asked her what I had done, she said 'Don't you remember that day when I came long ago, when you said, if you go on living with that chap you will never be well.' Naturally I did not, and would be willing to swear on holy writ that I never made any such statement in words, though obviously in other ways she must have received that message.

Lastly there is the situation in which one's observation is limited by blinkered vision. H. G. Wells²² describes how the Trained Observer only observes what he has been trained to observe. So the young woman with gynaecological symptoms, examination of whom shed no light on them, remained a mystery until a receptionist overheard her in the laundrette, telling her friend that she had much more sexual satisfaction from the examination with the speculum than she had with her husband. So much for the superiority of the untrained observer! It was a reminder that it is openness towards patients which leads to understanding.

What do these anecdotes amount to? Not much in themselves perhaps, but illustrations of the importance of observing what is happening between patient and doctor all the time. The need to encourage standing behind oneself during each and every consultation and review that vital, in all senses of the word, space between patient and doctor. It is there that I am certain lies the way forward, though it will take a lot of unlearning by our profession before we can go down that path. Let our continued endeavour to proclaim that the use of the doctor/patient relationship is the corner stone of general practice be a fitting memorial to Michael Balint.

References

1. Royal College of General Practitioners, 1972. *The Future General Practitioner: Leaving and Teaching*.
Vol. 17, 1989
2. Gosling, R H, & Sutherland, J S. *The Work of Michael Balint 1988*. Meeting of the British Psycho-analytical Society.

3. Pellegrino, E D. 1979. Engelhardt H I. et al
4. Howie, J G R. Research in general practice: the pursuit of knowledge or the defence of wisdom? *Brit. Med. J.* 1984. **289**: 1770-72.
5. Kuhn, T S. *The structure of scientific revolutions*, 2nd ed. 1970. University of Chicago Press, Chicago.
6. McWhinney I R. Changing Models: the Impact of Kuhn's Theory on Medicine 1983 *Family Practice, O.U.P.* **1**, 1, 3-8.
7. Fox, J. Making decisions under the influence of memory. *Psychological review*. 1980. **87**: 190-211.
8. Barrows, H S. & Tamblyn, R N. *Problem-based learning:- an approach to medical education*. 1980. Boston. Springer.
9. Carlton, W. 'In our professional opinion . . .' *the primacy of clinical judgement over moral choice*. Indiana. Univ. of Notre Dame Press, Notre Dame.
10. Buchem, F I L. 1981 Therapy of acute otitis media; myringotomy, antibiotics or neither? *Lancet*. 1981, **2**: 2883-887
11. Bain D J G. & Sales C M. Referring children to an E.N.T. department and prescribing psychotropic drugs to their mothers. *Brit. Med. J.* 1981, **283**: 585-587
12. Banks, M H. Factors influencing demand form medical care in women aged 20-44 years. *International Journ Epidemiology*. 1975, **4**, 189-195
13. Howie, J G R., 1989 Quality and the use of time in general practice: widening the discussion. *Brit. Med. Journ.* 1939. **298**: 1008-1010.
14. Balint, E & Norell, J S. *Six Minutes for the Patient*. London, Tavistock Publications. 1973.
15. Holland, W. Proceedings of Royal Society of Medicine, 1989.
16. National Audit Office 1989 National Health Service: Coronary Heart Disease
17. Morell, D. 1989 The new general practitioner contract: Is there an alternative? *BMJ* **298**, 1005-1007.
18. Dornhorst, A C and Hunter, A. 1967 Fallacies in medical education. *Lancet* ii.666-667.
19. Courtenay, M J F. Balint-groups for trainee general practitioners in *The Human Face of Medicine*. 1979. pp. 238-243. Pitman Medical.
20. Balint, M, Balint, E, Gosling, R & Hilderbrand, P. *A Study of Doctors*. 1966. London: Tavistock Publications.
21. Benson, P. 1988 Too much or too little compassion? *Brit. Med. Journ.* 1988, **297**: 801.
22. Wells, H G. *The Food of the Gods*.

The Seventh International Balint Conference

The Seventh International Balint Conference will be held at the Karolinska Institutet, Stockholm on 7-9 August, 1989

General Title

What factors shape the doctor/patient relationship?

Organised by

The Swedish Association for Medical Psychology, section of the Swedish Society of Medicine

Main topics

- **Sympathy-Empathy**
- **The meaning of the prescription in the doctor/patient relationship**
- **The everyday situation for the patient, the doctor and the Balint-group in different countries**

There will also be large group sessions on stage, demonstrating the work of a Balint-group. Small group sessions will give interested delegates an opportunity to participate in a group.

Official languages: English, French, German.

Plenary Sessions will be interpreted simultaneously.

For further information and registration form, apply to:

7th International Balint Conference
Dr Conny Svensson
Utvecklingsheten
Drakenbergsgatan 39
S-117 41 STOCKHOLM
Sweden

The Basic Fault and Therapeutic Regression*

by Dr. Harold Stewart

Consultant Psychiatrist, The Tavistock Clinic.

Michael Balint, from the beginning of his analytical career, had been interested in the psychopathology and treatment of severely regressed patients. In 1968, he wrote the book, *The basic fault: therapeutic aspects of regression*, in which he brought together his changing views and experiences in this field as they had developed over forty years.³ It should be noted that the concept of therapeutic regression is absent from both the Contemporary Freudian and the Kleinian literature; it is in the Independent Group of the British Psychoanalytical Society, most notably in the writings of Michael Balint and Donald Winnicott, that this concept is given its due weight and importance as an important agent for psychic change in our patients. In this paper I want to examine some aspects of Balint's thinking on this topic and the technical problems encountered with them and I shall start by reminding ourselves of his thinking when he coined the term, basic fault.

Like most other analysts, he noticed that although an analysis might have started and proceeded reasonably smoothly with both analyst and patient intelligibly understanding each other, at some point suddenly or insidiously the atmosphere of the analytic situation changed profoundly. The foremost change was that interpretations ceased to be experienced by the patient as such but rather as persecuting comments or as seductive and gratifying statements. Common or garden words became highly charged positively or negatively and every gesture or movement of the analyst assumed great importance. Furthermore the patient seemed able to get under the analyst's skin and apparently understand too much about the analyst in interpreting the analyst's behaviour with great accuracy but in a lop-sided and out of proportion manner. The patient could even become telepathic or clairvoyant. A patient of mine knew it was my birthday although she had no way of knowing or finding this out; another knew that I had been left some money by a relative, even to knowing almost the correct amount. If the analyst failed to 'click-in', to use Balint's phrase, to respond as the patient expected him to do, there was often no reaction of anger, contempt or criticism but a feeling of emptiness, deadness, and futility, coupled with an apparently lifeless acceptance of everything offered by the analyst. Sometimes persecutory feelings emerged in that the patient thought that the analyst was behaving intensively maliciously towards him, although at the same time the patient showed unshakeable determination to get on with things in the analysis which made him very appealing to the analyst, a sign of positive countertransference. The appearance of this total picture of a near-psychotic state indicated, according to Balint, that the level of the basic fault

had been reached.

Why did he give it this name? Firstly, Balint believed that the events described indicated that they were more elementary and primitive than those belonging to a three-person oedipal psychology but belonged rather to the field of a two-person psychology, and secondly, that the events lacked the dynamic structure of a conflict. Hence the use of the word, basic. The word, fault, arose from the fact that this word was used by many patients to describe the state, as though there was a fault in their minds that had to be put right, since the cause of this fault was that someone had failed or defaulted on the patient. It was more akin to a geological term than a moral one. The anxieties in the analysis were that the analyst should not also fail the patient. Since the term basic fault has readily been accepted into our analytic terminology, it must be that it touches on a basic resonance in the thinking of analysts. This psychic state is clearly akin to that of a transference psychosis but as far as I know, no-one, other than Balint, has included parapsychological phenomena in their descriptions of such states. No doubt, Freud with his interest in the occult would have been interested in Balint's observations.

The basic fault was then a manifestation of psychopathology and Balint had his own views on human development. He did not accept Freud's theory of primary narcissism and in the chapter in his book, *Primary narcissism and primary love*, he set out in detail the reasons for his objections.⁴ He believed in the concept of primary love which is considered in detail in his book, *Thrills and regressions*², but briefly he maintained that 'a healthy child and a healthy mother are so well adapted to each other that the same action inevitably brings gratification to both . . . the theory assumes that there exists a harmony between the individual and his world; that is, there is not — and cannot be — any clash of interest between the two', 'At this stage of development there are as yet no objects, although there is already an individual, who is surrounded, almost floats, in substances without exact boundaries; the substances and the individual mutually penetrate each other; that is, they live in a harmonious mix-up'.² He compared this state with the water in a fish's gills or oxygen going into the lungs; was the water or oxygen outside or inside the organism? Equally the organism took the water or oxygen completely for granted, to be used without effort or thought. Balint maintained that hate and sadism were secondary to frustrations of the primary love relationship, rather than their being primary drives in their own right; in this, his theorising is akin to that of Fairbairn.

Inevitably this ideal state of primary love could not last and it was here that the basic fault arose in the individual's response to the traumatic discovery of frustration and separation from its primary object. In his view, 'the origin of the basic fault may be traced back to a considerable discrepancy in the early

*Paper presented at the British Psycho-Analytical Society's Day of Public Lectures on the Work of Michael Balint, on 5 November 1988. With grateful thanks to the Secretary of the British Psycho-analytical Society for permission to publish.

formative phases of the individual between his biophysiological needs and the material and psychological care, attention and affection available during the relevant times. This creates a state of deficiency whose consequences and after-effects appear to be only partly reversible. The cause of this early discrepancy may be congenital . . . or environmental, such as care that is insufficient, deficient, haphazard, over-anxious, over-protective, harsh, rigid, grossly inconsistent, incorrectly-timed, over-stimulating, or merely un-understanding or indifferent'.³ The more the discrepancy, the more intense and pathological became the consequences for the individual.

Balint then suggested that there were two methods by which the individual might have responded to the trauma of this relationship with the primary object, which were distinct from the withdrawal of libidinal cathexis from the object back into the ego which would have given rise to secondary narcissistic states. The first way entailed the cathexes adhering to the objects, making them feel safe and comforting, but having as a result, the spaces between the objects feeling horrid and threatening; the second entailed the spaces between objects being experienced as safe and friendly, whereas objects were felt to be treacherous hazards. The first method he called ocnophilia and the second, philobatism. He noted the close relationship of these to the state of agoraphobia and claustrophobia, and in view of the fact that borderline states and severe perversions have been recognised by analysts of differing theoretical orientations as having a pathology along the claustrophobia-agoraphobia axis, and the severe anxieties of merging and of separating, there does seem to be a general agreement concerning this type of basic pathology.

Let us now return to the patient who has regressed to the basic fault level as described by Balint and let me give an example. A patient in this phase experienced my customary way of ending a session as an expression of my hating her, of my picking on her, and of treating her very badly. She demanded to know why, if my wife and family lived in my house in which I practice, she had to leave my house as she had as much right to be there as they did. She could see no difference between my relationship with my family and my relationship with her. Patients in this state may often expect full gratification of their needs and wishes by the analyst since they are often experienced as compulsive and concrete in nature, and the technical problems involved will be discussed later in the paper. Balint defined the problem as 'how to enable an uncooperative part of an individual to cooperate; that is, to receive analytic help . . . to stimulating, or perhaps even to creating, a new willingness in the patient to accept reality and to live with it, a kind of reduction of his resentment, lifelessness, etc. which appear in his transference neurosis as obstinacy, awkwardness, stupidity, hypercriticism, touchiness, greed, extreme dependence, and so on'. In my experience, this description is not strong enough as it does not encompass the sheer malice, destructiveness and extreme envy that is also behind the lack of cooperation. Khan in his essay on Balint's researches had previously made this point as a result of his experience of working with these patients.⁵

Before coming to technical considerations, we

should look at Balint's views on the regressed state itself. He had continued, in spite of the atmosphere in the psychoanalytic world towards therapeutic regression following on Freud's open disagreement with Ferenczi's experiments, to allow patients in regressed states to gratify their needs for certain satisfactions in the analytic situation, the most extreme seeming to be touching or holding the analyst's hand. Gradually he began to think that such gratifications, given in what he called an '*arglos*' atmosphere, were not important in themselves but as a way of freeing the patient from the complex rigid and oppressive compulsive forms of object-relationships to which the patient had regressed. He defined '*arglos*' as 'a constellation in which an individual feels that nothing harmful in the environment is directed towards him and at the same time nothing harmful in him is directed towards his environment'.³ It is comparable to basic trust. This state is an essential precondition for a 'new beginning' in the patient, which is 'the capacity for an unsuspecting, trusting, self-abandoned and relaxed object-relationship'.¹ The '*arglos*' atmosphere and 'new beginning' are clearly closely related to his concept of primary love. Balint then postulated that this form of regression is not an attempt on the patient's part to gratify an instinctual craving but rather a way of using the environment to enable him to reach himself; he called this 'benign regression' or 'regression aimed at recognition'.³ This concept is very close to Winnicott's ideas of ego-needs as against id-wishes and his dividing of the primary maternal figure into the environment-mother and the object-mother.¹¹

However, we should note that in the near-psychotic state of the basic fault as described, the '*arglos*' atmosphere and its significance for new beginning could not exist. This is the realm of the other type of regression described by Balint, 'Malignant regression' or 'regression aimed at gratification'.³ He noticed that patients had seemed to fall into two groups; in one, the enactment of some form of simple gratification in the analysis where the atmosphere was an *arglos* one was sufficient to allow a satisfactory new beginning to occur. In the other, however, if there was any form of gratification and satisfaction of primitive wishes or needs, further demands for gratification were made and a constant spiral of urgent demands occurred often leading to addiction-like states which were very difficult to handle. The atmosphere in these states was not *arglos* in the attempt to reach the self, but desperate, passionate and of high intensity in the demands for gratification by external action on the part of the analyst and hence the name, malignant regression. Balint noted that the clinical picture in these patients showed signs of severe hysteria. Ferenczi's treatment of these patients had often led to malignant states of regression and his attempts to find ways and means of dealing with the spiralling demands had led to Freud's disagreement with these attempts. Nevertheless, Balint believed that Ferenczi's work in this area had led to two major discoveries. One concerned 'the immense effect of the analyst's 'customary', 'habitual', or 'classical' attitudes towards practising as an analyst on the developing transference relationship, and on the course of the analytic treatment; the other was about the technical

possibilities of a counter-transference interpretation'.³

We now need to turn to the technical features and problems which arise when working at the basic fault level and see how Balint regarded them. He started from the observation that in some patients, where he believed that their compulsive patterns of behaviour and object relationships originate in a reaction to the basic fault, interpretations would have incomparably less power since (a) there was no conflict that needed to be resolved, and (b) words were no longer experienced as very reliable tools. He believed that in these cases additional therapeutic agents other than interpretations should be considered and in his opinion, 'the most important of these was to help the patient to develop a primitive relationship in the analytic situation corresponding to his compulsive pattern and maintain it in undisturbed peace till he can discover the possibility of new forms of object-relationship, experience them and experiment with them . . . a necessary task of the treatment is to inactivate the basic fault by creating conditions in which it can heal off'.³

How does one foster this process in the analysis? Interestingly, Balint started by emphasizing three things that the analyst should try to avoid doing. The first was to avoid interpreting everything first as a manifestation of transference, which is one present fashion in interpretative technique. Balint thought that this style of interpretation 'tempts us to turn into mighty and knowledgeable objects for our patients, thus helping — or forcing — them to regress into an ocnophilic world'.³ In this way, independent discoveries by the patient about himself tended to be discouraged. I myself believe that by working only in the transference, the effect is to devalue all the patient's relationships with other people other than the analyst, which forces the patient into the ocnophilic world of the analyst himself, i.e. it can be countertransference manifestation in its original sense as used by Freud.

