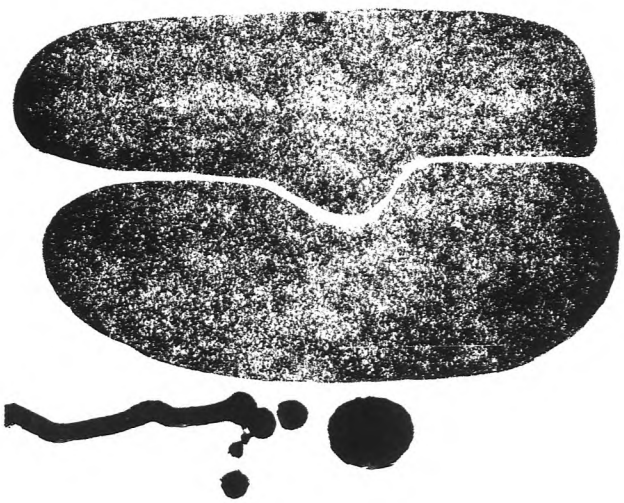
Journal

of the

Balint Society

1991



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President of the Balint Society

The Balint Society:

The Balint Society was founded 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 Balint-groups in London. Residential Balint Weekends are held in Ripon in May, and in Oxford in September each year (see page 44).

The Annual General Meeting is held in June each year.

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.

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

Editorial

The Nation's Health

The 'copy' for this issue of the Journal was ready for the printers when I saw the reports in *The Guardian*[4] and *The Times*[8] about the Prince of Wales having been made an honorary fellow of the Royal College of Psychatrists.

It seemed appropriate to replace the previously written Editorial, not only in order to congratulate the psychiatrists on having His Royal Highness with them but also, of course, Prince Charles too, for demonstrating his great interest in, and understanding of the increasing problem of mental health in our society.

The report in *The Times* quotes Prince Charles as having 'called for the removal of the stigmas and taboos that surrounded mental disorders, for better community care of sufferers, and for psychiatrists to resort less often to the "chemical cosh" of powerful drugs in their treatment.' He also challenged the wisdom of large scale closures of mental hospitals . .',[9] as indeed, many of us in general practice have done, and still do.

The Guardian reports that he said, '. . . it would be helpful if more people understood that a psychiatrist's first problem was to decide how to reach out to patients . . .'[5]

'Psychiatrists rightly emphasises the importance of communicating clearly and skilfully, and he welcomed the *growing importance given to listening and counselling skills in all branches of medicine.*'[5] (my italics, Ed.)

One of the first significant lessons many of us learned from Michael Balint was that before a doctor can arrive at what we called a 'deeper' (later, 'over-all') diagnosis, we had to learn to *listen*. Later, Balint showed us that 'listening is no more the whole of psychotherapy in general practice, than diagnosis is the whole of therapeutics in clinical medicine.'[1]

Since then, many of us have been developing and applying our Balint-training to the huge number of patients we see in general practice who need psychological understanding and a psychosomatic approach as a large part of their medical care. Dr Zalidis' paper shows very well what can be done with this approach in general practice, (see p. 16) and Dr Carne's address at our Annual General Meeting touches on the need to persue this further. (see p. 33).

As a result, we refer very few of these patients to psychiatrists, which is just as well, since the facilities in the National Health Service are very limited for patients to obtain psychotherapy, (or 'psychological therapy', as the British Psychological Society has recently suggested it should be re-named.[2])

How different, and how welcome is Prince Charles' approach, compared with the proposals set out in the Government's Green Paper, 'The Health of the Nation.'[6] A 'popular' summarised version of this has been produced for the information of our patients, and the Chief Medical Officer of the Department of Health, has sent copies to all doctors in England.

In the Foreword to this document, The Secretary of State for Health emphasises the three points he considers to be the prime role of the authorities: to (i) assess the state of health of the people they serve, (ii) obtain the services needed to ensure effective action is taken to maintain good health, prevent and treat ill health, and (iii) ensure the quality and effectiveness of the services used.[6]

He goes on to say that 'The development of a health strategy is a new concept for England. The NHS reforms give us for the first time a firm foundation on which to build . . . (p. 3) But Mr Waldegrave has not done his homework — the aims of the National Health Service Act (1946) included statements about 'A medical service for positive health, the prevention of disease and the relief of sickness . . .'; and 'All necessary medical services — general and specialist, domiciliary and institutional — available to every individual . . .'[8]

There are many more words about 'finding the right balance',[6] which Sir William Beveridge (author of those famous words predicting the reduction of the cost of health care with our wonderful new Health Service over the years!) described as the three key areas, 'prevention, treatment and rehabilitation'.[8]

Under the heading of Mental Health, only three lines are devoted to the objective of 'reducing the level of disability caused by mental illness, by improving significantly the treatment and care of mentally disordered people,' (p. 14) followed by reference to the need for 'realigning resources currently spent on specialist psychiatric services into district based care . . . thereby allowing many of the remaining 90 large psychiatric hospitals to be closed by 2000.' (p. 15)[6] Sadly, there is no reference to the provision of a comprehensive service which should, of course, provide the facilities for psychotherapy for patients in the National Health Service.

We know from our experience in general practice, that the psychotically ill represent only a small fraction, possibly 3% - 4% of the mental health problem which is the main concern of psychiatrists. As pressing as their needs are, however, they are as nothing compared with those of patients with psychoneurotic, psychological or emotional disturbances, many of whom present with psychosomatic symptom-complexes and disorders.

It may be, as Prince Charles has commented, that the diagnosis is missed in some 50% of depressed patients by general practitioners. Yet our psychiatric colleagues will seldom accept these patients for treatment, while the organ-specialists can only refer them back

to their general practitioners with the well known 'nothing wrong' label. In this situation, the buck stops in the general practitioner's consulting room.

We must therefore continue to consider possible ways of developing Balint's ideas further, including the need to increase the awareness of those who teach medical students, the future generations of doctors, about the value of introducing Balint's approach early in the medical curriculum,[3, 11] as was agreed at the recent Annual General Meeting. Inviting 'comments and suggestions from all those who feel able to make a contribution to the extensive consultation on the proposals for a health strategy for England.'[6] The Society's council will certainly prepare a report on Balint's influence on general practice and the need to develop this further. All comments and suggestions from members will be welcome.

May we hope that when Prince Charles becomes the President of the Royal College of General Practitioners later this year, he will find this another subject for his concern and attention, and that he will feel able to add his influence to encourage this development in the training of our future doctors.

Indeed, in view of Prince Charles' considerable awareness of, and interest in the importance of these matters, he could well be eligible for invitation to become an Honorary Member of the Balint Society!

PHILIP HOPKINS

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The Balint Society Prize Essay, 1992

The Council of the Balint Society will award a prize of £250 for the best essay about the implications and relevance of the question asked by Balint about the group's discussion of a case, 'So, what are the predictions . . . ?'

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 23rd Annual General Meeting in 1992.

Entries must be received by 1st April, 1992 and sent to: Dr D Watt, Tollgate Health Centre, 220 Tollgate Road, London E6 4JS.

Why Regression in Psychoanalytical Psychotherapy?

by Harold Stewart
Consultant Psychiatrist, The Tavistock Clinic

The Ninth Michael Balint Memorial Lecture, given on 12th March 1991

The topic of regression, and particularly its use in therapy, has had a chequered career in the history of psychoanalysis and partly becauase of this, the topic is an interesting one for most therapists. Therapeutic regression has been present from the beginning and even before the beginning of psychoanalysis and in order to understand its vicissitudes, we should start by briefly recapitulating what we mean when we speak of regression.

Regression is regarded as the opposite of progression and in general refers to a reversion to an earlier state or mode of functioning. The term was first used by Freud in the last chapter of *The Interpretation of Dreams*[6] to provide an explanation of the fact that dreams are hallucinatory phenomena and that this differentiates them from remembering. He assumed a normal progressive direction of processes in the mind, starting with the perception of a stimulus and going first towards thought and then to action, thus reducing the psychic version of the stimulus. If action is not possible, a regressive movement occurs which in normal waking life goes to memory traces; regression beyond that point to the perceptual elements of experience gives rise to hallucination in the waking state or dreams in the sleeping state. In the third edition of this book in 1914, he later distinguished three types of regression, which he called the topographical, the temporal and the formal.

The topographical concerns the backward movements of mental processes as described above, and takes place in space; the temporal takes place in time and is from the present towards earlier experiences; the formal concerns behaviour observable clinically in which the more complex and advanced forms go back to simple ones. Regression is also conceptualised as a mechanism of defence in which the subject seeks to avoid anxiety by returning to an earlier stage of libidinal and ego development. This concept is linked with that of fixation-points towards which the regression occurs.

Freud followed the English neurologist, Hughlings Jackson, in his conceptualising of mental processes in that earlier simpler forms of functioning are superseded by later, more complex forms and that any type of inhibition or damage to the later forms will result in the reappearance of the earlier ones. Looked at in this way, regression can occur in terms of libidinal drive level, in terms of object-relationships, in terms of the structural theory of the mental apparatus of id, ego and superego; in terms of the positions from the depressive position to the paranoid-schizoid. Lastly, we have the concept of therapeutic regression, where regression, particularly of the formal type, acts as an ally of therapeutic progress and is typically associated with the patient's dependence on the analyst. It is in this concept of regression that controversy lies and it is to this aspect that the rest of this paper is devoted.

Earlier, I mentioned that regression has been present from the earliest days of psychoanalysis and even before that, and in this, I am referring to the original use of hypnosis as a therapeutic procedure. We should remind ourselves that it was a hysterical patient of Joseph Breuer, Anna O who, by going into hypnotic trance states and recovering lost memories that were associated with individual symptoms, gave her physician the gift of a new therapeutic procedure, the use of emotional abreaction of repressed traumatic experiences to remove symptoms. Breuer accepted the gift and proceeded to induce hypnotic trance states himself in Anna O to expedite the process. But unfortunately for him, when faced with a hysterical miscarriage in his patient when he had decided to terminate treatment, he became so anxious about these consequences of this type of therapy that he could never again use their procedures. Fortunately for us, he had related his experiences to his young friend, Sigmund Freud who made of sterner mettle than Breuer, decided to pursue this technique for himself, and from this, psychoanalysis was born. The point of interest in this for us is that hypnosis is a form of regression. The patient is induced by himself or the therapist into an altered state of consciousness of varying degrees, exhibits various types of behaviour, some being quite bizarre, in accordance with the suggestions of the hypnotist, and develops access to past memories and experiences which were previously inaccessible to the normal waking state.

Freud, for reasons which must be familiar to you, gradually gave up the use of hypnosis in his quest for the recovery of traumatic past experiences and instead developed the technique of free association, the key to psychoanalytic technique, which in turn led to changes in the aims of therapy. However even though hypnosis itself was given up, a great deal of the actual therapeutic setting was retained in the analytic situation. The use of the couch, a quiet warm room not too brightly lit, frequency of sessions, an attentive therapist are all in fact aids to promoting regression in the patient. Free association itself, in encouraging the patient to

give up the vigilance and logic of ordinary secondary process thinking tends towards the establishing of more regressed primary process dream-like states. These then are the concomitants of the standard analytic situation — the patient lying on the couch, freely associating as well as he can, the analyst behind the patient listening to, and being with the patient, occasionally commenting or offering a interpretation, and the sessions of a fixed frequency beginning and ending on time. However, with some patients this pattern is interrupted to a greater or lesser extent and it is to these changes that we must now turn.

Breuer was the first therapist to experience such a change. Instead of his patient going into a hypnotic state and verbalising her experiences, she presented him with the shock of a hysterical miscarriage, which he was able to treat by hypnotising and quietening her and then departing as fast as possible. The sexuality of this asexual virgin proved too much for him.

Freud, in his turn, having hypnotised a female patient found that she threw her arms round him in great passion, whereupon he called for his maidservant to remove her. He recognised the sexuality but was disturbed by its manifestation. It is such behaviour that we would call acting-out or else describe as formal regression. The patient acts or repeats or regresses rather than remembering and recollecting, and on the whole, it is found in hysterical female patients, particularly with male analysts. It is more often the case that the patient does not necessarily act herself but wants or requests or demands that the analyst should gratify her needs or wishes as the patient sees them. These requests or demands may seem innocent or not so innocent but the therapist is still faced with a situation with which he must deal.

How does he deal with such regressive behaviour in theraphy? This, of course, will apply to all forms of analytic psychotherapy, since although the instances given above occurred in hypnotherapy, they are in fact ubiquitous. Freud had no doubts on this score and his opinions must have been based on his own and his colleague's experiences with such patients. As far as he was concerned, therapy had to take place in an atmosphere of abstinence and privation as far as these issues were concerned and any attempt to do otherwise was fraught with the potentiality of dire consequences. He was well aware that improvements could occur if satisfaction of these requests and demands were offered but that they were only temporary. For him, abstinence and privation was the only answer, and interpretations were to be the only therapeutic tool and source of gratification.

This technical advice was excellent and sufficient to help the majority of patients, but unfortunately there were patients, usually severely disturbed hysterics, who were not helped by privation and interpretation, at least as far as interpretive technique was understood in the twenties and thirties of this century. This will be discussed later in the paper. Patients who wanted various forms of gratifications from the analyst, and did not receive them, gratifications ranging from the most apparently innocent such as a little extra time for a session, an extra session, to be allowed to contact the analyst between sessions, right up to blatant physical contact demands, responded by becoming lifeless, despairing, often mildly psychotic, and could not be helped further. These reactions influenced Sandor Ferenczi in Budapest to think on these problems and resulted in numerous technical papers in the twenties and thirties of this century. He believed that what was being experienced by the patient in these abstinence situations was a replay, a re-enactment, of original traumatic experiences that the patient as a child had undergone at the hands of adults resulting in an under — or over — stimulation of the child, to which the adults had responded by a lack of involvement on their parts, thus implicitly disclaiming all responsibility for their share of the traumatic situation. Ferenczi was suspicious of the benevolent sympathetic but neutral attitude of the analyst, who by his setting and technique had invited regression in the patient to experience his longings and demands. The patient was faced by privation from the analyst, who offered interpretations and reconstructions of the original traumatic situation instead; this was experienced by the patient as the analyst himself not accepting his responsibility and involvement for the present emotional state of the patient but just remaining cold, detached and intellectual; thus the original postulated adult reaction had been replayed in the present. Ferenczi regarded these analytic attitudes as part of the professional hypocrisy of the analyst and he tried numerous experiments in technique to try to reach his patients in a different way. He believed that the aim of therapy should be to help the patient to regress to the original traumatic situation, to assess the degree of tension the patient could tolerate while in this state, and to see if the patient could be kept at this level by positively responding to the regressed patient's cravings and needs.

It was this positive responding that caused the rift between Freud and Ferenczi. Freud maintained that it would prove impossible to satisfy every need of a regressed patient, that any improvement by doing so would only persist as long as the analyst was at the patient's beck and call, and that even if improved, the patient would never be really independent. Ferenczi believed otherwise. He had experienced a number of successful analyses in which the regression had not been too severe, or in Michael Balint's later terminology, the regression had been of a benign type. Although he had also experienced some cases of malignant regression, Balint's other type, he had felt sufficiently encouraged to continue experimenting along his own path.

Ferenczi had always been clinically adventurous and had acquired a reputation of being able to take on and treat cases that colleagues had failed with. He was an ardent believer in the effects of trauma in the pathogenesis of mental illness and to quote from the editor's introduction to his Clinical Diary, 'he draws parallels between the child traumatised by the hypocrisy of adults, as described in his 'Confusion of Tongues' paper, the mentally ill person traumatised by the hypocrisy of society, and the patient, whose trauma is revived and exacerbated by the professional hypocrisy and technical rigidity of the analyst. He described the process that takes place in people who are victims of overwhelming aggresive force: 'the victim, whose defences have broken down, abandons himself in order to survey the traumatic event from a great distance. From this vantage point he may be able to consider his aggressor as sick or mad, and may even try to care for and cure him. Like the child who can on occasion become the psychiatrist of his parents, or the analyst who conducts his own analysis through his patients.' (p.xviii)

This diary of 1932, kept in the last nine months of his life, is a fascinating document of Ferenczi's technique and theorising at that time. He believed that every technical rule could be abandoned if that was appropriate in the interests of cure. In the entry of 17 January, he described the development of his technique over the years. At first he had tried to obtain catharsis of traumatic experiences by regressive means but this had not necessarily worked as his attitude had been professionally impersonal; he then tried to increase tension in the patient by what he called active therapy in forbidding the patient to perform certain actions but this hadn't worked; he then tried lowering the tension by encouraging relaxation but this didn't necessarily work; he then tried admitting to the patient what he was feeling during the session i.e. admitting his countertransference feeling of pleasure, annoyance, anger, boredom, etc. This helped somewhat in some patients but it was not enough. This led him to his most extreme experiment, mutual analysis, in which both analyst and patient took turns in analysing the other in a systematic fashion either in double or alternating sessions.

In this way, it was not only the patient regressing with the analyst but also the analyst regressing with the patient. It soon became evident to him that this technique created immense problems, such as the patient's projection of her problems into the analyst's declared problems and so deflecting attention from herself, the impossibility of the analyst being completely open and sincere about his thoughts and feelings towards the patient without prejudicing the continuation of the analysis, the impossibility of revealing one patient's confidences to the analyst to another patient if free association is to be really free. All of these problems were noted by Ferenczi in his diary and eventually he realised that this technique too would have to be given up.

We must also remember that Ferenczi was allowing himself physical contact with patients, kissing and being kissed by them, and it was to this that Freud wrote his letter of 31 December 1931 to Ferenczi, pointing out the almost certain consequences for his successors if erotic behaviour were gratified in analysis as a part of technique 'resulting in an enormous increase of interest in psychoanalysis among both analysts and patients'. As a consequence of his experiments and Freud's attitude towards him, formal regression in the interests of therapy developed a bad name and was dropped from the therapeutic armamentarium of most analysts. It took several years before people, particularly Michael Balint, the analysand of, and collaborator with Ferenczi, and Donald Winnicott looked again at this issue to see what positive features could be extracted from these experiments. Both were members of the Middle, now Independent, group of the British Society and it is notable that the work and conceptualising of therapeutic regression is specifically associated with this group. Balint and Winnicott were the foremost workers, although Margaret Little, Masud Khan, Christopher Bollas and Harold Stewart have further developed our understanding of these states.

Let us first turn to Donald Winnicott. His most important paper on this topic, 'Metapsychological and Clinical Aspects of Regression within the Psychoanalytical Set-Up'[13] opens with the sentence, 'The study of the place of regression in analytic work is one of the tasks Freud left us to carry out and I think it is a subject for which this Society is ready.' He classified patients into three categories; firstly, there are those who operate as whole persons, whose difficulties are in the realm of interpersonal relationships, and who need the technique of classical analysis; secondly, are those in whom the wholeness of the personality can only just be taken for granted, where the analysis is of the stage of concern, or depressive position, where the analysis is that of mood and the survival of the analyst is an important management problem; thirdly are patients who have no secure personality structure, before the achievement of space-time unit status, where the analysis is very dependent on management. Regression is particularly important for this last group of patients, where illness is related to early environmental failure leading to the development of the false self organisation. He describes the sequence of events in treatment.

> '1. The provision of a setting that gives confidence.
> 2. Regression of the patient to dependence, with due sense of the risk involved.
> 3. The patient feeling a new sense of self, and the self hitherto hidden becoming surrendered to the total

ego. A new progression of the individual processes which had stopped.
4. An unfreezing of an environmental failure situation.
5. From the new position of ego strength, anger related to the early environmental failure, felt in the present and expressed.
6. Return from regression to dependence, in orderly progress towards independence.
7. Instinctual needs and wishes becoming realisable with genuine vitality and vigour.

All this repeated again and again.' (p287).

Winnicott regarded regression as regression to dependence. The reason for this is that he regarded the mother and her baby as an inseparable unit; there was no such thing as a baby, only a baby and its mother. Hence the environment, firstly the mother and her management, is essential to his conceptualising. Dependence on the mother and her management, in treatment, the analyst and his technique, are inseparable from the patient's responses and behaviour, both fundamentally influencing the other. He further stressed the important fact that interpretations of whatever nature given during the regression can ruin the emerging processes, whereas the interpretative work that needs to be done after emergence from the regression is essential for the progress of the analysis. Regression to dependence is not synonymous with the earlier described cathartic abreaction of repressed experience; the difference is that the first is a naturally occurring spontaneous phenomenon that the analyst allows to occur whereas the second may be an artificial state deliberately induced by the therapist, which has no place in psychoanalytic technique, although it would have in the cathartic therapies.

Margaret Little has written on her own analysis with Winnicott in two papers, 'Winnicott Working in Areas where Psychotic Anxieties Predominate' and 'On the Value of Regression to Dependence'[9,10] Regression to dependence is 'a means by which areas where psychotic anxieties predominate can be explored, early experiences uncovered, and underlying delusional ideas recognised and resolved via the transference-countertransference partnership . . . in both positive and negative phases. She described his management of her, how he would increase the length of sessions to one and a half hours on a regular basis, and how he would hold her hands on her head for long periods when he felt this was appropriate. Many of us would not necessarily agree with these management arrangements but the idea that it is the 'unthought known', to use Bollas's felicitous phrase, the past experience or perhaps the phantasy of the past experience, that needed to be experienced is well conveyed.[3] A quaint, rather artificial, situation is the picture given of patients having to queue up to go through a period of regression as the experience was such a taxing one for the analyst.

Yet Winnicott also described less dramatic types of experience embraced by the concept of regression to dependence. In his paper, 'Withdrawal and Regression',[13] he described a patient who did not clinically regress but went into momentary withdrawal states during sessions. If the analyst then understood the patient correctly and did so by a correct, well-timed interpretation, the withdrawal was converted into a situation in which the analyst was holding the patient and taking part in a relationship in which the patient was in some degree regressed and dependent. This gave the opportunity for correction of inadequate adaptation-to-need in the patient's own infancy management and this must obviously be a fairly regular happening in all well-conducted analyses.

We shall now turn to Michael Balint and his contribution to this topic. This culminated in 1968 in the publication of his book, *The Basic Fault,* which has the subtitle *Therapeutic Aspects of Regression;* this represented a distillation of his thinking and working on regression for a period of over forty years.[2] He had seen after Ferenczi's death in 1933 that several of the patients that Ferenczi had treated so heroically had broken down again and this had made Balint wary in trying to assess the value of Ferenczi's techniques. However, some of the cases had done well and this encouraged Balint to make a careful examination of the techniques used and their results to get a more realistic assessment of their value. In doing this he was gradually able to reach certain conclusions and concepts that I shall briefly describe and these, like Winnicott's, are bound up with ideas on infant development and psychological functioning.

He did not accept Freud's theory of primary narcissism and set out his objections in great detail. He believed in the concept of primary object love, maintaining that 'a healthy child and a healthy mother are so well adapted to each other that the same action inevitably brings gratification to both . . . there is 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 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.' This quotation is from his previous book, *Thrills and Regression*[1] (pp 65-66). He believed that hate and sadism were secondary to frustrations of this primary love relationship and as inevitably this frustration must occur, the basic fault arose in the individual's response to the traumatic discovery of frustration and separation from its primary object. He coined this term to indicate that it was more basic than a three-person oedipal relationship, belonging to the realm of

a two-person psychology, and that it lacked the dynamic structure of a conflict. The fault, a geological and not a moral metaphor, arose from patients describing a fault in their minds that had to be put right since its cause was felt to be in someone having failed or defaulted on them. He further postulated two methods by which the individual might respond to the trauma; the first, called ocnophilia, entailed objects feeling safe and comforting but the spaces between objects horrid and threatening; the second called philobatism, was the reverse where the objects felt treacherous and unsafe and the spaces safe and friendly. These techniques of adaptation became part of the character structure of the individual. In these ways, both Balint and Winnicott believed in the primacy of the object-relationship and both postulated the development of pathological character structures from the discrepancy between the individual and his environment.

He believed that the analytic setting allowed a regression to the level of the basic fault with a potential for re-experiencing these early object-relationships, or phantasies about them, in different ways and with this, the basic fault could heal over and healthy growth recommence. Balint, too, noted the importance of not interpreting during the phase of a regression since this could be experienced as traumatic impingement on the patient, and also noted the importance of the interpretative work after the regression. In these ways both analysts from their differing backgrounds and theoretical views stressed the importance of the patient's experience in the regressed state, the importance of sharing the experience with the patient, the importance of not interpreting, particularly the transference, during these phases, and the importance of interpreting the experiences after the regression.

However, it was Michael Balint who particularly recognised the potential dangers and pitfalls of regression, the dangers that had previously estranged Freud from Ferenczi. He differentiated two forms of regression, a benign and malignant form. The benign form, as its name implied, was seen as a harmless state, where the analytic atmosphere was to use Balint's word, 'arglos', meaning guileless and innocent, and where the patient regressed in the interests of trying to find something within himself. This usually occurred during the later stages of treatment and the object-relationship between patient and analyst was though to be of the primitive harmonious nature. He also described the benign form as regression in the interests of recognition, the recognition of the 'unthought known'. As I previously mentioned, it was patients in this state that encouraged Ferenczi in its therapeutic potential. In *The Basic Fault* Balint gave some instances of this state.[2] One was a young woman whose main complaint was of an inability to achieve anything in life. During the second year of her analysis, she said that since earliest childhood she had never been able to do a somersault. In response to Balint's 'What about now?' she got off the couch and did a perfect somersault, leading to a breakthrough and new beginning in her treatment and personal life. Another was of a man who in the second year of his treatment was silent for about half the session and the analyst also remained silent, having previously had experiences with these silences. On this occasion, the patient broke the silence by sobbing and then spoke of being able to reach himself. Since childhood he had always had someone telling him what to do. Other cases were of allowing finger and hand holding when he felt the atmosphere was of the arglos type; in a previous paper,[12] I have expressed my reservations on this technical procedure and will discuss it further later.