The second thing to avoid was 'not to become or behave as a separate sharply-contained object . . . to allow his patients to relate to, or exist with, him as if he were one of the primary substances'.³ By primary substances, he meant water, earth, air and fire. In this way he seemed to be implying that the analyst tolerated some types of acting-out and that he also accepted the patient's transference projections and projective identifications without wanting to hurry to interpret them back into the patient. The third point was to avoid becoming or appearing to be omnipotent. 'This is one of the most difficult tasks in this period of the treatment. The regressed patient expects his analyst to know more, and to be more powerful; if nothing else, the analyst is expected to promise, either explicitly or by his behaviour, that he will help his patient out of the regression, or see the patient through it. Any such promise, even the slightest appearance of a tacit agreement towards it, will create very great difficulties, almost insurmountable obstacles, for the analytic work'.³

He noted that several other analysts had described this sort of object relationship of being like an indestructible primary substance in their own particular terms: 'need-satisfying object' (A. Freud), 'average expectable environment' (Hartmann), 'container and contained' (Bion), 'good enough

environment', 'ordinary devoted mother', 'medium', 'Primary maternal preoccupation', 'holding function of mother', 'facilitating environment', (all these by Winnicott), 'basic unity' (Little), 'protective shield' (Khan), 'mediator of the environment' (Spitz), 'extra-intensive matrix' (Mahler).

Balint continued with his technical recommendations. He suggested that with patients regressed to the basic fault level, the analyst should bear with the regression without any forceful attempt at intervening with an interpretation, particularly those that are aimed at trying to get the patient out of the regressed state. The regression might have lasted for minutes or for many sessions but nevertheless it should have been borne with and tolerated as a mutual experience. He maintained that the analyst accept the acting-out in the analytic situation as a valid means of communication and that it should not be speedily organized into understanding interpretations. He insisted, however, that this did not mean that the acting-out was not to be eventually understood by interpretative work with the patient, but that for the time being, the non-verbal communication had to be experienced in its own right and only later, be put into organized verbal concepts.

These recommendations of accepting the experience of the regression and acting-out without speedy interpretative work, meant that the emphasis was placed on the mutual sharing of the experience in the analysis and that this is an important therapeutic agent in its own right and not simply as the vehicle for therapeutic insightful interpretations. This emphasis I believe, is one of the most important theoretical differences between the Independent and Kleinian groups in England and it is, of course, a most important ingredient of Winnicott's theoretical position. In addition to this space for non-verbal experience, Balint stressed the importance of the provision of time and *milieu*; 'what the analyst must provide — and, if at all possible, during the regular sessions only — is sufficient time free from extrinsic temptations, stimuli and demands, including those originating from the analyst. The aim is that the patient should be able to find himself . . . discover his way to the world of objects — and not be shown the 'right' way by some profound or correct interpretation'.³ He also held that 'interpretations should be scrutinized most particularly, since they are felt more often than not as an unwarranted demand, attack, criticism, seduction or stimulation; they should be given only if the analyst is certain that the patient *needs* them, for at such times *not giving them* would be felt as unwarranted demand or stimulation'.³ This, then, to re-emphasize, is not to deny or denigrate the vital importance of interpretative work; it is to dispute its exclusive role as a therapeutic agent in analysis.

We should now look at some of the clinical examples that Balint gave to illustrate this aspect of the work at the basic fault level. I should say at once that his examples are all taken from patients in a state of benign regression and none from a state of malignant regression. There is no discussion of techniques that could be used for patients when they have regressed to this state but there are recommendations of how to try to prevent patients from regressing into

a malignant state. I shall attempt to discuss technical issues concerning this state later in this paper.

The first case described was the well-known one of the girl who did a somersault in the consulting-room. She was in her late twenties and her main complaint was an inability to achieve anything. In the second year of her analysis in response to an interpretation, she said that since earliest childhood she had never been able to do a somersault. In response to Balint's comment 'What about it now?', she got off the couch and did a perfect somersault; this led to a breakthrough and new beginning in terms of her treatment and personal life. He called this acting-out a regression since although it was not a repetition of an actual early event, it was a repetition of a more primitive form of behaving and experiencing.

Another case was one of a woman who he allowed to hold one of his fingers for some time during the analysis. He mentions this allowing of finger or hand holding as a part of his technique when he felt that the atmosphere was of the *arglos* type. Two further cases described were rather opposite in nature. The first was of a man who had to be on sick leave from work for several weeks during a new beginning period. He stayed in bed, came regularly to his sessions and asked for extra sessions especially at weekends or that the analyst should telephone him, which he did. The second was of a man, on Fridays, often asked for an extra weekend session and had been given them. This had not helped the analysis to progress, the patient being one who had always resisted real analytic contact. Eventually the analyst decided not to accede to the request for an extra session, giving the reason that to accede made the patient feel small and weak and the analyst seem all-powerful. The patient telephoned that evening to tell the analyst he was near to crying and following this, some progress was made in the analysis. In the only other case given, a man who was in the second year of his analysis was silent for about thirty minutes of the session and the analyst also remained silent, having previously had experience of the silence. On this occasion the patient had broken the silence by sobbing and then speaking of being able to reach himself. Since childhood he had not been left alone but had always had someone telling him what to do.

These cases illustrate the comparatively unobtrusive technique of the analyst and are no doubt familiar to most analysts from their own technique although some of these examples would be controversial. The tacit encouragement given to the somersault patient, the finger and hand holding, and the telephoning of the patient show a more active technique that many of us would disagree with; one could say that this activity, perhaps acting-out, on the analyst's part is not easy to reconcile with the concept of unobtrusiveness although this could well be a matter of balance. Nevertheless, all the cases demonstrate some degree of acting-out by the patients which the analyst accepts, and they do seem then to be able to reach to something new in themselves which is beneficial to their therapeutic progress. Yet interestingly, not all of the cases demonstrate a gratification of the patient's needs or wishes; the man who was refused the extra session was certainly not gratified in the usual sense of the word, yet the refusal was helpful to him. This represents a topic not

discussed by Balint, which is crucial at times, and this is the importance of being able to say No, to frustrate the patient, when appropriate. It is a truism that a vital part of the analytic situation without which the analysis cannot succeed is the maintenance of the analytic setting and its boundaries. Some patients repeatedly test these boundaries to see the quality of the analyst's holding capacities; this is indeed one of the characteristics of a malignant regression. This maintaining of the setting and its boundaries may be described, in Winnicott's term, as an ego-need of the patient, which is crucial for the patient's gradual differentiation of self from others; the necessity for the analyst, as for the parent of a child, to say No is an ego-need. If we use Winnicott's other term in this respect, the id-wishes for gratification of the patient are those to which the analyst must say No. The problem for the analyst is to differentiate an ego-need which needs to be gratified by the analyst's acceptance from those where the gratification of the ego-need lies in the saying No to an id-wish. Balint had attempted to do this by the differentiation of the different atmospheres and intensity of desires in his two types of regression, but at least in one instance, he seemed to be underestimating the problem and this was in the context of physical contact between patient and analyst, even in finger- or hand-holding.

He thought that in the context of an *arglos* atmosphere, this physical contact is not only acceptable but therapeutically helpful, and his experience that it did not seem to be addictive must have encouraged him in this belief. It is very important here to note that Balint was very much against allowing physical contact of any sort except in this context. My own experience of him very firmly forbidding me to hold or allow any hand contact with my first supervised training case during the second year of her analysis bears this out. In this respect he differed considerably from Winnicott and he indicated this gently in Chapter 18 of 'The Basic Fault'. Strangely enough, Balint seemed to sound a warning against touching in his previous book 'Thrills and Regression'; 'I thought that the need to be near to the analyst, to touch or to cling to him, was one of the most characteristic features of primary love. Now I realize that the need to cling is a reaction of a trauma, an expression of, and a defence against, the fear of being dropped or abandoned'.² In the more recent literature, Casement gives a description of his patient's early traumatic experiences with her mother which emerged in the analysis when he refused to allow hand-holding;⁴ this confirms Balint's seeming warning. Pedder describes his experiences with a patient in which he allowed hand-holding and found it therapeutically helpful.⁹ Yet in a preface to this paper, published in 'The British School of Psychoanalysis, The Independent Tradition' ten years later, he writes: 'The technique used has not become a standard part of my therapeutic repertoire and I have not handled a case in a similar way since. Perhaps I now rely more on the interpretative mode'.⁹ I have noted, and so have some colleagues, that after allowing hand- or finger-holding, even though it is late in the analysis and in an *arglos* atmosphere, the patient will have a dream, frightening or otherwise, of being raped or sexually assaulted. The inference is that the unconscious experience of the patient had been very

different from that of an innocent physical contact. My last point concerning the wish or need for physical contact is that I have only experienced such requests from female patients and never from a male, but perhaps this may be because my experience of treating male homosexuals is relatively limited.

My conclusion from these points is that although physical contact may be therapeutically useful, it may also conceal more than it discloses. Furthermore it also makes me wonder about the nature of the *arglos* atmosphere. It could well be that on some occasions, the atmosphere may seem to have this quality because the psychic realities of persecutory traumatic and sexual anxieties have been split-off and denied, leaving the opposite state of innocence and guilelessness in a hysterical-type defensive manoeuvre. As the analyst cannot differentiate the real *arglos* state from the fraudulent, it seems therapeutically more advantageous to forego physical contact rather than risk colluding with the patient's denials.

Before coming on to the issue of malignant regression, I do want to re-emphasize the vital feature of this work with regressed patients and that is the necessity of thorough interpretative work on the regressed state, but afterwards. Balint's examples do not illustrate this aspect and this could lead to the notion that Balint is only concerned with acting-out and not with the rigorous interpretative work of an analysis; this would be a great mistake in considering his technical recommendations for analysts.

As I mentioned earlier in the paper, Balint gave only a cursory look at malignant regression. Khan in his paper on such a case thought that malignant regression was basically reactive to a dread of surrender to resourceless dependence in the analytic situation.⁶ He characterized the patients as coming from an overprotected environment in infancy and childhood, which did not allow for aggressive behaviour which is essential to the crystallization of identity and separateness of selfhood in the child. He also noted the presence of severe destructive envy which spoils and negated any indication that the analyst's work had been helpful to the patient. My own experience would support his views on dread of surrender and of destructive envy, but I found that some of my patients came not from overprotected environments but underprotected ones, where the parenting had been unpredictable, often violent, and associated with prolonged separations. They were all very severe hysterical personalities, as Balint had suggested, with an underlying borderline-psychotic psychopathology.

When we consider malignant regression in the analytic situation, we need to think, with Balint, on the contribution to the regression that comes from the analyst and his technique as much as the contribution from the psychopathology of the patient. He believed, as previously described in the paper, that the more the analyst's technique was suggestive of omniscience and omnipotence, the greater is in danger of malignant regression. In addition to this, I would secondly add that interpretations in sexual terms concerning sexual fantasies and conflicts, if given early in the analysis or else when the patient is regressed to the basic fault level, can easily lead to severe acting-out in a malignant fashion. The third contribution the analyst can make

to a malignant regression is to gratify the patient's wishes. A patient of mine had had a previous analysis, ending in disaster. The analyst had given the patient extra time and extra sessions and had allowed her to be destructive of objects in the consulting room at no cost to the patient and had even been given a piece of clothing to wear and take away as a token to the idea of a transitional object. The patient became increasingly more violent and demanding until the analyst had stopped treatment when he had reached his limits of tolerance of the unending spiral of demands.

Can we know at an early stage, apart from the patient's history, of the potential for this type of regression? I will give an illustration. A patient in the first few months of analysis telephoned on a Friday evening in an agitated state to tell me how unhappy she felt about her last session and the weekend break. We spoke for a few minutes and she felt relieved. On Monday we discussed the call and the break and things were quiet through the week but on Friday she telephoned again in an agitated state for a few words. I then knew that in her repeating her acting-out, I had a problem; if I spoke to her as she wanted, she would be calm for the weekend but would there be further demands? If I didn't comply she might become more agitated over the weekend or else act-out in some other way. I felt I wouldn't comply but I pointed out that she was repeating her behaviour of the previous Friday and that I thought it better to discuss it with her on Monday. When she slammed her phone down, I knew what I was dealing with and some weeks later, trouble started in earnest.

This leads us to the situation in analysis where the analyst's contribution to the regression is minimal and that of the patient maximal. The types of acting-out that can occur in these states are many, but I will confine myself to a consideration of the very considerable difficulties that arise when the patient is violent or destructive or when the patient does not want to leave at the end of the session. The patient of the telephone calls has been described by me in a paper concerned with problems of her management.¹⁰ The patient, who felt divided into a good and an evil part, had developed a compulsive desire to know if I had an erection during the session, which changed into the active state to feel if I had one. This was at first controlled by interpretations which were kept not overtly sexual in nature but these soon proved to be of little avail. She started to get off the couch and approach me and although for a time this was controlled by interpretations, these again became useless and she attempted to physically force me to let her feel I had an erection or not. I naturally physically restrained her and she soon stopped and I was then faced with the problem of future tactics. I could have warned her that if this physical attack happened again, I would have stopped her analysis but I had reason to be fairly certain that she would not have heard my warning threat as anything but a challenge for her to actively face and this would have meant the end of the analysis. I could have sent her to another analyst but I also knew that this or something similar would almost certainly have occurred with the new analyst and so this was no

solution. As I wanted the analysis to continue, I decided that the only course for me to take was to continue to physically restrain her, which I could do as I was bigger and stronger than she was, but I also had to wonder about my own countertransference in allowing such close physical contact with a female patient. Would this be a sexualization of the analytic situation? On inner reflection, I decided that I was not taking this course in the interest of my sexual gratification and I therefore decided to see where this enforced active technique on my part would lead. In fact, after a few weeks of this and much analytic interpreting in the sessions when she felt she was good and not evil, this behaviour stopped, never to be repeated and it proved to be an important step forward in her progress towards health. What the interpretative work made very clear was the extent to which these physical attacks were a manifestation of her extreme destructive envy of my abilities and my potency as an analyst, and my functioning during these attacks was to be literally a physical container for them and the maintainer of sanity and boundaries in the analysis. It was a literal physical saying No to her and it is interesting in this respect that Winnicott wrote that 'violence is an attempt to reactivate firm holding'.¹²

The patient who had destroyed her previous therapies presented different problems. Almost from the beginning of her treatment, she would get off the couch, bang around in my room and shout obscenities at me, but she did not physically attack me. At the end of sessions, she slammed the doors as hard as she could, rushing out into the street still shouting obscenities about me. Interpretative work was useless with her and when I noticed that the paintwork on the doors and surrounds was being chipped, I decided that I would insist that she stop this damaging behaviour to my property or I would terminate treatment. My limit of violence had been reached. She stopped this behaviour by difficult self-control, even going to the length of tying her hands together with string around her wrists, rather like handcuffs, in order to control her violence, but now her behaviour changed in that she did not want to leave at the end of sessions. I eventually had again to threaten to stop treatment if she didn't leave in order to control this but interestingly, she still did not understand why she should have to leave at the end of a session. She wanted to know why she had to leave my house, whereas my family, whose presence in the house she was aware of, did not have to leave. Why was she any different from them? She was incapable of understanding any distinction between my family and herself, and it took quite a time before I realized how basic her difficulty in understanding things we tend to take for granted

really was. It was not until I spelled out to her that I chose to have my family staying in the house and that I did not choose to have her staying, that she was satisfied and understood what I was talking about, and after this, we had no further trouble on this score. This would serve as an illustration of Balint's description of the phenomenology of the basic fault, where words lose their usual socially-accepted meanings and overtones, resulting in a fracture of communication.

These issues concerning the maintenance of the analytic setting, particularly by the confrontation of the patient with the analyst's boundaries and limits, are complex in nature but we should take a brief look at some of the theoretical ideas involved in them. Winnicott as I previously mentioned described violence as the patient's attempt to reactivate firm holding, and in several papers, he wrote of the necessity of giving patients the opportunity for experiencing legitimate hatred towards the analyst. The maintenance of the setting most certainly provides such opportunities. Bion's concept of the container which acts to accept the patient's projections without retaliation but with understanding and firmness is relevant here. Little,⁷ writing of her experience of analysis with Winnicott when she was in a psychotic state, thought that in the context of the delusional transference, also called the transference psychosis, there is an identification with the analyst whereby his prohibitions automatically become the patient's own prohibitions and that these joined up with some element of sanity in the patient. Ogden writing on projective identification, postulated that the patient projected the sane aspect of himself into the analyst since the patient's anxiety was that the destructive aspects of himself would annihilate the sane.⁸ The aim then was to protect this sanity by projecting it into the analyst to join with the analyst's sane aspects. Ogden thought that the evidence for this was that the patient accepted, perhaps under duress, the analyst's boundaries and limits without completely destroying them and the analysis. I would like to add the notion that the analyst needs to have the firmness and strength to maintain the setting and that he would not confuse these qualities with sadistic cruelty, which might well undermine him by making him confusedly anxious and guilty of his own healthy aggression.

To conclude, I would like to repeat that Michael Balint, whose views I have necessarily had to simplify in the interests of writing this paper, had always seen the positive therapeutic potentialities of regressed behaviour in our patients. The technical procedures, that I have been discussing about both types of regression, are valid in dealing with a very wide range of experience with our patients and not just those at the level of the basic fault.

References:

1. Balint, M. New beginning and the paranoid and the depressive syndromes, in *Primary Love and Psychoanalytic Technique*. London: Hogarth Press, 1952.
2. Balint, M. Regression in the analytic situation. in *Thrills and Regression*. London: Hogarth Press, 1959. p.65.
3. Balint M. *The Basic Fault*. London: Tavistock Publications: 1968. p.22.
4. Casement, P.J. Some pressures on the analyst for physical contact during the reliving of an early trauma. in *The British School of Psychoanalysis. The Independent Tradition*, ed. G. Kohon. London: Free Association Books, 1982.

5. Khan, M.M.R. On the clinical provision of frustrations, recognitions and failures in the analytic situation. *Int. J. Psychoanal.* 1969. **50**. 237-248.
6. Khan, M.M.R. Dread of surrender to resourceless dependence in the analytic situation. in *The Privacy of the Self*. London: Hogarth Press. 1974. pp.
7. Little, M.I. Winnicott, working in areas where psychotic anxieties predominate. A personal record, *Free Associations*, 1985, **1**, 3:9-42.
8. Ogden, T. On projective identification. *Int. J. Psychoanal.* 1979, **60**: 347-374.
9. Pedder, J. R. Attachment and new beginning: some links between the work of Michael Balint and John Bowlby. in *The British School of Psychoanalysis. The Independent Tradition*, ed. G. Kohon. London: Free Association Books. 1976.
10. Stewart, H. Problems of management in the analysis of a hallucinating hysteric. in *The British School of Psychoanalysis. The Independent Tradition*, ed. G. Kohon. London: Free Association Books. 1977.
11. Winnicott, D. W. The development of the capacity for concern, in *The Maturation Processes and the Facilitating Environment*. London: Hogarth Press. 1963.
12. Winnicott, D. W. Youth will not sleep. in *Deprivation and Delinquency*. ed. C. Winnicott, R. Shepherd, M. David. London: Tavistock. 1964.

International Ascona Balint Meeting, 1989

Another successful annual meeting was held at Monte Verita in Ascona, Switzerland in April this year, attended by more than two hundred European medical students (unfortunately, none from Britain). This year's theme was 'The ageing person and his doctor'.

The original Balint-seminars were restricted to established family doctors who wanted help, but later on Michael Balint did begin to take on undergraduates from the University College Hospital Medical School. Professor Boris Luban-Plozza, who has been organising the Ascona meetings for nearly twenty years, showed us the room in his own residence where Balint had actually led a student-group in 1968. He kindly arranged for our English-speaking groups to be held there this year.

We had an unexpectedly large attendance of more than thirty students, and so a series of 'fishbowl' groups were formed with the optimum number of eight members. A useful result of this arrangement were commentaries by the surrounding students and tutors about the way the inner group handled the situation.

An important reason for having Balint-groups is the opportunity it provides for learning from everybody. Michael Balint did learn much from us naive practitioners; now we are experienced we are learning from students. An example of this occurred in one of our groups. A tutor commented about the inadequacy of the data provided, and the necessity for more facts about the patient. A female student then questioned this, wondering how much information would help us get a truer feeling of this particular doctor/patient relationship.

A major event at the Ascona Meeting is the award of prizes for the essay competition for medical students. To promote the concept of patient centred

medicine, the students are encouraged to write about personal experiences of their relationships with patients; how these developed; reactions with other members of the medical team, such as nurses and specialists; and the sort of medical training they feel would help them achieve more awareness about individual patients.

This year the judges included Dr Arthur Trenkel, of Berne; and Professor Wolfram Schuffel, of Marburg. We were very proud to hear of the first prize being awarded to a British medical student, Mary Keany of Leicester University. Her paper dealt with the evolution of her ideas about psycho-sexual disorders, having spent an extra year as a student on a research project in a general practice setting.

Most interesting was the way in which the standard concepts derived from academic sources were modified, as relationships with individual patients developed. Instead of trying to fit every patient into pre-conceived categories, this student let herself feel puzzled and challenged by apparent discrepancies, and she gradually adapted her original ideas to what was being actually presented by the particular patient. Judging from her essay, she now recognises the importance of close awareness and proper communication with patients, not just expert knowledge. This is true Balint philosophy, and so this student deserved the very generous first prize.

Like so many of the other Ascona events, this one certainly justified medical student Balint-training, of which Professor Luban-Plozza has been the foremost tutor for very many years. Next year's meeting is planned to be in Szeged, in southern Hungary.

J. S. NORELL

What Balint Means to Me

by Jack Norell,
General Practitioner, London

It is almost 20 years since Michael Balint passed away, yet I am still learning things from him that are helping my personal as well as professional development. I feel increasing admiration and gratitude towards him. His most outstanding way of teaching was not as tutor or instructor or demonstrator, but an inspirer. He conveyed a model of personal and professional relationships; perhaps not wholly recognised by me at the time, but appreciated more and more now. I wish not that I had not been all that slow, because I recall that when he sensed he had little time left he became a little impatient, which was uncharacteristic. However, this itself was a true model of real life.

His main objective in running the groups was to help widen the perspectives of us general practitioners, so that we could be more responsive to our patients. He wrote that the family doctor was being offered new ways of thinking and acting: 'not by devaluing his present knowledge and skills, but by using them as a basis upon which to extend his therapeutic resources'. I am sure that he hoped this would achieve what he dearly wanted, which was to benefit a greater number of needful patients.

What Balint means to me, I would like to express under a variety of sayings, starting with aspects of *Training-cum-Research* and followed by *Doctor/Patient Relationship*.

Blind leading the Blind

Balint-groups are really think-tanks, not teaching sessions; workshops, not talk-shops; we are expected to learn from each other rather than from experts. Someone presents an account of a recent experience with a particular patient; the group then express their feelings about what they have heard, saying what they think; and then, with the assistance of a skilled leader, we think about what is said. It is a fresh perspective that I seek from my colleagues, not an actual answer to my problem.

Teaching and Learning

The most reliable people know that they know, or that they know not. The really difficult ones are unaware that they do not know. The rest of us who do not fully realise what it is we do know, will benefit from being taught. I found that as an established practitioner I could only be taught what I already partly knew, though perhaps not fully aware of. I think that this relates to Michael Balint waiting for us to learn a little from our own experience before he would offer comment on a particular topic.

True Meaning of Meaning

Authoritative statements by experts about the meaning of this, the meaning of that, has not proved all that helpful in reaching real understanding about what is happening in our relationships with patients. I found it more useful reflecting with the group, 'what it means to me, what it means to him, what it means to you'.

Limited but Essential Change

This description by Michael Balint of what a family doctor's personality undergoes during training has frequently been misrepresented as its aim, instead of just the consequence.

Why Speculate? Why not try the Experiment?

Whenever anyone put up a fresh idea during a group discussion, Michael Balint immediately encouraged us to test it out and then report back. We recognised, of course, that we were practising the art of medicine, not yet a medical science; but he quite rightly wanted us to adopt the approach which would help 'make the art more scientific', as Alvan Feinstein recommended. Science had been defined as 'disciplined scepticism', and Michael Balint went in for questioning — and self-questioning, which I greatly value. However, conventional science insists on generalising; whereas the Balint way relies on anecdotal accounts and personal revelations to enable us to reach decisions on individual matters. An example of Balint research was an attempt to establish proper criteria for judging the successful outcome of the handling of our patients. It became evident that it was not sufficient just to rely on the freedom of symptoms. Nor on no further attendance, because this could be alleged to be the so-called retreat into health! Even the presence of a pleasant relationship was not enough: it might hide the existence of awful relationships in the world outside. We realised that all these criteria would have to be combined.

Disciplined Fantasizing

We always assumed that we ought to think very carefully before we dared to express any ideas in our groups. Michael Balint gave us the courage to put this aside, and to realise that the sharing of spontaneous thoughts would be much more productive for gaining understanding about what was being experienced. There is now a favourable attitude towards the feelings of patients — and of doctors. We are no longer short of feelings. What Michael Balint devoted so much time to, was sensible thinking about feelings.

Selective Attention Implies Selective Neglect

For generalists such as we family doctors, getting our priorities right can be most taxing: anything that we defer still remains our responsibility. Nor do we enjoy the luxury of being able to discard difficult patients on the grounds of their unsuitability for treatment of a particular kind, or for being unco-operative, resistant or non-compliant. We have to make frank decisions on what to do, as well as what not to do. Unfortunately, such selectivity will not help us achieve an overall diagnosis.

Our Need to be Needed

This is something to beware of. We have given up expecting to be praised for all we do; but believing that patients are dependent on us, though it may be a source of job satisfaction, can lead to our misjudgement. One cause of medical problems is solutions.

Journal of Balint Society

*The Balint Society Prize Essay, 1989.

Doctor means Teacher

Michael Balint frequently quoted this. But more important, he urged that before attempting to teach our patients, we must first learn from them.

Patients are our True Teachers

Doctors can learn from their patients as well as from their peers and from pundits. Rather as teachers themselves learn from pupils, and parents from their children. In Michael Balint's groups, I adopted the guidance about keeping my mouth shut and listening carefully to patients. But I could not be taught to hear what was being said, or to be sure what was meant. I only achieved this after long experience with patients of mine, who were the ultimate testers. The groups were, of course, most vital in helping me to learn from patients, mainly by illuminating my blind spots.

Ticket of Entry

Another of Michael Balint's well-known phrases. As I learned more and more from him and improved my relationships with patients, they then had less need to brandish such tickets.

Actions Speak Louder than Words, Words, Words

Caring, like justice, must be seen to be done. More important that what I say to my patients is how I behave towards them. They would like to be taken seriously and treated as human beings. We cannot always talk patients out of their troubles (although they themselves may succeed by doing so). In his last group-discussion with us, Michael Balint said: 'The question is not whether a patient tries to communicate, but how the doctor can respond to the communication, and here we come back to the *flash*. This is the difference between the detective-technique and the flash-technique. The detective only collects material and understands it; how he responds to it is different. Whereas the flash-technique, if I am right, is not only sensing what has happened and understanding it, but responding, so doctor and patient should feel that their talk is in the same language, not at cross purposes.'

Acceptance Involves Understanding

I once presented a case in a group led by Michael Balint, when he questioned the way my patient had behaved. I just shrugged my shoulders and said that we family doctors had to accept that sort of behaviour. He agreed, but added 'Let us try to understand what it is we are accepting'. Quite: otherwise it is merely tolerance.

Every Case is Different, and Very Similar to All Others

I kept watching backwards and forwards: appreciating patients' uniqueness, then regarding them as all the same, then back again. Eventually I got around to accepting that the individuality of patients could be combined with their having much in common.

Diagnosis First, Treatment Afterwards

In the Balint context, this applies to when we *try to reassure*. It does not always satisfy patients to be given a blanket reassurance: to be told that there is nothing at all to worry about. It would be better to try to identify something they are worried about, of which perhaps they may not be fully aware.

Vol. 17, 1989

The Courage of One's Stupidity

This sounds a bit anti-professional, yet in way it reflects the reality of family medicine. I did often rely on intuitive impressions; and sometimes felt forced to act, despite uncertainty about the diagnosis, whether this was due to lack of sufficient evidence, to naivety, or to sheer ignorance. But what actually made this courageous was my being prepared to raise it in the Balint-group, whose members understood me — only too well!

Make it up as You go Along

The purpose of medical education is to pre-determine the nature of the problems which are going to be encountered by us, so that the illness which each patient presents can be fitted into these categories. But Michael Balint taught us to accept everything as fresh, and to try relating symptoms to the nature of the patient.

Real Understanding Means Standing Under

Humility helps to sense the thoughts and feelings of patients:

' 'Tis a gift to be simple, 'tis a gift to be free,
'Tis a gift to come down where we ought to be'

Though I Mens's Master be, Their's is the Teaching Mind

This quotation from *God's Education* fits in well with the way Michael Balint related to us general practitioners. In the very early days, we kept pleading for advice about the best way to manage our patients. The reason why Michael Balint held back from providing such answers was because he knew he knew not. What he did know, was that he would be learning the answers from us as we described our regular encounters with patients.

Trial and Error

One of Michael Balint's marvellous teachings was his very frank demonstration of the evolution of his own ideas, including the readiness to discard original thoughts in favour of new ones brought up by his superb practical experience. For example, his recognition of how incongruous his former belief was, that classical psychotherapy techniques were quite applicable to family medicine. (This is what he later labelled as a 'foreign body'.) Instead, he introduced the concept of getting on to the patient's wavelength; tuning in properly to patients; every patient, not just the favoured few. By this, he helped me to realise that true learning will involve unlearning.

Is this the Job for a Medical Man (or Woman)?

Yes, because Michael Balint taught us to accept responsibility as general practitioners for exploring whatever it was that seemed to be making our patients feel unwell. For me, Michael Balint's philosophy reflected proper medicine, not alternative medicine.

Six Minutes for the Patient

A more correct title for that book might have been *Six minutes with the patient*, because the thoughts and feelings devoted to these patients can go far beyond the period actually spent in eye-to-eye contact with them. Anyway, length of time is not all that significant in assessing the value of such consultations. There was one I had (tape-recorded by Ann Cartwright during a research study into general practice consultations)

which lasted exactly one minute. The patient was a middle-aged, working class woman, who had been attending me just over a year at monthly intervals. It went exactly as follows:

Doctor: Sit down.

Patient: It's a bit blowy.

Doctor: Blowy. Now then.

Patient: The tonic.

Doctor: The tonic.

Patient: Yes, it's fine.

Doctor: The tonic was all right, was it?

Patient: Yes it made me feel a lot better, a lot better.

Doctor: What do you need today?

Patient: Well, I think I'll have some more tablets. They're running a bit low. Save me coming back again.

(Doctor begins writing prescription.)

Doctor: Did you ever discover what it was that was upsetting you?

Patient: No, no. As you say, it might have been just one of those things; felt a bit run down or something.

No, I feel fine. Took all the tonic. Probably that was what I needed; something to settle me down, that's it.

(Doctor hands prescription over)

Doctor: You'll see me again if you're concerned, will you?

Patient: Oh yes. I definitely will. Oh yes I will. O.K.

Doctor: Right.

Patient: That's it. Thank you very much. Goodbye.

Doctor: Goodbye.