I will give an example of benign regression from my own practice and its interest lies in the fact that it extended over more than one session. A hysterical borderline patient after a few years of analysis was associating on the couch one Friday when the atmosphere suddenly changed, and she felt that there was a dead man in the consulting room. She knew there was not one, but felt as though he were there on the floor. She described him as a good man who had lost his soul and could not rest as he was in such torment. He needed to be buried so that he could be at peace and his soul could return, but as only she seemed to know he was dead, no-one else had buried him. I did no interpreting, only trying to clarify the situation being described. The session ended and she departed. When she returned on Monday she told me that she had been to the library on Saturday, had photocopied the prayers for the dead usually recited at a burial and then had gone to her local cemetery. She could not find a freshly dug grave and so she sat on a seat in a quiet isolated part of the cemetery and recited the burial prayers, crying all the time. After doing that, she felt much better, that had now been buried and something completed, and then she suddenly realised why she had so often been in very tearful states for no apparent reason for most of her life. We were then able to work on this experience of her's both in and out of the transference, and she strongly felt that it had been very important to her that I had not interpreted the possible transference meanings to her on the Friday, as she felt that I would then have been experienced as not really listening to, and being with her, but rather pushing my own interests. Interestingly enough, exactly a year later, she went back to the cemetery as she felt that the man's bones had been disturbed and that some were sticking up out of the ground. When she got there, she realised that although she had felt that it was real, she now knew and felt that it was not, and that she could now smile at her previous beliefs about all this, knowing that they were all phantasy like a fairy story.

The malignant form of regression was almost the exact opposite of the benign. Here the patient regressed to an early demanding,

greedy, destructive, extremely envious state, where the analytic atmosphere was highly charged, intense and passionate and where the patient demanded active gratification of her wishes. The patients were nearly always female, suffering from a borderline or psychotic level of hysterical pathology. If the analyst acceded to the patient's demands, the atmosphere moderated and often extremely new interesting areas of psychopathology emerged, but very soon the demands returned, to escalate in a vicious spiral, usually ending in disaster for the therapy.

Balint gives no account of a case illustrating malignant regression, but did offer important technical advice concerning the things a therapist should attempt not to do in order to avoid the development of this state. He advised that one should avoid interpreting everything as a manifestation of transference; he did not accept that the only agent of psychic change was a mutative transference interpretation. He advised that the therapist tolerate some types of acting-out and also accept the patient's projections and projective identifications without wanting to hurry to interpret them back into the patient. He also advised the therapist to avoid appearing omnipotent or omniscient to the patient, as this will collude with the patient's projected expectations of the therapist. I would myself add to this list the avoidance of interpretations of the patient's sexual material in sexual terms in the early stages of therapy as this may easily lead to their concrete mishearing and misinterpretation by the patient, leading to mental states of overstimulation and over excitement which can easily precipitate severe acting-out.

The last piece of advice was to avoid gratifying the patient's wishes, but here one of the problems that I have found is the assessing of the clinical situation, mentioned in my paper on regression.[12] This particularly applies to physical holding which although being apparently therapeutically useful, may well help to conceal more than it discloses. Physical contact may well be colluding with a defensive structure rather than potentiating a growth experience. Balint himself had recognised this in 1959 since in *Thrills and Regression* he had written '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 realise that the need to cling is a reaction to a trauma, an expression of, and a defence against the fear of being dropped or abandoned.'[9,11] (p.100). By 1968 he seems either to have forgotten this or changed his opinion without acknowledging the change.[2] For this and other reasons I now advise against any physical contact unless one is very sure of the nature of the clinical situation.

If these pitfalls for the therapist have been avoided, malignant regression will arise from the contribution of the patient and I will briefly present a clinical description of such a regression in a patient of mine who I have previously written on in terms of the problems of her management.[11] The patient, who felt divided into a good and evil part, had developed the compulsive desires, first to know if I had an erection during the session, and then to feel if I had one. This was at first controlled by interpretations but these soon proved to be useless. She started to get off the couch and approach me and although controlled for a time by interpretations they again became useless and she tried to force me to let her feel if I had an erection or not. I physically restrained her and she stopped and I was then faced with a tactical problem. I could have threatened her with stopping the analysis if she attacked again, but I had reason to be fairly certain that she would have heard this as a challenge to be faced and that would have been the end of therapy. I could have sent her to another analyst but I knew that this, or something similar, would have occurred in the new analysis, so this was no solution. As I was interested and wanted the analysis to continue, I decided that physical restraint was the only solution as I was bigger and stronger than she was. I wondered about my counter-transference in accepting close physical contact with a female patient, but I decided that my decision was not made in the interests of my sexual gratification but rather to see where this enforced active technique would lead. In fact after a few weeks of restraint when she felt evil, and of much interpreting when she felt good, this behaviour stopped, never to be repeated and it proved an important first step in her growth towards recovery. The interpretative work particularly clarified the extent to which these attacks were an expression of her extreme destructive envy of my abilities and potency as an analyst and I literally functioned as a physical container for these aspects of herself and the provider of sanity and boundaries in the analysis. In this respect, Winnicott writes, 'violence is an attempt to reactivate firm holding'.[14]

Masud Khan, in a paper on such a patient described the analysis of a young woman who had already destroyed two psychotherapies and one psychoanalysis by her violent and destructive behaviour.[7] He noted that during her previous analysis, she had at one time been hospitalised; in this period she had been most helpful and compliant with the hospital staff whilst reserving her rages and demands for her analyst. He dealt with her by setting strict limits to his tolerance of her behaviour; if she were too dreadful during a session, he would stop the session and tell her to return the next day, which after much protest, she did. She too demonstrated the constant feature of malignant regression, the destructive envious attacks on any achievement and help given by the analyst's skill. He characterised these patients as coming from an overprotected environment in infancy and childhood, which did not allow for the aggressive behaviour which is essential to the emergence

of identity and selfhood in the adult, leading to a dread of dependence. My experience supports his views on dread of surrender in dependence and on destructive envy, but my patients have come from underprotected, rather than overprotected environments, where the parenting had been unpredictable, often violent, or else associated with prolonged separations.

For the sake of completeness on the topic of regression, I should mention the work of Ernst Kris. His interest was mainly from the viewpoint of artistic creativity. He, too, differentiated two forms of regression, one being characterised by the ego being overwhelmed by regression, whereas in the other, the regression is in the service of the ego.[8] These forms roughly coincide with Balint's malignant and benign types, and in fact, Kris first formulated them in 1935; he did not however elaborate on their clinical significance but used them in his theorising on problems of sublimation and creativity.

I hope that this survey has helped towards clarifying the topic for you. It is in the increasing understanding of the underlying psychopathologies and the techniques associated with them that the advances have come in dealing with regressed patients. Ferenczi, in his time, did not have the understanding of the real malevolence of the severe hysteric. He believed in the supreme power of the uncovering, the reliving and emotional understanding of traumatic experiences and was convinced that the analyst by his love, sympathy and understanding had to fit in with the patient completely and not be the uninvolved, neutral, verbal observer. He did not have the concept of envy of the good breast, the good analyst, and the compulsive urge to destroy the very source of help, love and understanding; nor did he realise that when the patient was apparently responding favourably, it was often in a state of idealisation and denial. Similarly the understanding of the analyst's inevitable failures of the patient in so many small ways, the understanding of the anger associated with these failures is a major step forward. we must not, however, forget the lead that Ferenczi gave us in the understanding and use of the countertransference and of the importance of the part played in treatment by the analyst's technique and behaviour. There are complex issues that I have not discussed concerning technique and the different agencies involved in effecting psychic change but I will conclude by maintaining that regression, where relevant and properly handled and understood, is a therapeutic tool of major importance.

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'Is it my nerves, doctor'*

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Because of its wide and important ramifications, this question is one of the most challenging for the general practitioner. It is not simply a request for information, nor even for an opinion, and so should not be answered except by reverse counselling, until the one who has posed the question can answer it.

Despite an undergraduate medical training designed to remove uncertainty as far as is possible, I now believe that the first wisdom to learn in general practice is that things are not what they seem. Social reality turns out to have many layers of meaning, and the discovery of each new layer changes the perception of the whole. In the minds of many patients, medicine has become the discipline that enables us to solve all their problems, with the expectation that every action taken by the practitioner is part of a solid plan known only to the physician. Perhaps this is the way the physician likes to see himself, as an exponent of the doctorine of progress, a secularized successor to theology as the mistress of the sciences. I have discovered that the more this is believed, the more counter-productive it is for my work. Furthermore, far from being acceptable, a diagnosis can be painful, and very hard to integrate into a person's life.

The question implies an awareness by the patient of the origin of the somatic symptoms, with the implicit hope that physical or structural disorders may be excluded. The danger here is in failing to foresee how a partial truth may be taken for the whole truth. The problem in medical practice is how to know in advance which level of explanation will be the most fruitful.

On the other hand, the full clinical picture is rarely seen, and it must be admitted that the same diagnosis can be arrived at on the basis of different signs and symptoms. The problem in medical practice is how to know in advance, which level of explanation will be the most fruitful, bearing in mind that the Cartesian division between mind and body is no longer tenable. It is well to keep in mind that what is at issue here is not medical understanding as such, but certain applications of this understanding.

The general practitioner then, is someone concerned with understanding patients in a disciplined way. The nature of this discipline is scientific. This means that what the doctor finds and says about the phenomena he studies, occur within a certain rather strictly defined frame of reference so that the consultations are bound by certain rules of evidence. As a scientist he tries to be objective, to control his personal preferences and prejudices, to perceive clearly rather than to judge normatively. The general practitioner does not claim that his frame of reference is the one in which society can be looked at. Indeed, very few scientists in any field would claim that one should look at the world only scientifically. The botanist does not dispute the poet's right to look at an object such as the daffodil in a very different manner. It is not that one denies other people's games, but that one is clear about the rules of one's own. This means the general practitioner must concern himself with methodological questions in reaching his goal, which is understanding for its own sake. I would dare to say that the general practitioner must be a person intensively, endlessly, shamelessly interested in the doings of others. Nothing that men do can be tedious for him or her. Naturally he will be interested in the events that engage men's ultimate beliefs, their moments of tragedy and grandeur and ecstasy, but he will also be fascinated by the commonplace, the everyday. Sometimes he may feel revulsion or contempt, but this will not be a deterrant to wanting his questions answered, questions which may lead him to all possible levels of society, to the best and least known places.

Any intellectual activity derives excitement from the moment it becomes a trail of discovery. Much of our time we move in sectors of experience that are familiar to us and to most people in our society, but sometimes we penetrate into worlds previously unknown to us — for instance the world of crime, or the world of some bizarre religious sect. Yet, it is not the excitement of coming upon the totally unfamiliar, but rather that of finding the familiar becoming transformed in its meaning. The fascination of general practice lies in the fact that its perspective makes us see in a new light the very world in which we have lived all our lives. We might think we have heard all this before, and ask whether, perhaps, we might have better things to do than to waste our time on truisms — until we are suddenly brought up against an insight that radically questions everything we had previously assumed about the familiar scene. Those who have no curiosity about human beings, who are content to admire scenery, without wondering about the people who live in those houses on the other side of that river, should probably stay away from general practice. Doctors whose interest is mainly in their own conceptual constructions would do just as well to work in the pathology laboratory. I do not wish to suggest that we general practitioners look at phenomena that nobody else is aware of, but that we look at the same phenomena in a different way.

* Balint Society Prize Essay, 1991.

We are poorly prepared to deal with patients who ask this question by the medical consciousness created by the cultural values instilled by medical school and hospital training, for much of which we have an annihilating nonremembrance. Within our own consciousness, the past is not fixed and invariable against the ever changing flux of the present. On the contrary, the past is malleable and flexible, and constantly changing as our recollection re-interprets and re-explains what has happened. The end of childhood has, presumably, always meant an eclipse of gods, and in growing into adulthood we move into worlds beyond the comprehension of many of our distinguished teachers.

Entry into the Trainee-year in general practice brings the experience of amazing transformations of identity and self-image that can also result simply from a change of residence. We begin to acquire the ability to look at a situation from the vantage points of competing systems of interpretation, where people exist under the domination of society's logic, acting by it often without knowing it. From the vantage point of the young principal in a practice serving a formative, rather than an artificial community, into which he or she has clawed their way, the doctor/patient relationship is seen to have undergone nothing less than a transmutation.

The anxiety disorders are among the most common illnesses. Last year's audit showed I was dealing with 142 on-going cases of emotional disturbance, 82% females, most with somatic symptoms. While the great majority do not seek medical treatment, those who do consult, go to a general practitioner, rather than a psychiatrist. Anxiety disorders that present with somatic symptoms often go unrecognized, and generate considerable costs through fruitless investigations and referrals for a physical explanation, although this confusion is reduced, as the component syndromes that make up the anxiety disorders are clarified and described. A large majority of these patients were female, with a peak incidence and onset in early adult life, while the patient is still within the influence of the family.