What was achieved, apart from the issuing of a repeat prescription? No doubt, in the opinion of psychotherapists, counsellors, social psychologists and behaviourists, the answer would be nothing. They would regard it as a non-event, a derisory interview, a superficial encounter lacking any meaningful communication. But experienced practitioners might discern in its admittedly compressed nature, a beginning, middle and an end. The consultation could be said to be a satisfactory one, in that to have done less would have been inadequate, while to have done more would have been too much. It was a follow-up and I wanted to know how she was, but I was not going to put words into her mouth.

I tried to widen the scope of the consultation and to explore her ideas about how she had felt, but she quite firmly resisted any additions to the agenda. I was left speculating, but not knowing. My only comfort was that she now appeared to feel she could cope, and was aware of my being available. This was hardly the sort of job-satisfaction we were brought up to expect, but in general practice it must suffice. If we do happen to miss the boat, there will be other occasions, the patient will find other ways of making us hear. Michael Balint helped me realise that unlike our specialist colleagues, we have no need for an intensive, once-and-for-all, now-or-never approach.

Patient-centred Medicine

This represents a major re-orientation for doctors brought up in 'curative medicine', and who therefore adopt a disease-centred approach. I gradually discovered that there was more to my patients than their signs and symptoms: patients were greater than the sum of their medical parts. I ought to treat them as human beings while never forgetting they were my patients; and every patient should be considered as

private. Furthermore, while I must obviously concentrate on the medical agenda of each patient, I ought also take on board their personal agendas. One more thing, I had to allow for the fact that the relatives of patients were usually self-centred: when they spoke on behalf of a patient, it was very likely initiated by a problem of their own.

Let Patients set the Pace, and call the Tune

The standard professional approach is for the doctor to take over once patients have recited their symptoms. I often noticed that patients were being rather selective in what they were choosing to offer, and that I had to accept the limits they were placing on how far I was allowed to go into their problems. My intrusion into sensitive areas would sometimes lead to scolding and rapped knuckles. In due course, patients usually became more trusting, but it was useless to try speeding this up. Patient autonomy had to be accepted, and it was pointless nagging about non-compliance.

Tune in to Your Patient

Michael Balint showed how important it was to try to get on to the patient's wavelength, and deal with the here-and-now, rather than just aiming to attach a diagnostic label by the interpretation of amassed data. This suggested to me that the classical medical model was not always totally appropriate for dealing with every single problem presented by patients.

Don't Just Do Something: Sit There

Our medical upbringing makes us want to act in a positive and decisive way. Yet there are occasions when my patients seem to benefit from just expressing their disturbed feelings, even though I remain unsure what it is all about.

Respond Thoughtfully, Instead of Reacting Automatically

This requires more time of course. But conjecturing and self-questioning is worth it, to bring up fresh ideas; rather than adopting the classical approach of trying to fit patients into pre-defined categories.

The Art that Conceals the Art

Asking searching questions and then making clever interpretations no longer seems to be as useful as I once thought. (I complained once to my group about a patient of mine who annoyed me 'because I couldn't get a word in edgeways'.) Not is it necessary to brandish compassion, or act as a detective-inspector. By adopting an ordinary, personal style we can probably achieve just as much as so-called non-directive and non-judgemental techniques.

There is More to Medicine than Medicines

Michael Balint held that there was nothing wrong in giving a tonic; what was wrong was giving a tonic *and nothing else*. This again implies that we must be sensitive to what patients are actually presenting, and treat the patient as a whole person.

Message Received and Understood

Proper communication is a two-way process. Just proclaiming something is not enough: I should find out what my patient makes of it.

The Drug, Doctor

Some troubled patients are thought to require psychotherapy, or hypnotherapy, behaviour therapy,

cognitive therapy, relaxation therapy, or even chemotherapy. But there have been some occasions when my presence itself seemed to be the therapy.

Psychic and Somatic are Distinct: Never fuse — Never Separate

A long, long time ago, an upset woman I was seeing developed some stomach trouble. Investigation suggested possible cancer, and I arranged a hospital referral. I felt so shattered that I confined my attention to the strictly physical aspects of her case, being unable to deal with her feelings any more. She begged me, 'Doctor, please, tell me it will be all right'; but I could only remain silent, and almost choked. Michael Balint taught us that nearly everything that a patient presents is either psychosomatic or somatopsychic, and I felt relieved at eventually giving up trying to decide whether a patient was 'genuinely' ill or not.

To be All Things to all Men and Women

This may not be totally realistic, but is still worth aiming for. It is more likely to be achieved by giving advice to each patient in terms of 'If I were you . . .', instead of 'If you were me . . .'

Guide, Philosopher and Friend

Some of my patients seem to want more of me than body technician. As well as medical guidance, they seek philosophy of a parental sort, and above all they would like to be befriended.

A Little Less Love, a Bit More Respect

This has to do with whether we go for empathy, or sympathy; do we identify with the patient's feelings, or project our own? I have often experienced being rather too close for comfort, but increasing one's distance is not the solution. Perhaps a more humble approach would generate an effective relationship. I reported a case about an attractive female patient to whom I was responding very sympathetically. She was having problems with a difficult child, and I felt furious at the way this poor woman was being tyrannised by that little brat. But it emerged in the group discussion that I had missed one or two things about her, and a member of the group commented: 'Why don't you speak to her as if she were a man? Forget she's an attractive woman, and behave towards her as you would any other patient.'

Be No More than Half a Step Ahead of Your Patient

This is one of Michael Balint's extraordinarily wise observations, although it seems at first to go against one professional style. It means restraining ourselves from superior understanding, from making it obvious that we know something they don't, and from explaining all the while (or more likely, explaining away). As it happens, I have to admit to sometimes

finding it even more helpful to be half-a-step *behind* the patient. When for instance I make a spontaneous comment, and the patient asks me, 'What do you mean, doctor?', I can often be rather slow in responding because of being genuinely unsure of what I did mean exactly. And while I am still trying to work it out the patient may then bring up some extremely interesting ideas, prompted by my vague remark.

The Doctor's Benign Despotism

We are having to cope with the trend towards greater consumerism, including the idea that the consumer is always right. How this was to be integrated with the professional approach, was raised quite often at Balint-groups. I certainly tried to encourage self-help amongst my patients as much as possible, but believed there was still a place for adopting the paternalistic approach (and maternalistic one). After all, there are still things that doctors know are best for patients. It is part of professional responsibility. But the trouble is that one could either be accused of arrogating such responsibility, or abdicating it. Can't win.

Be Natural

Our imitation of what we imagined to be the technique of our psychoanalyst teachers, was described by Bob Gosling, colleague of Michael Balint, as being 'a grotesque parody'. Instead of our trying to adopt impassivity and inscrutability, we might risk being ourselves — with discretion of course. It would probably be wiser to reveal how I actually feel, than to appear to be pleasantly tolerant while fuming inwardly. A new female patient of mine had been sexually abused in childhood, and was receiving specialist psychotherapy. She saw me regularly too, but I thought somehow we were not getting on all that well. She seemed to feel: *I do not like thee Dr Fell; the reason why, I cannot tell; but this I know, and know full well; I do not like thee Dr Fell.*

Then amazingly, she recently dropped a post-card in, that said: 'Thanks, for making illness a bearable place to learn from; for helping me get through it; for keeping on respecting me as an individual; for talking to me, not at or about me; for being a man and trustworthy; for sometimes being sarcastic enough to make me sit up and take notice; for letting me be sad; for having enough stamina to keep on telling me I will get better; for all the kindness and goodness; and, thankfully, for not being perfect. Take good care of yourself! Best wishes.'

This happens to represent the most recent manifestation of what Michael Balint means to me. More important, what Michael Balint does for me, and for my patients.

An Account of the Doctor/Patient Relationship During Medical Training

Mary Keany*,

Medical Student, University of Leicester Medical School

Pre-clinical medicine can be a very frustrating learning experience for young medical students eager to meet real patients and feel like real student-doctors. The wide range of subjects taught, all covered only superficially, is daunting and may seem pointless. Much of the information given is very 'scientific' and quite different from what many students expect. However, occasionally a subject is covered which sparks off a previously unsuspected interest in a student.

In my second year of medicine, I realised that I was becoming increasingly interested in the field of medical psychology particularly with regard to the problems of human sexuality. Unfortunately I felt that there was not enough time to devote to this subject and no chance to experience the practical aspects of it. For this reason, I elected to spend an extra year in training, between my second and third years of the course, and devoted this year to the subject of human sexuality by undertaking a small research project in a clinical setting.

My goals in this undertaking were twofold. Firstly there was the research project, which was a scientifically devised investigation into a specific area of sexual dysfunction, and which formed the basis of a thesis to be submitted to the examiners. Secondly, there was the chance for me to work in a general practice setting with patients with sexual problems so that I might gain some practical experience of the subject and learn something about relating to patients with these problems. The results of this second goal are presented in this paper.

At the time when I started this project, I felt very strongly that the area of human sexuality was badly neglected in medical education. Sexual behaviour, and more specifically, correct sexual functioning is of paramount importance to any species, because it is the key to that most fundamental goal — the continuation of the species. At the most basic level, sexual dysfunction may lead to non-consumation of the relationship and ultimately, if not resolved, the line will stop with the dysfunctional couple. In humans, sexuality makes an important contribution to the self-esteem and self-confidence of an individual¹. Despite this importance, educational programmes in human sexuality for health professionals have been slow to evolve².

The setting for my year's work was a large health centre in an inner city area of Leicester. Patients were referred to the sexual dysfunction clinic run by Dr W. from a wide variety of sources as well as being picked up from the health centre's own patients. Dr W. is a general practitioner working mainly in the area of family planning who has some additional training in psychosexual counselling. She was involved in the counselling of all the patients I saw. My role was largely observational in that I was not actively involved in the therapeutic process, but simply monitored the changes in attitudes of the patients as they passed through treat-

ment, in order to collect data for my project. However I saw all the patients at several points during their treatment, and interviewed each patient individually about their family background and early sexual experiences, so that a relationship between myself and each patient built up over the course of their attendance at the clinic.

I found my role with the patient quite difficult to evaluate, as I feel the patients did also. Despite my defined role which seemed to suggest that I was to remain totally on the outside of the therapeutic situation, the reality was more difficult. The patients were used to building a relationship with a practitioner so that there would be some benefit to themselves, but since I was there in a purely research capacity, benefit to the individual patient was not the primary goal. Some patients readily accepted the concept that research is for the long term benefit of future patients, and were prepared therefore to be 'used' to this end. However, as I started seeing patients the situation quickly became less clear. During the course of my interactions with them, patients were asked to expose themselves quite extensively and to disclose past experiences which they had often never disclosed to anyone before. This was not something I could simply record coldly without responding, and I often found myself disclosing experiences and fears of my own. I felt that the disclosures and subsequent talking through of experiences were probably beneficial to the patients as they underwent therapy, and so in this way I was involved in the therapeutic outcome. I felt that it would have been impossible for me not to form a relationship with the patients which allowed them to feel that I was not simply recording facts from a nameless subject in my research, but that I empathised with them and was prepared if necessary to discuss things which they wanted to discuss even if they were not on my prescribed list. On one occasion the interview, which usually lasted twenty minutes, lasted two hours.

The forming of a relationship with a patient brought with it problems, especially since many couples attended the clinic and I saw both partners of each couple separately. I had an obligation to each partner not to breach confidentiality, and this was sometimes quite difficult, especially when it became obvious that one partner was lying to the other. It was difficult not to take sides.

If my role was difficult for the patients and myself to understand, it seemed impossible for other staff members at the clinic. My student status, combined with the fact that I worked alone and yet was not a therapist, made other staff such as receptionists and practice nurses uncertain how to treat me. Since I was not a regular member of staff, I did not have my own office and always had to wait for someone else to vacate theirs. This meant that I spent a lot of time sitting in the waiting room. I found this quite embarrassing since I was young and female. I felt that

Journal of Balint Society

my reason for being in a family planning waiting room was being speculated upon by other people waiting, some of whom I would subsequently become involved with.

On a more personal level, the staff were unsure of my status with relation to them. Some were patronising and resentful of any requests I made; others assumed I had a greater status than I actually did, and this was also difficult to deal with. The most important member of staff for me was Dr W., and our relationship was vital since she made the initial contact with all the patients I saw. Her description of me and introduction to the patients was important in determining the success of the relationship I was subsequently able to form with them. In this respect I was extremely lucky in that her grasp of the situation was excellent and I always found the patients happy to see me and listen to my explanations of my role.

Although these problems and feelings tended to be quite non-specific and were experienced throughout the year, inevitably there were some interactions with patients which confronted me with aspects of the doctor/patient relationship of which I had been previously unaware.

Mr S., a 62 year old man, presented to the clinic complaining of erectile impotence. He had been married to the present Mrs S. (aged 40) for two years, having divorced his first wife of twenty-eight years in order to re-marry. Mr and Mrs S. had been having problems with their sexual relationship since they married but at the time of presentation Mr S. was unable to maintain an erection on any occasion.

Mrs S. was an attractive woman, although she looked older than her forty years. This was her first marriage. An only child, Mrs S. had had an extremely restrictive upbringing; her parents had frowned upon sexuality and she had experienced severe guilt feelings about sex and masturbation as a young girl. Many of these feelings persisted into adulthood. Mr S. was the first man she had had intercourse with although she had had several lesbian experiences before meeting him. She appeared very nervous and reluctant to discuss sexual matters, becoming embarrassed quite easily.

Mr S. was a very attractive man and looked a good deal younger than his sixty-two years. He had a pleasant open manner and seemed quite relaxed despite his present problems. He came from a relatively large family with three siblings, and while his parents had been quite strict he had not experienced any negative attitudes towards sex. As a young man, he had travelled extensively with the army where he had gained a great deal of sexual experience. It was in the army that he had adopted a very liberal attitude to sex and he seemed free from embarrassment or nervousness while talking to me. He did however show some signs of discomfort when the subject of his first wife was raised. It appeared that the divorce had been a lengthy business since she had not agreed to it. She had in fact been quite adamant that she would not give him a divorce, at least in part because she was a Roman Catholic, but also because she felt that as a woman in her sixties she would have little chance of building a new life for herself. This information was extracted with great difficulty from the normally garrulous Mr S. Sexual relations with his first wife had been free from problems while they existed, but in the latter years

of the marriage, their sexual relationship became non-existent. He had not had intercourse with his present wife until after they were married by which time he had been sexually inactive for over five years.

My interactions with Mr S. were some of the most difficult and enlightening that I experienced that year. One of the main problems, which incidentally also applied to some other patients, was my age. I was acutely aware that I was a different generation from many of the patients and I looked even younger than my twenty-one years.

At first I tried to make myself look as old as possible with a severe hairstyle and glasses, but after a few weeks I realised that despite my efforts I still looked young, and that the few extra years that I could add to my age by my 'disguise' were irrelevant to my interactions with the patients. My response to this realisation was to ignore the age difference unless the patient appeared to be having problems with it, and simply assume a professional approach from the onset to give the patients confidence in my maturity.

With Mr S. the age difference was particularly great and so I approached this interview with some trepidation. I resolved to tackle the subject directly if I felt it was becoming a problem by asking the question: 'Is it difficult for you to speak to someone of my age about this?' Having decided upon a strategy, I found that much of the stress was removed from the situation and in the event, no action was needed; Mr S. accepted my age and position readily.