This may be a symptom of our society which is becoming increasingly dehumanized. Patients often seem to be lost and lonely, and able to function only in a merely mechanical way, longing for communion, acceptance, and that difficult-to-find feeling of love. Whereas males are usually motivated by power, female patients are generally governed by romantic factors.

Case 1: Miss H. aged 83, suddenly left her bowls club, and took to her bed. Friends did not understand this change of habit, and were themselves too old to minister to her needs, for she complained of painful limbs, general weakness, and impaired vision. I was interested that when I was sent for, she scolded her friends for bothering me. When we were alone, Miss H. agreed that her record indicated life-long good health, and clinical examination was negative. Her personality structure, as reflected in her confident manner, and by the regard in which she was held by her friends, appeared excellent, so that the question: 'Could it be my nerves, doctor?' came as a surprise. 'Why do you ask?' I responded. She then told me she had suffered strong anxious, guilty feelings in church on the Sunday before she felt ill, and decided to leave the bowls club.

I have always regarded churches as agencies for the mutual reinforcement of meaningful interpretations. We adjust to a particular society, and mature by becoming habituated to it, but the fully adjusted, mature, middle-of-the-road, sane and sensible suburbanite, like Miss H. also requires a specific social context which will approve and sustain her way of life.

What then had upset her? She told me that the service had concentrated on the Day of Judgement which, at her advanced age, was becoming close. She had been filled with sudden fear because of her enduring hatred for her father, ever since she had brought home the only man she had loved, to meet him in the hope of marriage. Nervous at the prospect, the young man had asked if he might smoke, and had been sternly rebuked with the words: 'If you do, you will be the first ever to have done so in this house!' The young man left, and Miss H. remained a spinster, feeling her long life a wasted penance.

Although this had happened 60 years ago she was still held within the family orbit. A long discussion took place bearing on two questions: did she not have the right to feel hostile to her father; and to what extent had she based the concept of her heavenly Father upon him? Was not the latter merciful, forgiving, and able to understand his humble servants? Indeed, was it not even more sinful to ascribe to her God the draconian character of the man who had spoiled her earthly life? I suggested that she should discuss these points with her Minister, with the result that she soon recovered, and returned to the bowling club where she enjoyed another two years.

While her generation was raised in a climate where sex was surrounded by mystery, sacredness and taboos, more basic to that of the present time, which produces a pervasive confusion of feelings and values. The libertarian society has created unforseen problems for many therapists and their patients.

Case 2: Miss J.'s family had left the Asian continent five years earlier, when she was 12. Now 17, she appeared with her parents, grandparents and two older brothers, as is usual in such families. I knew I should eventually have to explain my findings to the grandfather. She had not been at all well for two months, and they thought she had developed asthma. She was also complaining of strange feelings in her face, hands and body, while her school performance had been impaired. It was clear when she entered

the consulting room that she was over-breathing, without any sound of bronchial constriction. I asked if I might examine her only with my nurse present, and this was agreed. As the family left the room, the mother turned and said: 'She has become a changed girl'.

It was clear the girl was going to remain silent, so I left, asking the nurse to take the history. When I returned, I learned she had had amenorrhoea for two months, but denied intercourse. There was no broncospasm and the Peak Flow registered 450l/min. It was decided to take blood for PCO_2 level, and to perform a pregnancy test next day and asked if she could come alone. The family agreed.

When she arrived, we knew she was not pregnant, but suffered from hyperventilation, which falls into the shadowy hinterland between physiology, psychiatry, psychology and medicine. She was noticeably relieved when told she was not pregnant, and I asked about her feelings. She began by saying how she found her life difficult as a member of a family which, through the influence of her grandfather, believed themselves to be of high caste, which even restricted her relationships with other Asians, she was becoming increasingly influenced by peer pressures, so that 10 weeks previously, an episode had occurred in the back of the car of a European youth. Temptation had taken over when the lightning shaft of Cupid had been guided strongly outside the very definite boundaries of class, income, racial and religious background in which she had been raised. It was from then that her symptoms had commenced, and it was difficult, short of elopement, to see how she could resolve her problem. I invited her to come once more with her grandfather. After some hesitation, she agreed.

Fortunately, though I was much his junior, her grandfather respected the high caste bestowed on me by my medical qualification! Also, the fact that I was able to show proper respect for transcultural values, enabled me to demonstrate that what is a 'problem' in one social system, is accepted as normal in the system in which he had now chosen to live. The love and respect in which he was held by his family now needed to be developed, and would be enhanced if, in his wisdom, he could permit his grand-daughter to become more integrated into British society. He agreed that if the young man would accept an invitation to meet him and his family, the situation could be investigated further. Surprisingly, the grandfather agreed; and when, as I had expected, the young man found himself unable to accept, Miss J. was relieved of all her symptoms and made wiser by her temporary deflection from her normal social perspective. I have found the question 'Is it my nerves doctor?' is asked only by Europeans, probably because ethnic minority Asians reject the concept of mental illness.

Case 3: I knew Mrs T. as an outgoing mother of three, and was concerned when her husband brought her, much against her will, on account of marital problems, irritability and menstrual irregularity. She was thin and pale, and no longer the cheerful responsive person I had known. After a pelvic examination, the question was posed about a nervous cause to which I commented that her nerves were not apparently serving her well.

Returning to the consulting room, she said she knew what had upset her. Three years earlier she had been admitted for a spontaneous miscarriage, more painful than any of her pregnancies, and was left feeling depressed. She had looked to her mother for comfort, but had been coolly reminded that she had three lovely children, there was no need to be upset, and things would soon settle down. No one had been able to understand that she had really wanted that fourth child, but her depression had become pathological when reinforced by her mother's apparent indifference, and failure to understand her feelings. As her emotional disturbance increased, isolated symptoms had shifted to clusters, and then to emotional disorder.

The situation appeared to be one where reliving the situation under hypnosis would produce catharsis, a practice in which I had been trained. When regressed through the pain and distress she reacted with violent emotion after which she became calm and could ventilate her thoughts and discuss her feelings. Within a week she resumed her normal personality.

Not every patient is so aware of the cause of their symptoms, but with time, an equilibrium is reached so that spontaneous remission appears to take place. The doctor, however, can never say: 'It'll clear up in time'. I was therefore embarrassed, rather than flattered when the senior partner of another practice stopped me and asked me to see his 16-year-old daughter who had developed thumb-sucking, adding, 'It's time she stopped it, and we're tired of telling her about it. I know you've had some success with hypnosis'. In agreeing, I pointed out that symptom-removal without understanding the cause could be dangerous.

Case 4: I had not met Clare before, but had briefly met her plain 19-year-old sister who had just been accepted into Medical School, to the great delight of her parents, who were partners in practice. Her mother tirelessly involved herself in sorting out psycho-social problems of young people in the practice, often interviewing well into the evening. Clare was an attractive girl and sat sucking her thumb, but I was interested to note that when I told her I did not mind her habit if she enjoyed it, she removed her thumb immediately. As she did not know why she had been asked to see me, we talked about her O-levels, and whether she would also go in for Medicine. This excited resentment both over the amount of attention paid to her sister's career, and her mother's preoccupation with patients and the feelings.

'I just don't count', she wept, 'they treat me like a baby and I suppose they would be proud of me if I wanted to be a doctor, but I

don't . . .'. She went on to say she sometimes did not know who she was, and faced this contingency as if surrounded by chaos on all sides, despite their socially well-constructed world. Sometimes she felt on a step removed from annihilation when she overheard her parents discussing cases, and wandered about a house full of proofs of past identity. She desperately needed her mother's support. 'Is that why you suck your thumb?' I asked, and she answered that it could be, recognizing that though she could no longer expect her parents to treat her as a child, she gained some attention by her parents' annoyed protests. She was beginning to overcome some of her dormant doubts, and agreed to let me transfer her overt thumb-sucking to flexing her right big toe, which would be her first step into adulthood, and would help her to deal with her parents, as we all have to do at a certain stage.

The socio-historical background alliance changes with the social climate. The victories of feminism and the progressive liberalization have also done away with many defences and taboos. Communication between doctor and patient has become more open and equal, and this has facilitated different types of transference and counter-transference. Freud warned that 'the psychoanalyst knows that the forces he works with are the most explosive and that he needs to be as cautious and conscientious as a chemist.' The therapist needs a particular personality structure, and to be experienced and knowledgeable in his field, understanding and empathetic, but not sympathetic.

It is important to be relatively content in one's own personal life, and to be aware of one's own unresolved inner conflicts and affective frustrations. Noting that the question being discussed is asked by females in most cases, the therapist 'should be able to deny the patient who is longing for love, the satisfaction he or she craves'. In a therapeutic relationship there should be, as in any good parent/child relationship, maximum social intimacy, coupled with maximum sexual distance.[2] But care must be taken in the modern world to avoid showing male chauvinism.

The cases I have described were suffering normal anxiety and depression, with varying degrees of somatization, from which many people suffer at times. They indicate the powerful control system of the family and personal friends, an influence that may last a life-time. The most intimate relationships are those able to sustain the most important elements of self-image. We are the masks we wear to play our role in society, for the personality must be seen as a process continuously created and re-created in each social situation that one enters, held together by the slender thread of memory. Yet, externally those others with whom we are involved demand that we present at least a relatively consistent picture to the world. There are therefore profound psychological needs to perceive ourselves as a coherent identity. But the successful control of external tensions while playing mutually irreconcilable roles in different areas of our lives produces internal pressures as we focus attention only on that particular identity that, so to speak, we require at the moment. Miss J. was torn between her development in her chosen society, while expected at home to be chaste until a marriage was arranged. Miss H., approaching a change of role caused by death, no longer felt her identity socially sustainable in the transformation her faith suggested would take place. Mrs T. continued to bear the painful loss of a child while trying unsuccessfully to carry on as 'normal'. Clare had begin posing in an inappropriate manner to fill the internal vacuum of a non-existent identity.

More biological and psychological evidence must be provided by scientific studies to create a unitary concept of the general neurotic syndrome, characterized by anxiety and depression, usually as a syndrome of continuous dimensions. For this syndrome to be categorized it is essential to stipulate a personality diagnosis.[3] The importance of vulnerability factors and their genetic determinants as causes of neurotic disorders, is generally recognised, but there is no evidence that the different anxiety syndrome develop within an identical personality setting, particularly as the hereditary factors responsible are almost certainly polygenic. It is to be hoped that the specialty of general practice will play a major part in directing clinical and scientific attention to the development, historical and personality settings in which neurotic disorders arise.

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Psychosomatic Encounters and the Scope for Interpretation in General Practice*

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Introduction

We are greatly indebted to the work of Michael and Enid Balint who explored the possibilities of psychotherapy in the general practice setting. Their ideas have evolved over the years and research-groups under their guidance have changed the focus of interest from formal psychotherapy to an integrated form of psychotherapy. In 1973, in the book, *Six Minutes for the Patient,* Michael Balint argued that the therapeutic work was considered to be done by tuning into the patient, understanding her communication and then communicating this understanding to the patient.[1] However, because it proved very difficult to observe reliably in what way the patient responded to these flashes of mutual understanding, the next research-group concentrated in studying the significant moments in the doctor/patient interaction.

In 1987 Enid Balint explained that the book, *While I'm here, doctor,* is mainly concerned with making observations about changes that take place in the doctor's feelings about the patient and in the patient's feelings about the doctor. The changes are not communicated at the time by the doctor to the patient. The doctor waits to see what happens to the patient when his feelings about the patient change.[2]

So, in the Balint tradition there seems to be a gradual shift of emphasis away from interpretation, towards understanding of the doctor's feelings, including counter-transference, as an instrument for therapeutic change.

In this paper I would like to explore a way of working psychotherapeutically with a psychosomatically ill patient in general practice, which stems from Winnicott's approach to child consultations.[4] This approach recognises the patient's hesitancy in forming a trusting relationship with the doctor. Interpretation is not the main feature of this work. The doctor gives the lead to the patient, who sets the pace going as fast as she feels comfortable. It is only within this trusting relationship that an interpretation can be effective as an instrument for change.

Anna

I first met Anna and her family in August 1987. They asked my help about Anna's mother, Mrs K whose behaviour was causing problems. Mrs K used to live alone until her progressing dementia made her so confused that she could not find her way back home, or count the correct change.

Her youngest daughter Anna and her husband Mark decided to take her into their home and look after her. Anna who was a security guard in an old people's home, at the time, was the breadwinner. Mark stayed at home and cared for their two-year-old daughter Rachel and Mrs K. They decided on this arrangement because Anna's job was the better paid.

Looking after Mrs K however, proved a very difficult task. She was a heavy smoker and she burned holes in the carpets and the curtains. She was incontinent of urine and very often she would refuse to wear her incontinence pads. She would urinate on the carpet in her bedroom and she would leave her dirty underwear on the kitchen draining board. She would have fights with Mark when he insisted that she had a bath. She would be verbally abusive and accuse him of being physically violent to her. Very often she would ask him what was he doing in her own house. Her behaviour was deteriorating and on a few occasions she went out and got lost and the police had to find her and bring her back.

Mark found her behaviour infuriating and asked me to see her in the hope that she suffered from a curable illness. All the tests were normal however, and the psycho-geriatrician who examined her confirmed that she was suffering from Alzheimer's dementia. In view of her offensive behaviour he arranged regular Day Hospital attendance, and put her on the waiting list for admission in a psycho-geriatric ward.

Anna came to see me at the surgery one month after my initial involvement with her mother. She was then 44 years old, very thin with short black hair. She had a deep masculine voice which contrasted with Mark's youthful voice which sounded almost feminine.

She complained of feeling awful. She had constant headaches, was sleeping badly, her appetite was poor, and she was losing weight. Anna found that when her mother had a temper tantrum at home, she reacted also to her mother's past violence. Mrs K had treated her children in a harsh way which amounted almost to physical abuse. Anna had always lived in fear of her mother who beat and threatened her with abandonment regularly. Her eldest sister went deaf in one ear when her mother banged her head against a wall in a fit of rage.

She told me that one of her greatest fears now was that Mark may crack up under the impact of her mother's behaviour. She had reason to fear this because four months after their wedding in 1984, Mark stole all her money and jewellery and he disappeared for several days. He had a binge on intravenous heroin during which he contracted hepatitis B and then infected her.

*Paper read to the Society on 12 February 1991.

Fortunately they both recovered, and Mark had not had another bout since then. Anna was afraid however that the present stress at home might precipitate another bout of drug-taking. Meanwhile Mark was showing his distress by withdrawing his services and taking to his bed. Anna was so obviously distressed that I asked her to come and see me weekly for support.

The situation at home deteriorated and so did Anna's symptoms. She was aching all over and was crying constantly. She developed generalised itching was later became localised to the pubic area. On examination the skin was red and raw with scratch marks oozing blood. As I could see no parsites, I prescribed calamine lotion which had no effect whatsoever.

Mrs K's condition deteriorated quickly and in January 1988 she became unable to get out of bed. I admitted her to hospital where she died one month later. One week after her mother's death, Anna came to the surgery saying that she needed to talk about her mother. Also the rash in her pubic area had spread to involve the whole hypogastrium. The itching was so intense that she wanted to tear herself to pieces. She said that she was terrified of the dark. She thought that this might have something to do with her mother telling her that when she died she would come and haunt her.

She felt guilty about her mother's death because she let the doctors give her pethidine to relieve her agony during the last hours. This probably made her die sooner than expected and Anna had the feeling that she had killed her. One day at the hospital she was struggling to change her mother's nightie when Mrs K started shouting 'Don't hit me, don't hit me'. Anna felt she could not cope any longer. 'You have been doing all the hitting' she shouted and ran away. Mark had to take over. I prescribed Nystatin cream and antihistamines for her itchy rash and made a mental note of the link between the desire to tear herself to pieces and her account of the hitting mother. One week later Anna came again. Her itching and the rash was as intense as ever. She talked and cried throughout the consultation. She said that she knew when she was little, that her mother could not cope with life for whatever reasons she had and that Anna made her mother's life that bit more difficult. When her mother was angry she would threaten to leave her and Anna would beg her not to. The more she begged, the more threatening her mother became. Then she would beat her and mother would get violent headaches. Anna used to pray that she got the headaches instead of her mother, so that her mother would be in a better mood.

Her mother would not let her cry. If she cried, she would beat her and so she had to pretend she was not crying. When her mother was in hospital Anna wanted to tell her that she always cared for her but she could not say anything until her mother was unconscious and could not hear her. Otherwise she was afraid her mother might say something terrible. Anna had never been able to show her any tender feelings without the mother shouting abuse at her. Just before she died she opened her eyes and looked at her in a terrifying way as if she was accusing her about everything.

Anna cried because she never had what she wanted from her mother. Love, companionship and care. A week later Anna's itching was no better despite my various remedies. Her fear that her mother would come and haunt her was so strong that she had to leave all the lights on. When she brushed her teeth in the bathroom she had to face the door in case her mother appeared behind her back.

Her fear infected me and I became worried that her excoriated skin was invaded by secondaries from an undiagnosed carcinoma. I began to wonder whether I should refer her for a specialist opinion. I contained my anxiety however, and told her very tentatively that I thought her itching had something to do with her relationship to her mother. 'Yes', she replied, 'sack-cloth and ashes.'

One week after this cryptic comment, Anna came to the surgery looking very well. She was elegantly dressed and had a confident happy look about her. She was almost beautiful. She reported that during the past week she had two dreams following which she felt a lot better. Her itchy rash had gone. In the first dream she was running through wide roads. A man called her to follow him. She had to make her way through brambles. Suddenly she came to the end of the brambles. There was a precipice and she fell. The fall caused a pressure in her chest and she woke up very frightened.

In the second dream, she felt there was something final about her mother's death. Anna was looking for her daughter and she could not find her. She was shouting and screaming, calling for her. Mark very calmly said that she was alright, she was asleep. She woke up in terror and she went to check if Rachel was alright. I interpreted to her that the brambles that tear her skin were her relationship to her cruel mother. When her mother died and the brambles came to an end there was nothing to support her and she fell. It was either brambles or nothing. All her life she was terrified that her mother might leave her and finally she had.

The second dream expressed her terror that along with the brambles, the bad mother, she might lose the good mother, represented by her relationship to her daughter, and be left utterly alone. This would be intolerable and she had to reassure herself in real life that her daughter was still there. These two dreams express Anna's problems in a nutshell: her clinging for comfort to a mother who inflicted pain, so that comfort and pain became inseparable.

After the resolution of her rash, Anna continued to attend the surgery two or three times per month for various minor complaints of her own or for Rachel. She also changed her

job and became a pest-control officer. This involved handling insecticides and poisons.

In January 1989, one year after the first appearance of her itchy rash, it reappeared. She complained that her pubic area was so itchy that she was tearing herself to shreds. She scratched so hard that she made herself bleed. The appearance of the rash was identical to last year's. I reminded her that last time she had a similar problem she was very upset about her mother's illness and I wondered if there was anything upsetting her this time. She was upset about Mark. He was in one of his foul moods. He was withdrawn, angry and swore at her. She was frightened of his verbal abuse. Also he was not reliable with Rachel and she had to take dependency-leave to look after her for the time being. She was worried that if Mark did not get out of this frame of mind, she would have to find a baby-minder and she hated this possibility. She was not sure whether Mark was fixing himself and she was afraid that if she told him that everything was all over between them he might take Rachel and disappear.

Then she said that Mark had got under her skin recently. I wondered out loud whether, in a sense she was attacking him where she thought she could find him, that is under her skin. My comment did not make much of an impression. I examined her hypogastrium and prescribed some calamine lotion and an antihistamine. A fortnight later she returned she said and I quote 'the itching is driving me dulaly.' She wanted literally to tear herself to pieces. She found finally a baby-minder who would look after Rachel while Anna would go to work. She did not trust Mark when he went into his moods. She found that Rachel was unsupervised, and watched a lot of television. One day she came home earlier than usual and found the Christmas tree stripped bare of the chocolates she had put on it. The electrical lights were next to them and Mark did not take the slightest bit of notice. She could have been electrocuted. She told him how disappointed she was that he did not look after Rachel properly and ended up crying and she hated it.

I asked her whether she was angry with him for not keeping his side of the agreement. She answered indirectly by saying that she pitied him and felt sorry for him. She said that Mark was full of hatred; that he was like a bag of pus. He felt sorry for himself and behaved for a while but now and then the bag exploded and all the pus came out on to her face. I asked her whether this hatred makes her angry. She evaded my questions by saying she did not like it when he showered her with verbal abuse. I interpreted to her that I thought her itching was her way of expressing anger.

'But this is silly,' she said 'because in this way I only hurt myself.'

I explained to her that she turned her anger against herself. Her mother had seen to that. It was never safe to show her anger when she was little because she was punished severely. Now her mother lived inside her. To my amazement she started crying and said that she had been missing her mother a lot lately. When she took her into her home to look after her she had hoped that she could change her. As the itching was so severe and had not responded to my previous remedies, I prescribed hydrocortisone cream and asked her to come again the following week.

When she arrived she was smiling and looked relaxed. She complained of a tummy upset and a lump behind her ear. Not a word about the itching. In the end I could not help it anymore and asked her about it. She astonished me by saying that her aunt told her to put surgical spirit on it and now she felt a lot better! It hurt a lot at first but then it got better. 'You see,' said Anna, 'all the creams and oily stuff you gave me warm the skin up and make the itching worse.' Anna had not given me any credit for the improvement of her itchy rash. It was only two years later when I was writing the history that I realised that on both occasions her rash improved after I had interpreted its possible meaning to her. It is very difficult to know in retrospect what was the therapeutic factor. Was it my interpretation, or was it the opportunity to talk freely about her distress? We know, after all, that when we do not make it possible for patients to tell us about the abuse they have suffered, we fulfil their transference expectations of our being uncaring mothers.

After the resolution of the second episode of her rash, Anna continued to attend frequently, sometimes once a month, sometimes three. Her dissatisfaction with Mark's behaviour increased. In April 1989 she had an accident at work. A puff of Drione powder, one of the insecticides she was using touched her face. She came to see me for advice. I contacted the poison-centre at Guy's Hospital and discussed the accident with the specialist. He did not think it was serious. After this incident, Anna's complaints increased in frequency and intensity. She developed back pain for which I referred her to the physiotherapy department. She developed tennis elbow which I injected with Depo-medrone. She developed irregular periods for which I referred her to a gynaecologist who put her on the waiting list for a dilation and curettage.

In February 1990, she complained of feeling chronically tired. She felt exhausted and found her job physically demanding. She enjoyed the mental part concerning the knowledge of the life-cycle of the various pests, but not the physical part which entailed killing them. She was aching all over and felt sick. Her mouth filled with saliva, she vomited and then felt absolutely drained. At the end of the consultation she added, 'My aunt says have your blood pressure and your blood checked.'

I knew what a beneficial effect her aunt had on her from the second episode of her itchy rash and I wanted to ally myself with her. I told her that I had the greatest respect for her aunt, and then examined her and ordered several tests

to help with the differential diagnosis. Everything was normal but her complaints became relentless and dramatic. She hurt all over and felt as if her bones were falling to pieces. She felt so exhausted that one morning she was halfway to work and had to turn her car around and go back home. She felt she had run out of whatever it was that had sustained her since Mark ran away with her jewellery to have a drug-binge six years ago. She asked me to refer her for homeopathic treatment. I had no objection, but while waiting for an outpatient appointment I thought that she needed some urgent help. I told her that I did not think she was suffering from a physical disease but that she was rather very unhappy. I asked her whether she would like to come and see me every week for twenty minutes until my summer holidays in three weeks' time. She accepted.

In our first session, she told me that she was physically in agony and she could not afford to be ill. She had lost her self respect. She had lost respect for Mark. She felt nothing for him. Nothing to build on. She felt sorry for him. She felt grateful to him for giving her Rachel who is hers. I asked her whether she was angry with Mark. She told me that she cannot experience anger. She cannot even feel angry with her mother. She told me again how, when she was little, she used to pray that she got the headaches instead of her mother because mother used to give her a hiding with a belt every time, she got a headache. These memories were painful and Anna started crying.

She even used to buy powders to cure her mother's headaches but her mother would still beat her. When her mother was ill at home, she asked her why she used to beat her all the time. The mother replied that somebody had to do it. Anna said that she put all these painful memories in little boxes but she cannot keep them away for too long. A week later Anna was feeling no better. The day before she came to see me, Mark had been aggressive to her and he ended up swearing at her. Anna was appalled at how subservient she became during the row. She blamed herself subsequently for getting in Mark's way.

I felt that this was the right moment for an interpretation. 'So from what you are saying it seems that when Mark is aggressive to you, he becomes your angry mother and you become the frightened little girl. You lose your adulthood and therefore your self respect.' This interpretation brought up a flood of memories about her relationship to her mother. Her mother used to beat her for as long as she could remember. She could not reason with her mother like she cannot reason with Mark when he is in one of his moods.

She was molested at the age of seven by a mentally defective neighbour who asked her to touch him. When her mother found out this from her brother, she was beaten by her mother, because mother said it was her fault. When her periods were late at the age of 13, her mother took her to a specialist and swore that she was pregnant. 'How frightening it must have been for you', I said. 'Yes', she replied. 'I was brought up in fear. If Mark ever hits Rachel, he will find himself out of the front door before his feet touch the ground.' The following week Anna was still very tired but she began making some startling discoveries.