The background to Mr S.'s problem posed another challenge. Having recently married a woman over twenty years his junior and found himself impotent, he was dwelling a great deal on his attractiveness and virility, and appeared to be using me as a means of getting some positive feedback about this. He was very keen to tell me of his experiences as a young man, and also emphasised the fact that he was very popular with the 'young ladies' in the office where he was currently working and that many of them seemed to enjoy flirting with him. He often compared himself with another male colleague of similar age who didn't receive this kind of attention. Being a 'young lady' myself, I felt that he was waiting for some confirmation of this story by my responding to him in a flirtatious manner. Since this aspect of our interaction occurred without warning I reacted instinctively at the time and only later had time to reflect on whether my responses had been valid. I found that the natural thing to do was to provide the positive feedback asked for in a quite non-specific and non-sexual manner. For example, when Mr S. told me that he was very popular with the young ladies in his office and paused for my response I immediately replied: 'I'm sure you are.' When I reflected on this aspect of the interview I was at first worried that my reactions were not 'professional', and that I had allowed myself to be manipulated by Mr S., but I subsequently felt that I had simply given honest responses and that these had in fact facilitated further communication between us.

Mr S., as a sixty-two year old, would be considered by many to be elderly, and his presentation with impotence raises the whole issue of sexuality in the elderly. This is a subject which is full of myths and misconceptions. A social stereotyping of the elderly

— 'ageism' — exists, and an important part of this stereotype is asexuality. Sexual expression is considered inappropriate in the elderly by society and these attitudes may be internalised by the elderly person so that he or she also perceives sexual desires as inappropriate. If the elderly person manages to rise above these social pressures and actually present to a doctor with a sexual problem, he or she may then be faced with a doctor who is a true product of society and who manages to convey the impression that the patient should not be thinking about this aspect of their life at their age. This is the manifestation of what Balint called the 'Apostolic function' of a doctor³: 'It was almost as if every doctor had revealed knowledge of what was right and wrong for patients to expect and endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients' (p 216)

In actual fact, research has shown that sexual activity is possible and indeed occurs frequently in elderly people.⁴ So this reaction on the part of many doctors is not based on any medical knowledge, but rather on their own prejudices.

For me, the challenge was not to allow my apostolic function to dictate my attitude to Mr S. and to regard his problem with the same degree of concern and respect I had for the young newly-weds who were unable to conceive because of severe vaginismus. Although I knew much of the theory about sexuality in the elderly, and did not have any negative feelings about it, I found it hard not to be influenced by the media image of sex as an experience only to be associated with young attractive people. I did not feel that this prejudice was conveyed to Mr S. and I was grateful that I had the advantage of having thought about this subject in the abstract before meeting it in practice.

A central issue in Mr S's problem was the guilt which he appeared to be feeling regarding his divorce from his first wife. This manifested itself in the difficulty he had in speaking to me about this subject. Perversely, I found myself wanting to pursue the subject more strongly, almost as if I wanted to increase his guilt still further. Reflecting on this reaction, I realised that I was placing my own moral opinions on to Mr S. Having been brought up as a Catholic myself, I empathised with the feelings of Mr S's first wife. I also found myself reacting instinctively to the story of a man leaving his wife for a much younger woman after many years of marriage, despite the fact that I knew nothing of the circumstances. Once I recognised that I had these feelings, I was able to think the problem through and confront them, eventually realising that it was not my place to be judgemental and that such feelings could have affected by relationship with Mr S. adversely. Balint³ suggests that human sexuality is the area where most care must be taken not to disclose one's own views about what is right and wrong, and certainly I found this to be the case. My reactions were governed by feelings which I did not even consciously acknowledge at the time. Apart from the immediate effect of this episode, which was to give me some insight into my continuing relationship with Mr S., I found that I gave a great deal of thought to some of my personal views on morality, and examined more closely the value judgements I made about other people in my personal and profes-

sional life.

Mr and Mrs S. responded very well to the therapy they received from Dr W. and were seen for the last time three months from their first appointment at which time they were both happy with the improvement that had been achieved. For my part I felt that the time I had spent with Mr S. had been extremely valuable for me, but also that Mr S. gained from the relationship which had developed; at the very least I know that he enjoyed the interactions which we had.

Medical education tends to concentrate on the 'hard facts' of medicine and very much leaves the young medical students to discover for themselves the problems which occur when these facts are translated into practice, without providing the back-up to support the student through these difficulties. In an area like human sexuality the student is even more isolated since many curriculae ignore the subject entirely. In the absence of guidance students and doctors alike tend to rely on their own gut feelings about the subject which may be quite inappropriate for the patient.

With regard to the teaching of human sexuality, it is important it is realised that in order to treat the patient as a person, which should always be the aim in good medical practice, one cannot afford to ignore such an important aspect of human life. Patients often present to the doctor confused and uncertain about the validity of their problem, and embarrassed at needing to disclose it. To meet a doctor who is equally ignorant and embarrassed is insulting to the patient and a failure for the doctor. In the same way that many students find it embarrassing to ask their first few patients about their bowel function but find that with practice it soon becomes second nature; familiarity with the language of sexuality would help remove the taboos. It is also important to emphasise that a student or doctor should be aware of sexual aspects of illness in any hospital ward. A patient having had a myocardial infarction may be more worried about when he can resume sexual relations with his wife, then when he may return to work. Yet rarely is he given any advice on this.

In summary, medical education needs to pay more attention to the area of sexuality and heighten awareness amongst students of its role as a cause of much unhappiness among patients in every medical speciality.

Although human sexuality is a particularly difficult area, all doctor/patient communication may present difficulties for the student, and while a good student may be familiar with the theory, he or she may be unprepared for the feelings elicited by the real situation. I found that my background knowledge of sexuality in the elderly did not prepare me completely for the situation in which I found myself with Mr S., although I was glad of the knowledge.

Role-play as a teaching method may be a good way to allow the student to experience different situations in a way which allows mistakes to be made and learning to take place in a setting which will not be damaging for a patient. The use of competent actors and actresses playing the part of patients ensures that there is realism. At Leicester Medical School this method of teaching is used in the General Practice Department, and is found by most students to be an

excellent way of learning more about themselves and more about the doctor/patient relationship in general. Video-tapes of these enactments allow the student to reflect on their reactions when they are removed from the situation and forces them to be honest about the feelings which they were experiencing, which are often revealed by the video-tape. Unfortunately, by the time students undergo this teaching, they will have completed up to two years of their clinical training during which time they will have needed to communicate with hundreds of patients. It seems sad that such attention to the doctor/patient relationship is seen as the domain only of the General Practice Department and that other hospital departments seem happy for students to blunder on regardless of the effectiveness of their communication with patients. It would seem more sensible for the responsibility for this aspect of doctors' training to be shared and started much earlier in the curriculum.

Despite the most careful preparation, most students (and indeed doctors) will experience times when they become overwhelmed by their own inadequacy in dealing with patients. This experience

is made all the more distressing by the fact that everyone else appears to be coping magnificently and forming perfect relationships with their patients. In these circumstances 'debriefing' is a great help. Some students may get this through informal networks of sympathetic friends but it would be much better for this to be a formal part of the curriculum, with time allowed for small group discussion of problems being experienced in the course of their work as student-doctors. Once again this concept has been adopted already by many general practices where partners meet regularly to discuss patients with whom they feel they are not progressing. It seems unlikely that hospital doctors never have such problems, yet no provision is made to cope with them.

All these strategies, while serving an important practical function, also have a secondary effect in simply acknowledging the fact that doctors and patients are firstly people and therefore their interaction will be complicated by the individuality of both participants. Once this is acknowledged, the road to good communication and successful doctor/patient relationships seems clearer.

References

1. Adkins, E & Jehu, D. Analysis of treatment programme for primary orgasmic dysfunction. *Behaviour Research and Therapy*: 1985, **23**, (2), 119-126.
2. Rosenzweig, N. & Pearsall, F P. *Sex Education for the Health Professional*. New York: Grune and Stratton. 1978.
3. Balint, M. *The Doctor, his Patient and the Illness*. Edinburgh: Churchill Livingstone. 2nd Edition, 1964.
4. Pfeiffer, E, Verwoerd, A, & Wang, H S. (1968). Sexual behaviour in aged men and women: I. Observations on 254 community volunteers. *Archives of General Psychiatry*. 1968, **19**, 753-758.

*First Prize winner of the Essay competition arranged by the International Balint Federation, and awarded 3000 Swiss Francs at the 17th Annual International Balint Meeting at Ascona in March 1989.

With grateful thanks to Professor Boris Luban-Plozza, Organizer of this highly successful annual event, for his permission to publish this essay. Ed.

Programme of Meetings of the Balint Society for the Twentieth Session 1989-90

The following meetings will take place at the Royal College of General Practitioners, 14 Princes Gate, London, SW7 on Tuesday evening at 8.30 p.m., preceded by coffee at 8 p.m.

DR. HAROLD MAXWELL Some thoughts on the 'so-called borderline personality':	31 October 1989
DR. PHILIP HOPKINS: 20th Anniversary Meeting: What Balint said:	21 November 1989
DR. BERNARD BENNETT: Reactions to suicide:	6 February 1990
DR. PAUL SACKIN: Work on Trainee-groups:	6 March 1990

THE OXFORD BALINT WEEK-END
will take place at Pembroke College, Oxford:

on Friday at 6 p.m.	15 September 1989
to Sunday at 1 p.m.	17 September 1989

An Evaluation of Balint Training for Psychiatric Nurses

Paul Ian Steinberg* and Brian F. Shaw**

INTRODUCTION

This paper reports on one of the few trials of Balint-training groups with mental health personnel. It is not known whether participation in the seminars actually improves the clinical decision-making, or induces other personal changes in the participants. It is of considerable interest whether this type of training would benefit other health professionals besides physicians. We would expect that nurses are affected similarly to physicians by difficult patients.^{13, 14} Only two previous efforts to use Balint-type groups with nursing personnel have been reported.^{8, 11} In contrast to these reports, the present study employed a controlled trial with these caregivers.

The main objective of this research was to assess the effectiveness of Balint-groups by determining the personal changes, relevant to their clinical practice, that resulted from nurses' participation in them. We assumed that these changes would be relevant to all health professionals engaged in similar work.

PAST WORK

Bacal, Molineux and Shaw², suggested that past attempts^{4, 12, 17} to evaluate attitudinal change in the physicians attending Balint-groups raised several questions: (1) what does the seminar teach its members; (2) do changes in attitude assessed by self-report measures reflect changes in the physician's functioning; (3) is the physicians' group performance reflected in their clinical work? Bacal² recommended two criteria to measure the gains made as a result of Balint-training. We state these criteria were as follows: (a) the nurse engages in work commensurate with her felt ability and stops on the basis of appreciating her limits, making appropriate use of available help; and (b) the interference by her own psychopathology in her work is minimal. Bacal (2) also indicated that physicians who manifest one of four types of 'Balint signs' (seriously neurotic, obsessional, superior and over-anxious) would not benefit significantly from the seminars.

Bacal et al.² found significant negative relationships between criterion B and features of both obsessiveness and anxiety in family medicine residents. Higher scores, indicating the presence of the Balint signs, were associated with lower levels of performance on criteria A and B. They also found negative correlations between the presence of Balint signs and the resident's overall competence and their relationship with patients (as observed independently by the residents' teachers). The residents' level of anxiety was

the strongest predictor of subsequent performance. Furthermore, ratings of criteria A and B at post-training were strongly positively correlated with measures of clinical performance.

Chassy⁵ suggested that there should be two kinds of groups: 'one in which the basic dilemmas of group interaction are resolved, and a second, in which the participants exploit their recently acquired sensitivities . . .'. He concluded that short-term groups could be successful in stimulating changes in participants' methods of patient care.

Paal¹¹ described a Balint-group with intensive care nurses. They were selected because of their important role in establishing contact with patients who have attempted suicide while the patients were regaining consciousness. Dress⁸ outlined the phases through which his nurses' Balint-group progressed: an opening phase in which the nurses became increasingly anxious over the efficacy of their actions; a depressed phase in which they experienced fear and helplessness in the face of their patients' demands for close interpersonal contact; and an individualization phase, with development of a desired professional identity. The nurses' feelings of competence and self-confidence were seen to develop realistically through an acceptance of the patients' and their own feelings.

The present study builds on this past work to determine the extent to which nurses who receive Balint-training undergo changes believed to be relevant to their clinical practice. The group of nurses who participate will be compared with a group of nurses who received no training. In accord with Balint's hypothesis⁶, it was predicted that greater change would be observed in the nurses who received the training. We decided to measure change with ratings made by experienced group-leaders and by two self-report measures tapping personality variables and clinically relevant attitudes.

METHOD

There were two groups of subjects, an experimental group and an assessment only group. Eleven nurses (mean age 40.2 years) received the Balint-training. Notably two experimental subjects joined the training-group a few weeks later than the others. Ten control subjects (mean age 45.5 years) served as controls by participating sessions only. The groups did not differ in either years or experience, (13.9 and 18.0 years, $t=1.04$, n.s.) or age ($t=1.03$, n.s.). All subjects were female, registered nurses (R.N.) with the exception of one experimental group subject who had a B.Sc.N. degree. This study did not involve a randomized design as subjects chose not to enter. Thus differences in the subjects' motivation for training were clear and will constrain our generalization of the results.

DEPENDENT MEASURES

All experimental subjects were assessed in a semi-structured interview with the group-leader. These interviews were audiotaped and a second rater, a

*Paul Ian Steinberg, Assistant Chief, Department of Psychiatry Coordinator, Liaison Psychiatry Service, St. Joseph's Hospital; Assistant Professor, Department of Psychiatry, The University of Western Ontario, London, Ontario.

**Brian F. Shaw, Departments of Psychiatry and Behavioural Science, University of Toronto, and Psychologist-in-Chief, Toronto General Hospital, Toronto, Ontario.

qualified Balint-leader who was blind to group assignment, completed ratings based on the tapes. All interview ratings were made on 7-point Likert scales ranging from no difficulty to severe difficulty. The interview proceeded to elicit information in the following areas: (1) the nurse's perception of her job (e.g., need to give advice, impose her ideas on others, intolerance of the ideas of patients); (2) the nurse's capacity to, and interest in understanding the patient (empathic interest; awareness of her own difficulties without a deleterious preoccupation about them); (3) the nurse's capacity to tolerate intense affect without reacting by attempting to control the patient's behaviour; (4) the nurse's capacity to tolerate difficulties without pressing for quick or 'active' resolution. The raters evaluated each subject on Bacal's¹ two criteria (work commensurate with ability, and interference by own psychopathology); the four Balint signs (seriously neurotic, obsessional, over-anxious, and superior). The seriously neurotic nurse would be one who had signs of borderline personality disorder and/or severe neurosis. The superior nurse presented with a rigid character; when under stress she reacts with disruptive or suspicious behaviour. The obsessional nurse becomes disillusioned when she cannot obtain simple and reliable rules of conduct, while the over-anxious nurse is insecure about her actions and fearful of criticism.

The Personality Research Form (PRF, Form E; 17) is a 352 item questionnaire yielding 20 personality factors (eg. achievement, nurturance, dominance) broadly relevant to the functioning of individuals in a wide variety of situations as well as two validity factors (infrequency and social desirability). Seven groupings of personality have been presented. These include (a) impulse expression and control, (b) orientation toward work and play, (c) orientations towards direction from other people, (d) intellectual and aesthetic orientation, (e) degree of ascendancy, (f) degree and quality of interpersonal orientation, and (g) test taking attitudes and validity. This instrument was intended to provide the study with a method to assess personality change. The PRF data was examined to identify indices related to successful outcome in the training program.

The Personal Tendencies Questionnaire (PTQ; 14) is a 232 item self-report measure specifically designed to measure the personality variables related to the work of psychotherapists or other mental health professionals. The personality scales, 20 in all, cover a range of characteristics including the need for closure, empathic interest, an authoritarian attitude, tolerance for ambivalence, individualism, work ethic, and nurturant anxiety.

PROCEDURE

The study was conducted in the Department of Psychiatry, of St. Joseph's Hospital, London (Ontario), where all the subjects were employed as psychiatric nurses. The group-leader is a psychiatrist with training in psychoanalytic psychotherapy who had qualified as a Balint group-leader.