She felt guilty for taking so many weeks off work. She was afraid that her boss would not believe that she was ill. She asked her aunt's advice who told her that it does not really matter whether her boss believed her or not. When she told her boss over the telephone, that she did not feel fit to come back to work yet, she was surprised by how easily her boss accepted it. She realised that she expected to be told off all the time. Never before did she associate her feelings with her mother's behaviour. Her mother never believed her. When she was playing with her sister and brother and someone cried, it was always her fault and she got a beating. When her periods started, she was totally unprepared for the experience. She soiled her underwear with blood, and was terrified that mother would beat her for this. When she was taken to a surgeon to have a cyst removed from her face, the mother did not warn her of the impending operation. When she recovered from the anaesthetic, she had excruciating pain in her throat. The surgeon told her mother that as her breathing was noisy, he had also removed her tonsils and adenoids. The bill as a consequence, was higher than expected, and her mother was annoyed with Anna for not breathing quietly under the anaesthetic. 'Even when asleep, I was in the wrong', said Anna wryly to me.

Suddenly the thought that her expectations of people's reaction to her had been conditioned by her mother's behaviour and did not correspond to present-day situations was both a revelation and a liberation. This was our last session before my holidays and I was going to be surprised when I came back.

She came to see me as soon as I returned from my holidays three weeks later. She told me that she could not wait for the homeopathic appointment to come through and so during my absence she went privately to a nature clinic. There she was seen first by a homeopathic doctor. As soon as he heard that she was working with insecticides, he blamed her exhaustion on chronic poisoning and advised her not to go back to the same job. Then he referred her to his wife who is a reflexologist and she had started weekly sessions of having the soles of her feet massaged. She had come urgently to ask me to write a letter to her employers recommending a change of job so that she did not handle poisons anymore. This came as a shock to me. I felt hurt that she did not give me any credit for her improvement and that she adopted so readily such a simplistic and naive view of her illness.

I also felt hurt that after all my efforts to help her, she found a more satisfying method

of help from someone else. I was able to contain my hurt however, by reflecting that this is probably how parents feel when their children become strong enough to leave home. They have done a good job if the children feel confident and secure enough, to look for people to love outside their immediate family. After a few moments of hesitation, I realised that I did not want to antagonise any agent that might be helpful to her. I expressed my scepticism about the cause of her symptoms, but as I knew that she did not like killing insects and animals, I wrote the letter and gave it to her there and then, I asked to come again to tell me of her progress. She came two weeks later and she told me for the first time since I had known here that she felt 100% better.

Several things had happened to contribute to her well being. First of all, she was praised by Mark's family for the good effect she was having on him by helping him to grow up. Anna had never been praised before and she lapped up the praise. Her boss at work agreed to redeploy her to a job that did not involve handling chemicals. Also she was having hydrotherapy at the physiotherapy department for her body pains, massage and reflexology weekly, plus homeoepathic treatment. She was enthusiastic about reflexology. She found that massaging the soles of her feet made her relax all over. In fact she was so enthusiastic that she decided to study reflexology herself and become a therapist. She had already enrolled in an intensive course. Two weeks later she came to see me again, beaming and exuding well being. Her clothes were smart and she looked younger and beautiful. I asked her about her progress and she launched into an excited and animated account of her reflexology treatment and her new training.

Suddenly there was a lot of purpose and meaning in her life. She explained to me how reflexology works and showed me the various areas of her feet on which parts of her body are represented. Perhaps I should treat you one of these days she said. There was a genuine warm feeling between us. I laughed and replied that I would wait until she was qualified. Then I told her how pleased I was that she looked so much better. Two weeks later she came back to tell me more about her progress. She had brought her books to show me, and with undiminished enthusiasm she told me that in one of her courses she met a chiropodist who taught her about the use of aromatic oils in the treatment of various ailments.

She had started massaging her tummy with warm castor oil clockwise. Her bowels had become completely regular and so had her periods. She had cancelled the gynaecology appointment. I told her that she had never looked after herself so well before. 'Yes', she replied, 'I feel I am spoiling myself.' I told her that she had quite a lot of catching up to do. Then I asked her how things with Mark were. She grimaced. She said that he was a lot better. He still gets his moods but she will not let this affect her anymore.

I was very pleased that her relationship to her body had changed so dramatically since I first met her. From tearing her skin to pieces, to the loving caressing with aromatic oils. This was a very impressive change that had to be supported and consolidated.

Discussion

Anna had two episodes of skin irritation. The first was related to her mother's illness, and the second to her husband's unreliable behaviour towards their daughter.

Winnicott has made the statement that chronic skin irritation emphasises the limiting membrance of the body and therefore of the personality. Behind this is the threat of depersonalisation and loss of body boundaries and of unthinkable anxiety which belong to the reverse process of which he called integration.[5]

When Anna took her mother into her home, she relived the terrifying experience of her childhood, when her mother beat her and threatened her with abandonment. She re-experienced the helplessness and the humiliation, the overwhelming anxiety and sense of worthlessness.

One of the most primitive and terrifying fears is the fear of being dropped from the mother's lap, of being abandoned by mother, the fear of falling forever and going to pieces. The effect of this fear is a disintegration of the personality and the anxiety is almost physical and unthinkable. The irritation of Anna's skin both defended her from, and expressed this anxiety in a physical form.

In a previous paper on holding in general practice, I have written about the importance of recognising the role of holding in the management of patients.[6] I was able therefore to recognise her intense anxiety which attracted me to her. I invited her to come and talk to me and in a sense, I caught her in her fall and provided the holding that she was missing at the time.

For the baby and the young child to develop normally it is essential that her body must be held and handling lovingly by the mother who enjoys looking after the child. Gradually the actual physical holding becomes internal and the meaning of holding becomes metaphorical. Loss of the internal mother results in falling which may be actual or imagined.

Anna could not experience anger with her mother despite her mother's threatening behaviour, because any expression of anger would being immediate retaliation and the fear of abandonment, and therefore of disintegration. My interpretation of the possible meaning of her skin irritability has to be seen within the context of my holding her. I was trying to put an unthinkable situation into words so that it could be thought about and elaborated mentally.

Anna's relationship to her mother was so disturbed that she had to defend herself against the terrors of physical punishment and abandonment by splitting the experience of her

mother in two. The two dreams that Anna reported to me after the death of her mother express the essence of her conflict.

In the first dream, she has to make her way through brambles. Suddenly she comes to the end of the brambles. There is a precipice and she falls. The fall caused a pressure in her chest and she woke up terrified. In this dream falling expresses the terror of losing the internal holding mother and therefore of disintegration.

In the second dream, Anna was looking for her daughter and could not find her; she was calling her and there was no response. Her husband told her that Rachel was asleep. Anna woke up in terror and went to check if Rachel was alright. Both dreams attempt to deal with the terror of losing the internal mother. However, the two aspects of the mother are dreamed separately.

The experience of the mother who tears Anna's skin with her physical punishments is represented by the brambles and the experience of the comforting mother is represented in the second dream by her daughter. It was impossible for Anna to think that she could be freed from one aspect of her relationship to her mother without at the same time losing the other.

We know that patients who had a faulty relationship with their mothers, tend unconsciously to select partners with whom they can repeat the pathological relationship with the mother of the childhood. Also their relationship to their bodies recreates aspects of the maternal care system that handled their body during infancy and childhood.

Anna's relationship with her husband and her physical symptoms could be seen as a repetition of her faulty past relationship to her mother. However, three years passed before I found the right moment to interpret this to Anna. I told her that when her husband is in a foul mood, he becomes her angry mother and she becomes the frightened little girl. She loses her adulthood and therefore her self-esteem. This interpretation made her conscious of the repetition of the past into the present, and she became able to liberate herself from the compulsion to repeat the past. She was able instead to look for the mothering she always needed. The tender, soothing, healing touch of another woman.

As we have seen, Anna never gave me any credit for her improvement. Was it because she was afraid to tell me anything nice in the same way that she never dared tell her mother? Or because she could not acknowledge her dependence on me?

It seems to me that our relationship obeyed the pattern of splitting that she established earlier in her life. She split her therapist into a listening part which was me, and a touching, comforting, soothing and relaxing part which was divided among several therapists, her homeoepath, the reflexologist, the aromatherapist, the physiotherapist and finally the aunt.

When I was first confronted by this I felt hurt and rejected. Perhaps this was her only way of expressing her anger and contempt. Had I retaliated with anger I would have fitted into her pattern of splitting the mother into a rejecting and punishing one and a comforting and soothing one.

She would have gone to the reflexologist in defiance of me, rather than with my blessing and we would both have been the poorer for this.

In this paper I have described my way of working psychotherapeutically with a patient in the general practice setting over a period of three years. During this time she attended the surgery a total of eighty-two times, either on her own or with Rachel. This was not formal psychotherapy. She was seen mostly on demand. Most of the sessions lasted five or ten minutes, while seven lasted twenty minutes. This was at the time when her distress was intense, and I invited her to come and see me weekly. There has been no question of termination. She continues to come to see me. Our present relationship benefits from the investment of so much psychotherapeutic work, and she has remained well since August 1990.

Although her dreams provided me with an early understanding of her conflict, she took three years to arrive at the point where she could use my interpretation to gain insight. It would be presumptious however, to assume that it is only the accuracy of the meaning of the interpretation that helped the patient.

An interpretation, at least when it is given tentatively, conveys to the patient the feeling that the doctor has been listening attentively, has remembered what the patient said and has been sufficiently interested to listen and remember and understand. And by indicating the doctor's sustained interest in the patient, they play an important part in maintaining a trusting relationship which is not entirely transference and which facilitates the healing process. Caring for the patient's body, adapting to her needs, showing concern and behaving reliably in the professional setting, all constitute the holding environment within which an interpretation can become meaningful.

General practice is potentially the ideal setting for treating psychosomatically ill patients. These patients find it difficult to depend on one therapist alone. Both Michael Balint and Donald Winnicott recognised this phenomenon, and referred to it as collusion of anonymity and scatter of therapeutic agents respectively. Anna's need to split her therapist was influenced by her attachment to a cruel mother that made integration of the caring aspects of the mother with the mother's actual behaviour intolerable. Facing up to my hurt when I realised that I was not the only therapist, enabled me to understand and tolerate the splitting. I remained in the background as a facilitating influence, as someone who could keep in his mind the irreconcilable elements of her internal world.

Eventually an opportunity for interpretation arose which made conscious some aspects of her relating to her husband which were responsible for maintaining her misery and she became able to develop a more self-caring attitude.

General practice allows patients like Anna to titrate their relationship with the doctor according to their tolerance and need. This approach contrasts with work in the same setting with psychoneurotic patients who may have a real need for formal intensive psychotherapy.

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A Winter's Call

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They put the call in for Mary early one winter's evening. 'She's got a terrible bad chest' said her daughter.

I drove out to the tenement block through the driving rain and the darkening night. I hauled my bag up to the fifth landing. The lift had long ceased working, the mechanism rusted solid by the urine of countless tenants condemned to live out their lives in these blocks.

Before seeing the patients I was shown into the parlour to talk to the three nubile daughters, Marlene, Sharon and Pat, all of whom had been 'Worried about Mam for weeks' but could only summon up courage to send for the doctor at 7 o'clock on a November evening.

I noticed en passant that Sharon was roundly pregnant. My professional eye estimated her to be about 28 weeks gone.

Having heard their worries I went into the bedroom to see Mam. Once my eyes had penetrated the fog of cigarette smoke, I was able to see Mary's nose and nicotined stained fingers peeping over the counterpane of the sagging double bed. Her acute exacerbation of chronic bronchitis was quickly confirmed. I didn't have the energy to admonish her yet again for her smoking, so I wrote the necessary prescription and returned to the parlour to tell the girls about my findings, to send one of them off to the chemist to get the antibiotic, and to calm their fears about their Mam.

I turned to Sharon and said casually, 'when's the baby due?' A look of horror came over her face and she burst out in her best scouse 'Shurrup — my mam doesn't know yet.' What could I say? I covered my confusion by packing my bag and beating a hasty retreat. It was not too long before I was back home with my slippers and the remains of my evening meal.

Months have passed. It is summertime and I am doing a morning surgery. The sun is shining through the window and I can even hear the birds twittering behind the noise of the lorries and buses outside. It is the usual sort of surgery. 'The baby won't sleep' and 'can I have a note for the Social to say that I need new clothes?'. Mary comes in, looking miserable, and sits down. Her fingers yellower than ever.

'What can I do for you Mary?'. 'I feel so depressed doctor, can you give me something to make me feel better?' Being a good Balint-doctor, I set about finding the reason for her depression. 'How is your appetite? How are you sleeping? Do you feel like doing away with yourself?', and quite a lot of other questions in that vein. I ended my interrogation by saying, 'what do you think it is that has upset you?' While she pondered this question I was busy writing my prescription for an anti-depressant and had duly shoved it across to her side of the desk before she could answer. 'I really don't know what it is that has upset me doctor . . .' a long silence, 'unless . . .?' 'unless what?' I countered. Another very dubious pause.

'Unless it was our Sharon,' she murmured, to nobody in particular. Something clicked. The picture of the three daughters — Sharon's bulging skirt and her horrified retort came vividly into focus. Metaphorically I felt Michael Balint tapping me on the shoulder.

'How did you feel when Sharon had to get married?' I asked.

'I was dreadfully upset — it was awful.'

'Really — can you remember what you were like when you were 18?'

Mam visibly brightening.

'Tell me — did you have sex before you were married?'.

'Aye, she said, smiling.

Then I delivered the coup de grace 'and tell me Mary, were you pregnant when you got married?'

'Yes I was' said Mary, who grinned all over her face. She got up and went smiling from the surgery.

The prescription for amitriptyline lay forlornly on the desk.

Michael would have been proud of me.

'Will you have a little drink, Doctor?'

John Salinsky
General Practitioner, London

Consider the following little scene from general practice. The doctor is on a regular visit to an old lady who he likes to keep an eye on because she lives alone and is in poor health. He listens to her account of her symptoms (with which he is very familiar), and he asks one or two questions about the home help or the chiropodist. He takes out his pad and writes out the prescription for her regular drugs (which he also knows by heart). Then the old lady says, 'Will you have a little drink of whisky, doctor?'

At this point, if this was an educational video or one of those questions from the MRCGP examination, one might stop the action, turn to the trainee and ask: how should the doctor respond? What options does he have in selecting his reply? What are the advantages and disadvantages of accepting the offer? Let's see now. The advantages of accepting the drink would quickly be disposed of by the well primed examination candidate. The old lady's feelings would not be hurt and the doctor's thirst (if he had one) would be satisfied. The good candidate would then be able to expand on the disadvantages: if he accepted an alcoholic drink, the doctor would be crossing the boundary between the professional and the social relationship; he might be receiving a bribe, arousing false expectations of special privileges in return. He might even later be found drunk in charge of his car. It really would be much wiser to decline politely and move on to the theory, but in real life I'm afraid I behave rather differently.

That old lady is only one of a dozen patients with whom I have had a little drink, sometimes on one occasion, sometimes regularly. I have been offered tea, coffee, soft drinks and solid food also, but I will come on to those later. Whisky is more potent both as a drink and a symbol, and I would like to explain to your worships how I came to be accepting it from that particular patient in the first place. She and her husband (when he was alive) lived in a small flat above a shop, accessible only from the back via a metal fire escape staircase, treacherous in wet weather.

I first met them when I was new to the practice and had been summoned to attend their daughter, Margaret, who had had a grand mal fit for the first time in her life at the age of 36. My hospital trained eye at once spotted Margaret's nicotine stained fingers and clubbed finger nails. My diagnosis of carcinoma of the lung with a cerebral metastasis causing a fit, was eventually confirmed and I felt a glow of professional satisfaction. Margaret died quite soon afterwards, and I began to learn the painful lesson that sharing a bereavement could be a more important part of my job than making a clever diagnosis.

The hospital had not taught me much about grief and loss — but something made me visit Margaret's parents after her funeral and talk to them about how much they missed her. That was when the custom of the little drink began. Mrs James was always the one who suggested it: Mr James was a bit worried about the whisky running out and sometimes claimed that he could not find it or there wasn't any. But his wife insisted that it be found, and I was given my little glass, despite my feeble protests that I really should not.

Perhaps I should have remained resolute and refused it the first time; soon the visits became regular and the whisky an integral part of the consultation. Mrs James never left the flat after Margaret died and suffered a good deal with her osteo-arthritis and headaches. Later on, Arthur, her husband, succumbed to a carcinoma of the oesophagus and she was left alone in the flat above the shop, refusing to move into more suitable accommodation, despite the pleas of her remaining children.

On my first visit after Arthur's death, she sat me in his chair by the gas-fire and limped painfully over to the sideboard to get the whisky. It has gone on like that ever since. I make sure it is only a small one these days — I usually pour it myself. She does not have any herself, but she likes to see me drinking it.

We talk about how lonely she is without Arthur, and sometimes about Margaret too. If her neighbour calls she hurriedly puts the bottle away and tells me to hide my glass: 'She's an awful gossip, that one, and we don't want her talking about you.' I'm inclined to agree. When the gossip has departed, I finish my drink, take my leave and make my way, still quite steadily, down the iron staircase and on to the next patient. I try to make it a rule never to drink with more than one patient a day.

But what does it all mean? What does the little drink of whisky do for me and for the patient? It seems to have become an important part of our relationship, a little ritual that reaffirms the bond between us. And the bond has something to do with sharing a loss, a memory of a loved partner, not there to do the drinking any longer. Guiltily, I try to remember how many other patients I have accepted drinks from — and how it all started. Immediately I can think of several others with whom the custom seems to have grown out of death and bereavement.

There were the Kellys for instance, who lived in a comfortable semi-detached house in a more up-market part of the practice than the James family. Patrick Kelly was a heavy smoker like Margaret James, and he too developed a bronchial carcinoma. The growth was inoperable, radiotherapy was unsuccessful, and Mr

Kelly was sent home to await the inevitable outcome. Mrs Kelly was told the bad news by the hospital doctors but nobody said anything to Patrick except that he had had 'a patch of pneumonia'.

In those days, I too was fearful of talking to patients about fatal illness and tended to go along with the accepted wisdom that the doctor should conceal the truth and go on telling the patient he was going to get better until he was no longer sufficiently conscious to hear the hollow words. If dying patients could be avoided altogether, that was better still, because there was really nothing you could do for them after all.

Mrs Kelly, however, had a different view and thought that her husband should be told the truth, indeed wanted to be told the truth about his condition. She could not find the courage to tell him herself, so she asked me to come round to the house and 'break it to him gently'. I was terrified and not at all willing, but she insisted gently and eventually persuaded me. When I called at the house, she installed me comfortably in an armchair opposite her husband, gave us each a large glass of brandy and left us to get on with it. We started talking about football and the Grand National. Assisted by the brandy, we warmed to each other and gradually got on to the subject of why his recovery was not making much progress. I mumbled something about there being something in his lung that was making him lose weight and was not going to go away. He said he had guessed it was something like that and looked very thoughtful. I have no doubt that any vocationally trained general practitioner would nowadays have managed it much better and would not even have needed the brandy. But Pat and I got on very well in our own way.

I visited him once a week after that and despite his increasing fragility, he was always pleased to see me. His death, when it came, was quite quick and seems to have been peaceful. The next day, I sat with Mrs Kelly, talking about what a lovely man he had been, and drinking my glass of brandy. That was 17 years ago. Since then Mrs Kelly has had two knee replacements, a lot of arthritis in other joints and enough renal insufficiency to need a special diet. She seems to go into hospital about every six months for some procedure or other; Each time, when she comes home, she asks me to call to review her progress, renew her prescriptions — and to drink a glass of brandy. 'Just like old times, isn't it, Doctor?' she says, and we both remember Patrick.

My drinks are not all commemorative — those seem to be just the regular ones. There are other invitations which I accept only occasionally and with a proper show of reluctance. They might also become regular if I let them, but so far I have managed to resist. I have had cherry brandy with Mr and Mrs Miller for instance — now how did that come about? Mrs Miller has mysterious and terrible back pains, stabbing in quality, excruciating in intensity impossible to diagnose or relieve. Occasionally she comes to the surgery herself, but more often, she is represented by her husband, a small, stout, woebegone figure in an old fashioned double breasted suit and voluminous overcoat. 'The wife is in terrible pain again,' he says, 'Can you do anything? Can you help us?' I try to oblige with a prescription for yet another non-steroidal, or an X-ray or perhaps another referral to that helpful but battled rheumatologist. 'Thank you for being so kind,' says Mr Miller effusively, 'I don't know what we'd do without you.' He always says this, although I'm not always as kind as I should be, and I sometimes wish they would do without me.

Not long ago, Mrs Miller's pain became so bad that I had to be called (with many apologies) to the house. When I arrived, there was great delight at my appearance ('Thank you for being so kind') and a lively, almost festive atmosphere. Mrs Miller arose from her bed of pain and produced biscuits. Mr Miller went to the cocktail cabinet and produced cherry brandy. I sat and sipped and ate biscuits while the Millers asked about my children and where I had been for holidays. I felt like one of the family and they felt relieved of their pain — at least for the time being. I refused a second glass of cherry brandy, took my leave, and was shown to the door by Mr Miller who thanked me once again for being so kind and said he did not know what they would do without me. It seemed as though my drinking of the cherry brandy had been therapeutic; a kind of prescription in reverse in which the patient provides the medicine and feels better when the doctor has taken it.

At this point in my confessions, I may be asked whether I have taken leave of my professional senses. Is this really the way a doctor should behave when visiting a patient? Surely the consumption of spiritous liquors has no place in a medical consultation. Offers of such drinks should be regarded as having an ulterior motive, being intended to ingratiate and pave the way for further unnecessary home visits. In my defence, I would say, first of all, that I do not always know exactly what I am doing and that this may have a beneficial effect in keeping my mind open to receive new impressions. Secondly, I would say that, in general practice, the doctor/patient relationship is paramount, and anything which promotes, fosters or even celebrates it has got to be a good thing. Within reason, naturally.

For I have to admit that these relationships may contain an element of seduction or even collusion. I recall, for instance, old Mrs Rowlands, whom I was urged to visit by her daughter-in-law because, she claimed, 'she needs to be in a Home.' The old lady, she said, was in a disgusting state, could not look after herself and was liable to have a serious accident if she was left alone in that house any longer.

Mrs Rowlands turned out to be a jaunty old lady, admittedly dementing a little and rather

unsteady on her feet, but still retaining a keen appreciation of human relationships. 'It's very good of you to come,' she said, 'but I'm quite all right here. Take no notice of my daughter-in-law. She's an interfering cow. Now, will you have a little drink with me?' Ignoring my muttered excuses, she led me into a cool shady dining room in which all the soft furniture was protected by light green canvas covers. I had the impression that it had been preserved in this state since her husband's death and was now used only for entertaining doctors.

Mrs Rowlands tottered to an impressive veneered walnut sideboard and produced a bottle of sherry and two glasses, made evidently of plastic, and rather dusty. 'Sit down, doctor,' she said. I sat down on one of the six Regency style chairs which surrounded the highly polished and glass topped dining table. With a gnarled and shaking hand, my hostess poured sherry into the two plastic glasses. With some dismay I saw that mine had a crack down the side; the sticky liquid was oozing through it and spreading over the glass table top. Mrs Rowlands paid it no attention — I do not think she even noticed. She raised her own glass with a triumphant smile; I raised mine also and we silently toasted the defeat of the daughter-in-law and all others who might try to remove her from her house.

Now I must not give the impression that all the drinks I have with patients are alcoholic. Cups of tea are frequently offered and accepted, despite the well known fact that the time taken to boil the kettle and set out the best china may seriously over-extend the visiting schedule. Soft drinks and orange squash are more quickly dispensed and I find them very refreshing in warm weather. I can see some of my colleagues shaking their heads and raising their eyebrows at all this imbibing. What is the matter? Do they not get thirsty too? They just keep their own physical needs under better control, I suppose. Perhaps I have a need to be fed by my patients which they detect and respond to. I had better think about that when I come to sum up.

Meanwhile there are more confessions: I accept food as well as drink. Actually, I am not sure whether hot soup counts as a food or a drink. I only ever had it once, and that was on a very cold morning when Mrs Collins had it waiting for me. Mrs Collins is 91 and she resembles in both voice and appearance, one of those wonderful old ladies in the Ealing film 'The Ladykillers' starring Alec Guinness. You may remember that the Ladykillers' 'victim', Mrs Wilberforce, invites four of her equally venerable friends to a tea party in which the luckless gangsters find themselves politely compelled to participate. They are utterly defeated by their deeply ingrained (and ultimately fatal) respect for genteel old ladies. I understand their plight completely and would behave in just the same way myself if I were a gangster. So when Mrs Collins opens the door of her terrace cottage and says in her 1950's Ealing Studios genteel voice, 'Come in, doctor. I've been expecting you. It's a very cold day and I've made you some soup. Now I want you to sit down and have it straight away before it gets cold.' — I comply instantly.

As I spoon down the delicious, warming fluid, I find myself wondering how she manages, with a weak heart, 91-year-old limbs and a home help only once a week, to keep this house looking spotless and to feed both of us? While I'm eating, she tells me that Mr O'Neill from across the road, who 'keeps an eye on her', will be coming over shortly for his own prescriptions. 'Couldn't he come and see me in the surgery?' I ask feebly. 'He won't be very long,' says Mrs Collins, firmly. 'Now would you like some bread with that soup? Then I want to show you my leg. It's been very bad again . . .'

I visit Mrs Collins once a month. I listen to her chest, examine her leg, and write prescriptions for both her and Mr O'Reilly. I eat cake, chocolate, occasionally a sandwich, sometimes an apply or a banana. Then I go to Mrs Roberts who is 95 and has had both legs amputated because of peripheral vascular disease. Since then, she has entered calmer waters, and seems to be largely free of pain, though very much truncated and restricted. She lives with her son who is single, gay, and in his 60s. Mrs Roberts is the widow of a Conservative Councillor and she naturally attributes the lack of home helps, bath nurses and chiropodists to the mismanagement of the local Labour Council. I would prefer to place the responsibility back with Mrs Thatcher, where I think it belongs. But you can not say things like that to a Conservative ex-Lady Mayoress with no legs who is just about to say, 'Will you have a chocolate? I've got your favourite Quality Street again.' That is probably unfair of me, and besides, they are nice chocolates.