The groups had the following format: one of the participants would describe, without formal preparation, a difficult situation they were experiencing with one of their patients or occasionally, with a group

of patients. The presenter and the other participants were encouraged to give their reactions following the presentation. The leader (P.S.) encouraged the participants to make their own formulations regarding the basis for the presenter's difficulty, and would only give his own formulation in an attempt to further stimulate the participants to continue generating hypotheses. The leader occasionally made didactic comments consistent with Balint's formulations. These comments were judged to be facilitative of the group discussion but they may have had the disadvantage of discouraging independent thinking on the part of the participants. Each group meeting ended with an exchange of suggestions on how an increased understanding of the presenter's difficulties could be utilized in working with the patients.

All subjects were seen individually for each assessment interview. The psychological testing was completed following the interviews. As noted previously, the interviews were audiotaped and 29 interviews were randomly selected for an inter-rater reliability study (we had planned to sample 30 interviews but one audiotape malfunctioned).

RESULTS

Attendance at the groups was a significant problem for many of the subjects in the experimental group. Unfortunately, due to shift-work and other scheduling problems the nurses on average only attended 17 of the 30 possible seminars. Despite the considerable variation in attendance (range was 7 to 28 sessions) we decided that each member of the experimental group had been exposed to the training to a sufficient degree to allow for the possibility of significant change.

Analyses of covariance (ANCOVAs) using the pre-scores as the covariates were used to assess the significance of any differences between these groups either on the personality test subscores or the interview based ratings (only interview data based on acceptable inter-rater reliability were entered in the data analysis).

INTER-RATER RELIABILITY

Prior to the ANCOVAs, the inter-rater reliability coefficients and the intercorrelation of all measures was calculated. Past research⁴ has pointed to the difficulty obtaining acceptable inter-rater reliabilities with interview-based evaluation. For this reason, we were particularly interested in the overall correlations between our raters. The reliability

TABLE 1:
INTER-RATER RELIABILITIES OF THE RATINGS
FOR BALINT SIGNS AND BACAL CRITERIA

	Correlation Coefficients (in brackets)
Balint Signs:	
Seriously Neurotic	0.61* (29)
Superior	0.34 (29)
Obsessional	0.30 (29)
Anxious	0.60* (29)
Bacal Criterion A (work commensurate with ability)	0.36 (27)
Bacal Criterion B (inference by own psychopathology)	0.58* (28)

(*p < .001)

coefficients are listed in Table 1. Note that in the inter-rater reliability study, due to missing data 29 interviews were evaluated on the Balint measures while only 27 and 28 were made on the Bacal criteria A and B, respectively.

As can be seen, the inter-rater reliability was acceptable, although not particularly high, for two of the Balint signs ('seriously neurotic' and 'anxious'), ($r = .61$ and $.60$, $p < .001$ respectively) and for one of the Bacal criteria ('interference by own psychopathology', $r = .58$). Balint et al⁴, discuss the difficulties rating complex, interview-based data. These inter-rater reliabilities are comparable to other ratings of therapist competency.^{7, 16}

Our data suggest that the two Balint signs 'seriously neurotic' and 'anxious' and the Bacal criterion 'interference by own psychopathology' are significantly reliable for use in this study and in future research. Consistent with past research we will report on the mean scores of the two raters. Because our subjects' responsibilities are more limited than those of family practitioners, Bacal criterion A ('work commensurate with felt ability, appropriate use of consultants') turned out to be more difficult to evaluate. This difficulty may have contributed to the lower reliability. The unreliability of ratings of superiority or obsessionalism are more difficult to interpret. For now, we must be content with reporting the difficulty with reliability and exclude these evaluations from future consideration.

INTERVIEW AND PERSONALITY DATA

Our analyses were initially focused on the experimental group to assess for change on the interview-based ratings. We conducted an analysis of covariance on the mean of the two ratings. None of analyses were significant, indicating little observed benefit of the training.

In all, 42 variables representing different personality scales were examined. To reduce the number of variables in the analyses, factor scores from both the PRF and PTQ were used. The post-test data from the experimental and control groups were evaluated by analyses of covariance with the pre-test data as the covariate. Unfortunately, none of the analyses were significant. Three personality subscales approached significance with each mean value being lower in the experimental group compared to the control group at post-test. They were: (a) PRF-cognitive structure: individuals with high scores have difficulty tolerating ambiguity, want questions answered completely and prefer to make decisions based on definite knowledge and not probabilities ($F(1,15) = 3.89$, $p < .07$); (b) PRF-nurturance: individuals with high scores give sympathy and comfort to others whenever possible and readily perform favours for others ($F(1,5) = 4.77$, $p < .05$) and; (c) PTQ — 'antidemocratic' attitude: a state that reflects an authoritarian view of care, consistent with custodial approaches with psychiatric patients ($F(1,15) = 3.54$, $p < .08$). Note that given the large number of analyses, these results are only seen as *suggestive* for future studies and cannot be viewed as more than *chance* findings until they are replicated. They may be useful to pinpoint specific areas of change in future studies.

One of the questions of interest to us following

the initial interview evaluations was the relationship of age and years of experience with the interview and personality variables. Within our sample of nurses we wondered whether age or years of experience might be related to certain personality features that may in turn present difficulties for the Balint training. In the sample (as would be the case with most) age and years of experience are confounded. Both variables were found to relate positively and significantly to a need for achievement and an authoritarian attitude toward treatment. For example the age and PRF Need for Achievement correlation was $.58$ ($p < .003$) and the age-PTR antidemocratic attitude correlation was $.61$ ($p < .001$). Scores on these personality variables were higher with the subjects' increasing age and/or years of experience. Older nurses exhibited a high need for achievement. This type of person 'aspires to accomplish difficult tasks; maintains high standards and is willing to work toward distant goals; responds positively to competition; and is willing to put forth effort to achieve excellence'¹⁰. Older nurses also manifested an authoritarian attitude toward psychiatric treatment preferring the custodial role. As either of these characteristics may be related to our interview ratings, correlations between them and the Bacal criterion and the Balint signs (serious neurotic and anxious nurse) were calculated and none were significant. There were other significant correlations (eg. PRF Harm-avoidance and PRF-Order, PTQ-Fervor and PTQ-Scientific Values), but given the large number of correlations, we adopted a conservative level of confidence ($p < .005$) to determine significance.

None of the interview rating variables were significantly correlated with age nor any of the personality variables.

DISCUSSION

This study suggests that Balint-training in a relatively *short-term* format for psychiatric nurses does not result in substantial change either in clinically relevant personality characteristics or in interviews.

The absence of significant differences between the groups may be explained in several ways. Four of the more obvious explanations are: (a) given the relatively low number of subjects, the power of our statistical tests was insufficient; (b) our evaluation measures were not sensitive enough to detect real changes; (c) the group-technique was not effective; or, (d) the group was not of long enough duration to have a significant influence. It is possible of course that combinations of these and/or other factors may have been at play. The latter explanation is supported by the fact that the average attendance was 17 hours, whereas Balint met his family practitioners for several years on a weekly basis. On the other hand, Chassy⁵ believed that even 8-10 sessions would have an impact on the nurses' work, an assumption that we were willing to evaluate in our study. Clearly the results of our investigation do not support this view. One could speculate that the changes obtained on the cognitive structure, nurturance, and the authoritarian attitude toward treatment dimensions might have reached significance with a longer training period but an equally plausible view is that these findings were a result of chance. In future research these variables could be considered specifically on a prior basis.

Personality is assumed to be stable and personality tests such as the PRF and PTQ are constructed to reflect this stability. We regret not having observed and documented the nurses' actual performance on the job, a method used by Bacal et al.² Future projects should ensure that standardized behavioural observations are utilized. Nevertheless, if change occurred, it was subtle and not detectable by either our interview-based ratings or our personality measures.

We conclude that subsequent work in this area should involve longer duration of attendance to the group. As well, an attempt should be made to guarantee more consistent attendance, a goal that was difficult in our study because the subjects had constantly changing work-shifts.

Interestingly, despite the lack of objective evidence, both the group-leader and the nursing supervisor subjectively reported some positive changes in the group members' clinical work, compared with the control subjects. The nursing supervisor noted increased professional communication between both experimental subjects and controls, during and following the group. She believed, however, that the experimental subjects' understanding of their patients generally improved, while, the control group remained unchanged. The group participants appeared to experience more job satisfaction and began to define their therapeutic objectives more clearly. The group-leader, in clinical work and in the groups, observed evidence that some of the group members learned to respond less according to their wish to obtain a particular therapeutic result, and were able to engage more with their patients in an attempt to understand the basis for the patients' problems. Some participants appeared able to tolerate wider ranges of affect

expressed by the patients. The leader concluded that possessing the following qualities would make a nurse more likely to benefit from Balint-group training: lack of rigid character style or severe personal pathology; ability to consider alternatives to her clinical conceptualizations; and an ability to reflect on her personality features.

This study is limited with respect to its small sample size; its lack of a completely randomized design; and the relatively short-term nature of contact with participants. Our subject population was selected from inpatient psychiatric nurses, as opposed to the family practitioners who composed Balint's original groups. We assumed that it is the individual resources of the therapist and not his/her professional discipline, that determines how successful he/she will be in managing patients.¹⁵ For this reason, combined with the fact that nursing personnel have previously been trained with these methods, we do not think that our study was limited by the selection of nurses as participants. Further work in the relevance and value of Balint-training is surely needed.

ACKNOWLEDGEMENTS

1. This research was supported in part by a grant from the University of Western Ontario Research Fund. Our appreciation is extended to Dr. H. Bacal, Dr. T. Turpin, D. H. Mersky, Miss T. Yott, Ms. G. Kay, Ms. Debra Wilson-Smith, Ms. D. Wellsby, Ms. P. Cheverie and to the nurses who participated in this project.

2. Please send reprint requests to:

Paul Steinberg, M.D., F.R.C.P. (C)
Department of Psychiatry
St. Joseph's Hospital
260 Grosvenor Street
London, Ontario, Canada

REFERENCES

1. Bacal, H A. Training for psychiatry in medicine: An attempt to assess Tavistock clinical seminars. *Psychiatry in Medicine*, 1971, 2: 12-22.
2. Bacal, H A, Molineux, J E. & Shaw, B F. The assessment of training in Balint groups. In P. Hopkins (Ed.), *The Human Face of Medicine*. 1971 London: Pitman, 132-144.
3. Balint, M. *The Doctor, his Patient and the Illness*. 1957. London: Pitman Medical.
4. Balint, M, Balint, E, Gosling, R & Hildebrand, P. *A Study of Doctors*. 1966. London: Tavistock.
5. Chassy, P. Toward an understanding of interprofessional socialization. In J. B. Pearson (Ed.), *The Assessment of Short-term Seminars in Psychiatry for Non-Psychiatrist Physicians. Report of the Western Interstate Commission for Higher Education*. 1969. University of Colorado.
6. Dent, J K. *Exploring the Psychosocial Therapies Through the Personalities of Effective Therapists*. 1978. Rockville: U.S. Government Printing Office.
7. Dobson, K S, Shaw, B F & Villis, T M. Reliability of a measure of the quality of cognitive therapy. *British Journal of Clinical Psychology*, 1985, 24, 295-300.
8. Drees, A. The establishment of a Balint-group among the nurses on a psychosomatic ward. *Vol. 17, 1989*
9. Hopkins, P. (1987), Michael Balint: Training and Research. *Journal of the Balint Society*, 1987, 15, 4-11.
10. Jackson, D N. *Personality Research Form Manual*. 1974, Goshen, N.Y.: Research Psychologist Press.
11. Paal, J. Suicide prophylaxis within a Balint-group with the staff of an intensive nursing station in a general hospital. 1978, *Israel Annals of Psychiatry*, 16, 46-49.
12. Pearson, J B. Evaluation of short-term seminars for general practitioners. In J. B. Pearson (Ed.), *The Assessment of Short-term Seminars in Psychiatry for Non-Psychiatrist Physicians. Report of the Western Interstate Commission for Higher Education*. 1963, University of Colorado.
13. Steinberg, P. The psychiatry of family practice: Personality disorders. Part I: The problem patient. *Canadian Family Physician*, 1983, 29, 1942-1947.
14. Steinberg, P. The psychiatry of family practice: Personality disorders. Part II: Interview the patient. 1983, *Canadian Family Physician*, 29, 1963-1967.
15. Szasz, G. Interprofessional education in the health sciences. *The Milbank Memorial Fund Quarterly*, 1969, 68, 449-475.
16. Vallis, T M, Shaw, B F & Dobson, K S. The

THE BRITISH PSYCHO-ANALYTICAL SOCIETY

PSYCHO-ANALYSIS IN BRITAIN TODAY

A SERIES OF INTRODUCTORY LECTURES AND SEMINARS

At the Institute of Psycho-Analysis, 63 New Cavendish Street, London W1M 7RD.

CHAIRMAN: Earl Hopper, Ph.D.

PART 1: BASIC PRINCIPLES

AUTUMN TERM 1989: Wednesdays 4th October to 6th December 5.30 - 7.45 p.m.

October	4	THE INNER WORLD OF THE CHILD	Miss R. Edgcombe
	11	DRIVES, OBJECT RELATIONS AND FEELINGS	Mr E. Rayner, Ph.D.
	18	THE EGO	Mr A. Couch, Ph.D.
	25	SUPER-EGO, GUILT AND ANXIETY	Dr N. Coltart
November	1	THE OEDIPUS COMPLEX	Mrs E. O'Shaughnessy
	8	TRANSFERENCE AND COUNTERTRANSFERENCE	Dr. D. Pines
	15	DEPRESSION AND THE DEPRESSIVE POSITION	Mrs I. Brenman Pick
	22	PSYCHIC CHANGE AND RESISTANCE	Miss B. Joseph
	29	THE DEVELOPMENT OF PSYCHOANALYSIS IN BRITAIN	Dr. J. H. Padel
December	6	CONCLUSION: PLENARY DISCUSSION	

**PART 2: DEVELOPMENTS: THEORETICAL AND
CLINICAL IMPLICATIONS**

SPRING TERM 1990: Wednesdays 10th January to 14th March 5.30 - 7.45 p.m.

January	10	TRAUMA: INTERNAL AND EXTERNAL REALITIES	Dr. B. MacCarthy
	17	GENDER IDENTITY AND REALITY	Mrs E. Laufer
	24	HYSTERICAL PHENOMENA	Dr. D. Duncan
	31	AGGRESSION AND THE "DEATH INSTINCT"	Dr. J. Pedder
February	7	PERVERSIONS: 'INFANTILE SEXUALITY' AND 'PSYCHOTIC ANXIETIES'	Dr. M. Glasser
	14	DREAMS AND UNCONSCIOUS PHANTASY	Mrs E. Spillius, Ph.D
	21	PROJECTIVE IDENTIFICATION: COMMUNICATION OR EVASION	Dr. R. Britton
	28	BORDERLINE AND PSYCHOTIC PROCESSES: THE RECOVERY OF PARTS OF THE SELF	Dr. J. Steiner
March	7	THE EXPERIENCE OF THE SELF	Mrs C. Bollas, Ph.D.
	14	CONCLUSION: PLENARY DISCUSSION	

Each lecture will be followed by discussion in small group seminars. To ensure continuity of discussion participants are requested to attend the entire series of lectures and their accompanying seminars. Group seminars will be led by **Dr. G. Fitzpatrick, Dr. G. Fornari Spoto, Dr. J. Garner, Mrs I. S. Hahn, Dr. B. Martindale and Miss B. Tamblyn.**

THE FEE FOR EACH SERIES IS £100 OR £175 FOR BOTH. SOME BURSARIES ARE AVAILABLE FOR STUDENTS. THE CLOSING DATE FOR THE AUTUMN TERM IS 30th JUNE 1989 AND FOR THE SPRING TERM 1st NOVEMBER 1989. APPLICATION FORMS ARE AVAILABLE FROM THE EXECUTIVE SECRETARY.

Do We Still Need an Analyst for a Leader?

John Salinsky,
General Practitioner, Wembley

In the beginning the leader was always an analyst. How could it be otherwise? Michael and Enid Balint and their colleagues at the Tavistock Clinic were offering their psychoanalytic skills and insights as their contribution to a joint exploration of the psychological content of general practice. The work was to consist of 'research and training' and while the research partnership might be an equal one, the training was seen as a training in psychotherapy which a family doctor could not possibly acquire from a group led by another family doctor.

The Tavistock groups continue to be promoted and led by analysts. But since 1974 the Balint Society has also sponsored groups led by general practitioners (who were themselves trained in Tavistock groups). Furthermore, because of their enthusiasm for medical education, many of the early Tavistock graduates found themselves in charge of the new general practice vocational training courses. Not surprisingly, they wanted to give their vocational trainees a taste of the Balint-group experience by incorporating groups in their half-day release courses. These trainee-groups are led by Balint-trained general practitioners, either singly or together with a co-leader from another discipline which values psychoanalytic ideas, eg: a social worker, counsellor or clinical psychologist. Some trainee-groups stand up better than others to a comparison with the Tavistock Gold Standard, but the fact that their leaders are trying to promote the Balints' ideas must be seen as encouraging. Balint-training, or at least, Balint-influenced training is being made available to many young doctors who may never have heard of the Tavistock and are too far away from Hampstead to take advantage of it anyway.

There are very few analysts outside North West London and an even smaller number who show any interest in exploring the world of general practice with a Balint-group. So when our vocational trainees finish their training and look for a principals' group they are unlikely — unless they can go to the Tavistock — to find an analyst to lead it. Instead, we are now seeing the emergence of a third generation of Balint-group leaders: general practitioners who have had several years group experience as trainees but may never have been in a group led by an analyst. Does this dilution of the analytic influence matter? What exactly does a psychoanalyst's presence do for a group and can we manage without it?

To answer these questions I think we need to consider both the style and the content of group leadership. The style or attitude of the group leader is described by Michael Balint in Appendix 1 of *The Doctor, his Patient and the Illness*, where he says 'if he (the leader) finds the right attitude he will teach more by his example than by everything else combined. After all, the technique we advocate is based on exactly the same kind of listening that we expect the doctors to learn and then to practise with their patients. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching

for proper cues — that is, speaking only when something is *really* expected from him and making his point in a form which instead of prescribing *the* right way, opens up possibilities for the doctors to discover by themselves *some* right way of dealing with the patient's problems!

This passage seems to me to say it all, as far as the group-leader's style is concerned. It must make anyone who has ever tried to lead a Balint-group say, 'yes, that's the way I should be doing it — if only I could be that sort of leader more of the time.' Keeping quiet and being a good listener can be difficult: especially if the leader is eager to teach. It may even be easier for a general practitioner leader, who is not burdened with much theoretical baggage, to concentrate on being a listener and 'facilitator' (horrid word, but it serves my purpose) than it is for an analyst who has things to explain. Certainly my impression of our 3rd generation general practitioner leaders is they recognise the importance of this part of the job and they do it well.

But what of the content? When the leader does open her mouth does she have to make clever interpretations? By no means. Some of the most effective interventions are very simple ones in which the leader shows the group her own ability to respond emotionally to the patient's feelings, eg 'it makes me feel very sad to think of him sitting all alone in his bedroom with no one to talk to . . .' this sort of thing gives the group permission to have feelings too, and can be very liberating. It requires no knowledge of the Oedipus complex or Primary Narcissism.

So what do we need an analyst for? Even analyst leaders do not sprinkle their discourse with technical terms (at least the good ones do not). But are they using their psychoanalytical education in some less obtrusive way? Back to Appendix 1 of *The Doctor, his Patient and the Illness*.

In the paragraph headed *The Use of Group Methods*, Michael Balint writes, 'Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously in the patient's mind when doctor and patient are together.' He then refers to certain 'events' going on in the minds of both doctor and patient which are subjective rather than objective, 'often hardly conscious or even wholly beyond conscious control.' In other words there is a lot going on just beneath the surface of the ordinary doctor-patient discourse which it is all too easy to miss if your antennae are not tuned in to the language of the Unconscious.

My own acquaintance with psychoanalysis has made me realise that this language is rather like poetry. It expresses its meaning subtly and indirectly through images, metaphors and allusions. A patient may unconsciously say something very important about herself by attributing her own feelings to another person or even to a natural phenomenon; just as a poet may use the Pathetic Fallacy to show human feelings reflected in the state of the weather. Psychoanalysts

are familiar with this language and can recognise it when they hear it; the rest of us may not do nearly as well. I do not mean that I expect analyst leaders to offer detailed translations (interpretations) to the group: these are seldom needed, may be inaccurate and generally do more harm than good by turning the leader into a lecturer. But a little help with the language, enough to pick up a few phrases here and there; enough to get by, as the travel writers say, can be enormously helpful.

Let me illustrate with two examples from my own practice:

- 1) A young girl told me that she was afraid to leave her flat unaccompanied in case she met a dog. The barking of dogs terrified her: 'they seem so angry', she said. A little later she told me that she was often afraid her own angry feelings would get out of control and she would smash something.
- 2) An old man dying of cancer persisted in believing that he was going to get better until, one day, he stumbled and fell, hitting his head sharply on the edge of a table. Although there was no fracture, he felt that he had been severely damaged by the blow and would never recover. It occurred to me that the nearness of death had 'struck' him in that moment like a smack on the head (or in the head). I did not

'interpret' that thought back to him, but I was able to agree with and share with him the importance of the knock on the head as the cause of his decline.

Without some exposure to psychoanalytic ways of thinking it would have been impossible to tune in to these patients' feelings in quite the same way, and something valuable would have been lost. We seem to need the input from psychoanalysis to give us that extra dimension of understanding. Without the missing ingredient Balint-work can still be very nourishing but it does not taste quite the same.

So what is to be done? The shortage of analyst leaders is likely to continue. Not all analysts make good Balint-group leaders in any case; not many are interested in general practice and those who are, want to be paid! This seems to offend general practitioners, although I can see that it is entirely reasonable from the point of view of an analyst with a living to earn. But why should a Balint-group not be a learning experience for a young analyst or psychotherapist as much as for a general practitioner? Perhaps general practitioners should invite analysts and psychotherapists in training to join in, not as leaders, but as members with a special contribution to offer: the art of listening to the Unconscious. And if a group cannot find an analyst, perhaps they could invite a poet or a novelist to join them instead . . .

International Balint Federation Meeting:

Paris: 18 March 1989

The meeting was held at Unaformec, the Paris Postgraduate Centre, in the Boulevard Voltaire in the eleventh district on a beautiful sunny morning. At the suggestion of our president, Jacque Dufey, the business meeting of the International Balint Federation was preceded by a workshop to consider what was meant by a Balint-group: What is the difference between a Balint-group and other groups? What did Michael Balint say? What are its working methods, and what is its results?

Naturally it did not prove possible to answer all these questions in the time available. Although we started at 09.30 hours and, with a break for lunch, continued until after 16.00 hours, we did not come to any definite conclusions. We did however, agree that a Balint-group was not a therapeutic group; it was not a case-discussion group, as the main subject for discussion was the relationship between the patient and the doctor, rather than the patient in isolation.

There was the usual discussion about leadership and who the leaders should be, analyst or general practitioner, either or both? These arguments have been aired before, but I noticed there was more flexibility in the discussion than in the past, and a greater appreciation of the creative value of the

interface between the work of the general practitioner and the work of the analyst.

There was also some discussion about research. Research had been an important aspect of the earlier groups, but seemed not to be largely neglected. All agreed this was a pity and more thought must be given to this and to finding ways of promoting it.

The meeting was well attended with representatives from France, Germany, Belgium, Denmark, Sweden and Switzerland. Jack Norell, Lenka Speight and myself represented Great Britain.

In spite of the need for translation, which so often has a damping effect on discussion, there was lively participation by everyone and although we were unable to devise a definitive definition of the Balint-group, there was a general feeling of greater mutual understanding and progress.

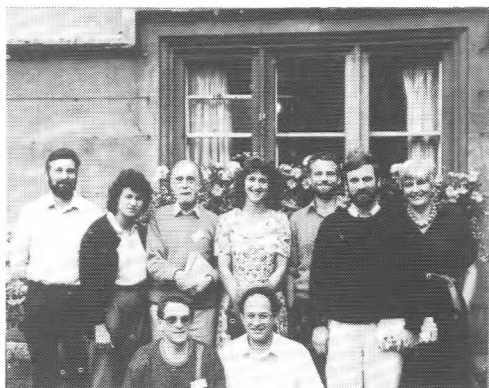
We then proceeded to the business meeting, much of which was taken up with discussion about the forthcoming international meeting in Stockholm. Dr. Katz was able to give us the revised programme, and expressed the hope that we would all give the Stockholm meeting the maximum publicity.

ERICA JONES

Balint Weekend at Oxford 9th-11th September, 1988

Saville Furman

President, South African Balint Society



'Group 3' — Oxford, 1988

On arrival at Heathrow Airport the Customs Officer asked about the reason for my visit; I explained that I was going to a medical conference. He then enquired about the nature of the conference and I tried to explain about the Balint movement and weekend workshops on doctor/patient relationships. He looked at me rather blankly and said, 'Oh you must be one of them physiotherapists!' I left it at that.

I was accompanied by my wife Shelly, and we took the Inter-City rail network from Paddington to Oxford which took about 55 minutes. In the brochure we were told that Pembroke College was only six minutes walking distance from the station . . . about 36 minutes later we arrived. We looked at the imposing building, and finally found the entrance after wandering around and questioning numerous bystanders.

The College is very close to the centre of Oxford and comprises three quadrangles. The sessions were held in the old quadrangle, which dates back to 1624. We were grateful that our room was in the quadrangle which was opened only in 1962.

We had a buffet supper in the magnificent Chapel Hall which was built in 1856, and met the other delegates who had come from all over the British Isles, Germany, Israel, Finland and Sweden. I was sole representative from South Africa.

After supper we had a 'fish bowl' demonstration-group led by Dr. John Salinsky who is Vice President of the British Balint Society and co-led by Antonia Shooter. I was one of the 'volunteers' who took part in the first demonstration-group. The case presented revolved around the symbolism of doctors receiving gifts from patients, and doctors

giving gifts to patients. It evoked strong feelings among the participating doctors in the ensuing discussion.

After a traditional English breakfast on the following morning we broke up into four groups. I was in group 3 led by Dr. Philip Hopkins, the Honorary Editor and Dr. John Salinsky. There were doctors from Bristol, the Isle of Man, Argyll, Ireland, Wales and Scotland in my group.

I was immediately struck by how quickly the group gelled together and worked very hard to help the presenting doctors with the problems which they had with their patients. It was heartening to discover that doctors all over the world have the same problems in interacting with their patients. The kind of cases presented in our group was similar to those I had experienced when I first entered general practice and joined a Balint-group. The cases presented were also similar to those presented at the annual weekend workshops which we have been holding in Cape Town since 1981, emphasizing how universal the relevance and importance of Balint-work is in general practice.

The issues discussed in our group related to confidentiality and how the doctor/patient relationship can be spoiled by a telephone call from a 'well-meaning' but interfering relation or friend. One lady doctor in our group had a telephone call from a patient's grand-daughter, which changed the whole relationship, she had built up with this family. The group discussed the problems involved in restoring this relationship again.

Another doctor presented a patient who he did not like. After much discussion in the group, the doctor got in touch with his own feelings about his mother, and how this patient was tending to try and 'mother him'.

Another doctor presented a patient with anorexia with whose parents he also had a social relationship, again raising the issue of the difficulties involved in managing families with whom we also have a social relationship.

Another lady doctor in the group was having a problem with a cancerphobic patient who felt she was going mad. The issue of confidentiality again emerged when another doctor in the group let slip to one of her heroin addict patients that she was treating a friend of his. She was very upset about it and, I think, received great support from the group.

Another very interesting case was presented of a patient with a fractured jaw. When the doctor asked her what happened, she poured out the whole story of a disastrous relationship. Unfortunately, the doctor was called out to an emergency and did not have time to examine the patient (who had already previously been examined and X-rayed). She became very angry with him and said that she had not come to talk, but to be examined! She was not even one of the presenting doctor's patients, but once again the issue was raised of how patients go to different doctors within a group

Dr Saville Furman was awarded the S.A. Balint/Fisons 1988 Travelling Fellowship.

Vol. 17, 1989

practice for different needs. Obviously she *did* need to talk.

I presented a patient from my practice who I had referred to a clinical psychologist. One day the patient was 'taken' to another general practitioner as an 'emergency', then referred to a psychiatrist and admitted to a nursing home where all her medication was changed. She had asked the clinical psychologist not to tell me what had happened, and came back to see me four months later as if nothing had happened. I felt stifled by not being able to reveal that I had known what had happened. This definitely affected the relationship with the patient who had originally had consulted me after the death of her first baby six years previously.

I was told that this would not happen in the U.K. as her records would be transferred from another practice when the patient changed her doctor. We discussed the merits of the two systems, and it was agreed that the second general practitioner should have contacted me as I had looked after her for six years.

These case-presentations took place on Saturday morning, Saturday afternoon and Sunday morning. On the Saturday afternoon we joined a walking tour of Oxford guided by John Salinsky. Oxford is known as 'the City of Dreaming Spires' and

we climbed a few towers to get a breath-taking view of the city. We walked through many of the famous Colleges before arriving back at Pembroke.

On the Saturday evening we had a formal dinner where speeches were made by Dr. Erica Jones, the President of the Balint Society, and I had the honour of replying to the toast to the overseas guests. The dinner was in fine British tradition with magnificent silverware dating back many centuries. I thanked Fisons for the role they were playing in CME, and especially for their contribution to the S.A. Balint Society. I presented Erica Jones and John Salinsky with collages of Cape Town and invited them and all present, to join us at our meetings in Cape Town if they visit South Africa.

Before lunch on Sunday, we met for a plenary session where a general discussion on group-learning took place. The age-old issues of why we should still talk about *Balint*-groups; once again the discussion centred on the issues of why the Balint-work is so active in the South-East and not in very many other places in the U.K.

It was a very stimulating and enriching experience for me and has made me more determined to start another Balint-group in Cape Town in the new year.

Residential Balint Weekend at Pembroke College, Oxford

From 6 p.m. Friday, September 15th to 1 p.m. Sunday, 17th, 1989.

General practitioners, whether trainees or established principals, and experienced teachers of general practice and course organisers are invited to sample the experience of attending a Balint-group for a weekend.

There will be an initial demonstration group, consisting of volunteers, on Friday evening: followed by an open discussion of the group's work. Most of the rest of the weekend will consist of work in small Balint-groups, each having two experienced group-leaders.

All who attend are requested to come with suitable case-histories to present for discussion, and all

group-members will be expected to be committed to stay for the full course of four group-meetings on the Saturday and Sunday.

Accommodation will be available for husbands/wives wishing to spend a weekend in Oxford. They are invited to share the meals, including the Conference Dinner on Saturday evening. All will be welcome to join in the walking tour of Oxford which will be arranged.

Section 63 approved. Further details and programme/booking forms from Dr David Watt, Tollgate Health Centre, 220 Tollgate Road, EC 4JS.

Obituary

Dr. DAVID MORRIS, F.R.C.P., D.C.H.
18.6.1915 - 27.3.1989



from MIMS Magazine

Dr David Morris died on March 27 at the age of 73, after almost ten years of fighting cancer, which he refused to allow to curtail his effervescent enthusiasms for his family life, work and tennis. He continued to cycle everywhere until shortly before his death.

After qualifying from the Middlesex Hospital in 1938, David's training in paediatrics was interrupted by the war. His fluency in French led to his secondment to the Free French Navy, and he spent most of this time at sea. In 1946 he was director of a hospital in Lübeck for displaced children, mostly from concentration camps.

He trained and worked at the Queen Elizabeth Hospital, in Hackney, and he was made consultant in paediatrics at the British Hospital for Mothers and Babies in 1952; and later at the Brooke General Hospital, at Woolwich, where he established the Children's Department, and soon became involved in those issues concerning the mother and her infant which were to preoccupy him for the rest of his life.

He was one of the few to join Michael Balint's group for specialists, and he continued to work with him over the years. He joined the Balint Society early and regularly attended meetings, including our Oxford weekends, where he was, as everywhere he went, a very popular and familiar figure.

He was interested in the psychosomatic aspects of paediatric illness, and was especially concerned about the relevance of separation of the mother from her newly-born infant, the lack of emphasis on the importance of breast-feeding, the care of children in adult wards, and the restricted visiting of children in hospital.

He had mothers stay with their children in hospital, and was the first paediatrician to have play staff, and like so many of the innovations which he put forward, he made sure that his pleasure in the success of this project was shared with others so that the movement spread rapidly.

David was one of the few paediatricians to undergo a personal psychoanalysis, and he had a child psychoanalyst sit in with him in his clinic. He set up the Anna Freud paediatric discussion group, whose like-minded members included some of the great names in paediatrics: Grahame Fagg, Ronald MacKeith, Dermod McCarthy, Aiden McFarland, Trevor Mann and Otto Wolf, as well as Anna Freud herself.

He wrote about parental reactions to perinatal death, and was probably one of the first to write about the management of perinatal death and bereavement. He was dedicated to helping parents to love and cherish their children whether they were sick, disabled or well. He produced with colleagues, the Royal College of Obstetrics and Gynaecologists Working Party's Report on the Management of Perinatal Death, and also participated very actively in writing the booklet issued by the Stillbirth and Neonatal Death Society, indicating what actions should be taken on the death of a baby. This has provided considerable comfort not only to the bereaved parents, but also to the professionals who looked after them. David wrote and lectured extensively on this subject and on related issues, such as the need to learn how to break bad news, and to do so with warmth and affection. Not only gifted with exceptional ability to talk to people, he was not afraid of showing his own feelings.

David lived by the precept which he set out in a beautifully written article on the bereaved child, 'How can we help?' which ends with:

'Children are honest and realistic and brave, that is what makes them so immensely attractive. If they are helped to face and recognize death and, as far as possible, to understand their own feelings, and the very unhappy feelings of those around them, they can be spared some of the misery of unexpressed guilt, fear and confusion. And both they and we can learn how important it is not to shrink from those who are suffering.'

After his enforced retirement from the National Health Service in 1980, when he reached the age of 65, in addition to his private practice, David extended his interest in his activities connected with children with mental and physical handicaps. He founded the Uphill Ski Club, and for many years accompanied groups of handicapped children on a skiing jaunt which he personally arranged and supervised.

Among his many appointments, David was president of the Hunterian Society in 1980; Chairman of the Nordoff-Robbins Music Therapy Centre, and of the Forum on Mental Retardation, which he established at the Royal Society of Medicine. He was a Member of the Medical Advisory Panel on Mentally Handicapped Children, and he remained active on this long after he retired.

His election last year, as chairman of the Association of Child Psychology and Psychiatry was particularly appropriate as he had forged links between them

and his paediatric colleagues.

He made his mark in the international, as well as the national paediatric scene. He was an honorary fellow of the American Academy of Paediatrics, and was awarded the order of merit of the International Union of Child Welfare.

The British Council recognised David's expertise, and regularly asked him to visit a number of countries including Cyprus and Greece, and others in South America, to advise on the creation of facilities for the handicapped. He regularly attended the annual meetings of the British Paediatric Association, and was for many years a member of its council.

David was a man of boundless energy and could certainly be described as young at heart. He seemed in his last years to have a youthfulness that many young people would envy. He loved life and was enormous fun and his optimism and cheerfulness never wavered even though sometimes he was extremely ill.

There was little that was conventional about David Morris. His irrepressibly brisk and friendly manner and his carefully chosen clothes, always complete with a flower in his buttonhole, immediately made him stand out in a crowd, but the causes he espoused and his tenacity in pursuing them, singled him out as exceptional.

Above all, he was exceptionally popular with his patients, children and parents alike. No doubt due, in part, to the unusual and charming way in which he wrote letters to his young patients, summarising their consultations with him, knowing of course that the parents would read them. The referring general practitioners received copies of these letters, and if the following examples inspire others to follow this style of practice, David would certainly have approved.

Emma was a physically healthy eight-months-old only daughter of professional parents; her mother's endeavours to combine her professional career with motherhood had not gone well, and Emma refused her feeds, cried all the time and was difficult in the extreme. Her referral to David seemed the only hope, and his subsequent letters addressed to Emma and marked 'copy to Dr P . . . H . . .', fulfilled that hope:

'Dear Emma,

It was so very nice meeting you yesterday, and so very kind of Dr P . . . H . . . to suggest that we meet.

I was very intrigued to see how you behaved in the first three quarters of an hour, absorbed as you were in your exploration of the environment and particularly your absorption in the paper that you found and enjoyed tearing and mouthing so satisfactorily. But then you started to show the sort of unsettledness that your parents had started to tell me about, and the difficulties and problems that there have been, and still are in your behaviour.

Let me see if I can clarify my own thinking and in a sense, summarize what I felt at the end of the time we spent together. Firstly you seemed to know very well what is right for you, and then you are very contented. Equally you know what is not right for you, and you are very demonstrative when you are displeased . . . You are a very demanding young lady, and somehow the impression I have is that you are

also very erratic and cannot really stay at one thing for a long time . . .

What intrigues me is that there are so many good parts, as for example, your behaviour with Mary with whom you are prepared to spend the day quite happily and contentedly, but the moment you see your mother, things change dramatically as you make clear your demand to have a breast feed, which makes you happy, and then you play for a bit . . .

Equally, I find that your father's role has been very important and helpful in meeting some of your needs some of the time. In essence, the problem seems to be one of conflict of adaptation, and as yet we do not seem to have found a way of life that suits you and to get on your wavelength when you become upset . . . The bad patches are neutralised by the good parts, and this, I think, is the real crux of the problem as to what we can do to help sort out this tedious, demanding and difficult problem.

I have suggested that we meet again . . . in the meanwhile, we decided to carry out a full physical examination which I did and found you to be absolutely normal . . .

Yours sincerely,'

A second letter followed three weeks later:

Dear Emma,

It was so very nice seeing you here again. Once again you demonstrated your very highly individual personality and character. We watched you at play, with your buoyant activity and fairly well sustained happiness. But then you showed once again your sudden and unexpected erratic behaviour.

I could not help but comment on how your relationship to your mother is unusual in the way that you try to consume her, and I do not understand what this means . . . You are obviously a very 'inconvenient' and difficult child because of the problems you pose to us to make you feel good . . .

Yours sincerely,'

The third letter, dated eight months later:

'Dear Emma,

It was so very nice meeting you here, and so very kind of Dr H . . . to permit me to give you your anti-measles injection.

I took the opportunity of observing your growth and development, and on all fronts you are the paragon of achievement. Your hearing, speech, motor activity and explorative abilities are quite outstanding.

On clinical examination I could find nothing in your chest that was unusual because of the suspicion about your tendency to have a bit of chestiness and wheeziness which could not be supported. You have grown and developed very well.

Let us hope you will not have a nasty reaction to the injection.

Yours sincerely,'

Excellent progress followed. Emma is now a very strong-minded four-year-old, and her parents are very delighted with their bright and intelligent little girl!

Another girl, Sonia, an 11-year-old with a growth problem which affected her and her parents equally. David's reply to the referral letter follows:

'Dear Sonia,

It was so nice meeting you here yesterday at the request of Dr P . . . H . . ., your family doctor, who has referred you to me for my opinion, with his carefully prepared records.

You have an impeccable past history but recently, in the last few months, you have become more concerned about your small stature, especially since your school friends have not been all that kind to you.

On routine clinical examination you are smaller in stature than you are in weight, coming as you do at 36 kilos on the 25th centile, whilst at 52 ins. you are below the 3rd centile.

I am of the opinion that we should get the opinion of Dr . . . at the . . . Hospital and let us see what he advises and whether, in fact, you do or do not need some help from human growth hormone.

Yours sincerely,

When seen recently, after just over one year on daily injections of human growth hormone, Sonia was a very much happier girl, having grown 9.4 cms in that time.

David is sadly missed by all of us in the Balint Society, as no doubt he is by his family, friends and patients. Our deepest sympathies go to Netta, his wife, to Nick, his son, and Sue, his daughter, and to his grandchildren, Jobie, Franny and James.

HRG.
PH.

Cyril Gill: An Appreciation

For the members of the 'Old Guard', it is the memories of Michael Balint's personality, his teaching and his leadership which have provided an influence and an impetus for the rest of their professional lifetime. For those of us who came to work too late to experience Michael Balint in person, there has to be someone else through whom we inherit the 'apostolic succession'.

In 1973 I was one of the UCH 'Tuesday Group' which Enid Balint started with Cyril Gill as co-leader. I remained in the group for the two years that Enid was leader and for a further two years while Cyril led the group with Bernard Barnett.

I continued to encounter Cyril afterwards in trainers' workshops and in the Royal Free Hospital undergraduate tutors' group, and then when as Course Organiser at the Whittington Hospital Vocational Training Scheme, I served my own apprenticeship as a co-leader with him for over seven years, until his illness forced him to give up.

We had also both been members of Enid Balint's research-group in the early 1980s which eventually produced the book, *While I'm Here, Doctor*. At times our encounters seemed so frequent that we used to greet each other with the old cliché, 'We can't go on meeting like this'.

It would be hard to quantify the value of such a prolonged association with a doctor of such qualities of humour, patience, understanding and intuition. As a group-leader he had an amazing ability to remain in the background, leaving the group on a loose rein (but my no means driverless) without interference, only

occasionally dropping in a comment, almost apologetically, which clarified and illuminated the problem, rather than diminishing the group members with a display of ostentatious cleverness — a temptation to which few of us are immune.

Outside the group he was a trusted friend and the wisest of counsellors in any personal, professional or family difficulty which one might confide in him. I feel myself greatly privileged to have learned Balint work at first hand from Enid Balint and then to have seen it applied in general practice so consistently by Cyril Gill. He used to have a saying about the sort of patient who needed to 'carry the doctor around in her head' to help her cope in a crisis. I think there are a few of us who would like to feel we carry a bit of Cyril with us when faced with some of the more difficult moments of general practice life.

From John Bunyan's The Pilgrim's Progress!

The death of Mr Valiant-for-Truth

'I am going to my Father, and though with great difficulty I have got hither yet now I do not repent me of all the troubles I have been at to arrive where I am. My sword I give to him that shall succeed me in my pilgrimage, and my courage and skill to him that can get it . . . My marks and scars I carry with me to be a witness for me that I have fought his battles who will now be my rewarder.'

So he passed over, and all the trumpets sounded for him on the other side.

M.R.C.

From the 19th Annual General Meeting held on 23rd June, 1988

Presidential Address given by Dr Erica Jones

I have become increasingly worried of late by the apparent willingness to exchange painstaking enquiry for simplistic answers and dogmatic solutions; perhaps, this has always been so. The attraction of a unitary theory that will give us answers to 'Life, the Universe and Everything' is seductive.

Our Zietgiest seems to favour style, instead of substance, all those labels worn on the outside of everything — all those Harrods bags at the laundrette. But style is no substitute for understanding, still less for diagnosis. We are battered from all sides by impressions and emotions. Few of us can escape intermittent attacks of sensory and emotional overload. As general practitioners, we seldom see less than a hundred people per week, each with an individual burden; we would be wrecks if we did not devise some form of filter or protection, against this onslaught of need, anguish and depression presented by our patients, and when we sit down to relax, maybe by turning on the television and being battered by news and current affairs.

One such defence is a firm moral or ethical stand as seen in the pro- and anti-abortion debate, soon I fear to be followed by the brain-tissue transplant debate. Behind this fortification is some safety against the demand to feel and understand. I am not arguing against a clear stand on ethics, merely against its use as an uncomprehending bolt-hole. The problem remains then, as to how to maintain a filter that can be used selectively, so that we can tune in accurately to one radio station at a time without being deafened by the total output.

The dictionary defines a good listener, and we would all in our Society hope to be that, as one who listens with interest and sympathy. Hearing, on the

other hand, is defined as perceiving with the ear. Unfortunately, what we hear is not always tidy, nor can we always shape it satisfactorily — at least not at once and sometimes not for a long time. This is so much more stressful than the neat labels with which we emerged from medical school and hospital work.

In the last two years, I have had the privilege of leading several groups abroad. This has inevitably meant that either the group or I, are working in a second language. Most interestingly, this is not necessarily a disadvantage, or does not appear to be so. In the former, there is far less intellectuallising and generalisation, most participants lacking the vocabulary for this. Happy and very vivid phrases occur which a more perfect knowledge of English would inhibit. In the latter case, our mutual effort to bridge any syntactical problem pares presentations to the very essence, and the joint group-effort at mutual comprehension spills over into more focused understanding of the case, at least I think that's what happens! It is a fascinating experience and I am still working on it, there must be lessons that can be applied elsewhere.

Through Balint-group work, we can sometimes make confusion and uncertainty tolerable, both for ourselves and for others. It seems to me that uncertainty must be the stepping-stone to any future knowledge and understanding. This is the particular, perhaps unique contribution we can make. I hope the Balint Society may be able to raise a bulwark against the tide of dogma and simplistic answers that threaten to engulf us.

Thank you for listening — perhaps some of you might even have heard.

Secretary's Report

An increasing number of younger members have joined the Society, mainly as a result of the recruiting drive at our annual week-end conference at Oxford.

In September 1987, 58 delegates attended Pembroke College. Five Balint-groups were run, and Dr. Michael Courtenay led the Demonstration group of Veteran Society Members.

The nadir of this year has been the sad loss of our dear friend Dr. Cyril Gill in December. However, we hope to set up in his memory 'The Cyril Gill Student Bursary' to encourage medical students in Balint-work, and also to publish a memorial book about him.

We have installed the Regional Representatives scheme to encourage Balint-groups in the provinces.

The Balint-group Leaders, Workshop continues to meet at the Royal College of General Practitioners every other month to discuss transcripts of different Groups across the country, under the newly elected Chairman Dr John Salinsky.

The series of evening meetings at the Royal College of General practitioners continues. In October we heard Drs. Sally Hull and Oliver Samuel give separate views of Methodology of Research in Balint-

groups. Sally spoke about the general problems of research in groups — and Oliver described how he had watched his group change over three years, both verbally and on video, and needed a Research student to analyse the mass of data.

On 24th November 1987 Dr. John Salinsky spoke about a Special patient and the Silver Screen who developed a powerful relationship with him, and reminded him of a fading Hollywood actress.

In February 1988, Dr. Peter Nixon, Cardiologist at Charing Cross Hospital spoke about Angina: Head or Heart, in which he argued that the main cause of angina and heart attacks was stress, and not atheroma, and that the best treatment was reduction of stress and not coronary angioplasty.

In March, Enid Balint led a mixed group of trainees and veterans in a demonstration group.

In April, Dr. Michael Courtenay chaired a discussion on the subject 'Whatever happened to Balint?' Two task-oriented groups were formed to discuss their ideas on where the Society had been going in the past, and where to move forward in the future.

PETER GRAHAM

Journal of Balint Society

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.
Produced by Haverstock Publications, 249 Haverstock Hill, London, NW3 4PS, for the Balint Society

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

Copyright reserved. BALINT SOCIETY, LONDON. ©