It is time to gather my thoughts and attempt to draw some conclusions about the phenomenon of drinking (and eating) with patients. Clearly, both doctor and patient gain some satisfaction from the ceremony, so I shall consider it from the point of view of both parties. Why do some patients offer me this hospitality and then turn it into a regular institution? I think because it has the effect of making me stay a little longer, relax a bit more and perhaps listen to what they have to say a little more attentively. I am freed, temporarily, from the urgent need to complete the visit and move on to the next; my pen is no longer poised over the prescription pad and my fingers are curled round the stem of a glass or busy unwrapping a chocolate. I become more human, less formal, more like one of the family. Some patients (like old Mrs Collins) probably feel they need to look after me as if I was their child or husband. Others may be unconsciously trying to seduce me with a love potion.

According to an analyst friend (who warned me against accepting any present, edible or otherwise), the patient may be trying, in fantasy, to enter my body along with the drink and to occupy it with part of her personality,

a process known as projective identification. If this is indeed the case, I do not find the occupation disturbing or the guest unwelcome. Some patients undoubtedly use me as a link with a lost spouse, or even get me to play the role of the spouse by sitting in his chair, having a drink and talking about anything or nothing, just as he must have done. This seems to me an entirely legitimate and valuable use of my time.

Now I must turn to the doctor's gains. Do I get some personal gratification from all these offerings? Of course I do. I probably want to be cherished and nurtured by old ladies who give me sweeties as if I were a little boy, and eccentric aunts who give me a secret glass of sherry when I am not quite old enough. It may not be totally professional but it does no harm that I can see, it may do some good, and it certainly makes routine visiting a lot more fun. General practice draws its strength from sustained doctor/patient relationships, and sometimes the doctor requires a little physical sustenance. The 'reverse prescription' pleases the patient and may be just what the doctor needs to revive his spirits and help him to function more effectively and humanely.

That reminds me of an encounter with Mrs Bernstein, a rather demanding lady, with whom I frequently had fights. On this particular occasion, I had arrived tired and in a bad mood. There had been too many visits already that day and hers seemed to me to be not strictly necessary. She had a bad cough after flu and wanted to know why it had not cleared up yet. What did she expect if she went on smoking 20 a day? We had a slightly acrimonious exchange about this point, I examined her hurriedly and then sat down to write a prescription.

'While you're here,' she said, 'I'd like my diabetic tablets renewed and have you got something stronger for sleeping?' I scowled and told her there were not any stronger ones, and anyway they were bad for her, she should really try to wean herself off the existing ones. Observing the ragged state of the doctor/patient relationship, Mrs Bernstein suddenly said, 'Would you like a cup of tea?' 'No thanks,' I said, irritably. Cup of tea, indeed. Trying to get round me with a cup of tea. 'How about a smoked salmon bagel?' enquired Mrs Bernstein, with brilliant psychology. 'Now you're talking!' I was amazed to hear myself say — and was soon munching away contentedly, my good humour completely restored . . .

Obituary

Dr TOM MAIN, MD Durh, MB, BS, FRCPsych, FANZCP, DPM Dub.
25.2.1911 - 29.5.1990

On a cold dark wintry night I ventured to ask Tom Main's advice after his lecture to the psychotherapy course at the Tavistock Clinic. I had been a member of Michael Balint's seminars for general practitioners and for Family Planning Association doctors for some years and was at a crossroads in my career. 'What would you really like to do?' Tom asked, and I replied that I wanted to be able to use the skills I had learned in the seminars in a more permanent setting then the hard-pressed and uncertain ones that prevailed in the F.P.A. clinics in which I then worked. Tom looked away for a moment and then said 'I have an idea'. Thus it was that I went to start the marital clinic at the Cassel Hospital, where Tom was Medical Director, and worked under him for seventeen lively years.

This autobiographical note shows some of Tom's most lovable characteristics, his empathy with anyone in a genuine dilemma, his quick decision-making and action, and his disregard for convention — I had no psychiatric qualification.

It is not easy to work with Tom, indeed he did not intend that it should be; but it was always stimulating, even when his dreaded red pencil disfigured one's hard-written papers.

In the years of working with and under Tom, I came to value most his instances on recognising everything, whether good, bad or just boring, as worthy of interest and study as to what lay behind it. Thus incidents as varied as the arrival of a cat in the hospital, the reaction of a woman to the offer of a vaginal examination, or the reaction of the College of Psychiatrists to reports of Soviet abuse of psychiatry could all be used as clinical material to further understanding.

Tom Main came from a working class North Country family and made his way by scholarships. His work with the Army in the second world war was as a psychiatrist developed his interest in social systems, and after the war he started his training analysis with Michael Balint. He became Medical Director of the Cassel Hospital in Richmond, where he developed the 'Therapeutic Community' as a setting for individual and group psychotherapy, later specializing in the inpatient treatment of whole families. Doctors and nurses at the Cassel were treated in this innovative work, and many went abroad to start units on similar lines.

Tom was interested in Michael Balint's seminars for general practitioners and F.P.A. doctors, acting as co-leader with Michael, and taking over the F.P.A. seminars when Michael retired from them. Michael had already sent some members of these seminars to lead groups for those F.P.A. doctors who were clamouring for help in the provinces. Tom fostered this development and organised a scheme for a nationwide system of training and accreditation of doctors working with psychosexual problems. This led to the establishment of the Institute of Psychosexual Medicine, of which he remained President until his death, and which continues to expand and develop. Several papers and books have been published by members of the Institute.

Tom himself delivered many important papers, but resisted publication because of his conviction that only by supervised experience rather than by reading could his ideas be transmitted to trainees. However, his psychoanalyst daughter, Dr Jennifer Johns, at last persuaded him to publish some of his collected papers in *The Ailment and Other Psychoanalytical Essays.*[1] This book, which was published a few months before Tom's death, would be rewarding reading for all members of the Balint Society.

Tom gave the Michael Balint Memorial Lecture in 1978 on the subject of the defence mechanisms used by doctors against the many anxieties of medical practice.[2] The Balint Society can be proud that Tom Main was one of its Honorary Members.

JEAN PASMORE

1. *The Ailment and Other Psychoanalytic Essays,* Tom Main. Ed. J Jones. (Pp. 256. ISBN 1-85343-105-2) London, Free Association Books. 1989.
2. Main, T. Some Medical Defences against Involvement with Patients, Michael Balint Memorial Lecture, 1978. *Journ. Balint Soc.*, 1978, 7,3-11.

From the 21st Annual General Meeting held on 21st June, 1990

Presidential Address given by Dr Erica Jones

It has been an interesting and rewarding year. An account of the meetings is included in our Honorary Secretary's report. There are just a few points I would like to highlight.

Dr David Morris, consultant paediatrician and long time very active member of the Balint Society, died last summer at the age of 74 years. I attended, on your behalf, the memorial celebration of his life at the Royal College of Physicians. It was, like David, an unusual and remarkable occasion of reading and music, which will stay with me a long time.

The Seventh International Balint Conference was held in the Karolinska Institute in Stockholm last summer. The British Balint Society was very well represented, both in papers presented, as well as in groups led. Stockholm is a glorious city in the sunshine, and the organisation was unusually good. There were also many papers which were both interesting and useful, not such a common occurrence at international conferences.

The presence of three medical students at the Oxford Balint Weekend this session, added a freshness and a new slant to our work. Two of them had already won international essay competitions, and the third was about to do so. I hope by next year that we may have devised a suggested form of student membership of our Society for you to debate, because it has to be with medical students and trainees that our future lies.

This year, we are twenty-one years old. Some of us started attending Balint-groups twenty years before we founded our Society, as Philip reminded us in his Anniversary Lecture.

In April, I was invited to Bratislava, in Czechoslovakia, where they are in the process of starting a Balint Society. It was a very exciting time to be in Czechoslovakia, rather like walking into the bubbles in Champagne. I had the terrifying experience of running a 'fish-bowl' group with a translator, with only thirty minutes notice. And then having to repeat it all again with another group, because not everybody could get into the room at one time. I was greatly assisted however, by the amount of body language, something that is singularly absent in a British group.

There are many difficulties in reorganising their health service as they feel they have wasted forty years. Many young doctors and medical students would like to come to the U.K. They have virtually no hard currency, so if anyone feels able to offer hospitality to any of these young doctors or students, perhaps you would let me know.

In spite of the efforts of Mr Clarke, I think we have something to offer in the generalness of general practice in this country, with its 'cradle to the grave' approach. In the forties, Albert Einstein said, 'We shall require a substantially new manner of thinking if mankind is to survive.' Perhaps our way of working in Balint-groups may be one way in which we can begin to acquire this.

I would like to announce two new honorary members:

Michael Courtenay, who was our President in 1972-74 and retired two years ago. He is now retiring from the Council, having done an immense amount of work for the Society.

We would also like Philip to be an honorary member. Sadly, he will be forced to retire from the National Health Service next April. We hope that he will continue to edit our Journal, as he has done since 1974. Philip was our first President, and was instrumental in getting the Balint Society or, as it was then, The Society of Balint Groups, off the ground in 1969, happily before Michael Balint's death. Thank you.

I am very pleased to announce that for the third year running, a British medical student has won the international prize essay competition arranged by the Ascona Balint Centre. The first was Carol Tallon from Leicester, in 1988. Last year it was Mary Keany, also from Leicester. With us tonight, is Jonathan Goldin from Manchester, who is a very worthy successor. I had great pleasure in reading his essay, and I am delighted that it received the award it deserved.

The time has come for me to hand over my Presidency to John Salinsky. I have enjoyed being your President for the past three years, at least mostly. I think I have been exceptionally fortunate in the help and support from a truly superb Council, without whom there would, no doubt, have been quite another tale to tell. I would like to take this opportunity to thank the Council most sincerely for everything during the last three years.

John is the beginning of a new generation, having the distinction of being the first President of the Society who was not a member of Michael Balint's earlier groups. Perhaps this is an important turning point which might be regarded as appropriate, as after all this is our twenty first year, which traditionally symbolises coming of age and receiving the key to the door to new opportunities.

ERICA JONES

From the 21st Annual General Meeting held on 21st June, 1990

Secretary's Report

The Society's 21st year began with the Oxford Balint Weekend from September 15-17th, 1989, attended by 48 delegates, including for the first time 3 medical students, 2 of whom were recipients of the Cyril Gill Bursary. Their presence was welcomed, as was that of Enid Balint who came to lead the demonstration group on Friday evening with great success.

The first lecture meeting was on October 31st when Dr Harold Maxwell spoke about the Borderline Personality and its presentation. As last year, this October meeting was very poorly attended. Philip Hopkins' 20th Anniversary Address on the 21st November attracted an audience of 26. He spoke on the origins of the Society and our opposition to a consumerist view of general practice.

On February 6th, 1990, psychoanalyst and Society member Bernard Barnett spoke of his experiences with patients who had had relatives die by suicide. One theme was of 'survivor guilt' akin to that felt by concentration camp survivors. One very powerful case history was of a patient, 'Lenny', whose brother had died in his 'teens.

Paul Sackin on March 6th talked about his visits some years ago to many general practitioner trainee-release courses. He felt that Balint-groups were not *ideal* in this situation, but that their exploratory mode had much to offer and that they had been very important in training group-leaders.

On April 24th, a discussion was led by Michael Courtenay, who has now retired from general practice, on the New Contract. Under his guidance it was far more productive and thoughtful than many similar meetings under other auspices. Marie Campkin pointed out that we are now enfringing our terms of service almost all the time as we are so beset with regulations. Erica Jones wondered whether we could gain therapeutic benefit from the new short check-up. Many participants expressed their feeling of an increased pressure of work.

In May we had a second weekend meeting in Ripon which was again a success, with 21 participants, including 7 new to Balint work. It will be repeated next year. It was learned that one of the delegates, Dr Philip Wilson, had organised funding for a new Balint-group to start in Glasgow, led by an analyst.

The Balint-group Leaders' Workshop continues to meet at the Royal College of General Practitioners, convened by Peter Graham.

The Society gained 7 new members following the weekend meetings which prove to be the main source of recruitment. Membership is stable as we continue to try to bring subscriptions up to date.

It is a pleasure to express our gratitude to Mr Arnold Wolff, of Bennett Nash, Wolff and Company, for continuing to act as our Honorary Accountant.

It was with great regret that the Society recently learned of the death of Dr Tom Main at the end of May, an Honorary Member of the Society, President of the Institute of Psychosexual Medicine, and long associated with Michael Balint.

I look forward to the Oxford Weekend from September 7th to 9th. It will hopefully get 2 days of PGEA accreditation partly under Disease Management and partly under Service Management.

Next year's lecture series will also be PGEA approved which we hope will attract a wider audience.

DAVID WATT

From the 22nd Annual General Meeting held on 18th June, 1991

Presidential Address given by Dr John Salinsky

The Balint Society is now in its 22nd year and I am the Society's 10th president. I am the first president who was not one of the foundation members and also the first president who never met Michael Balint. I was, however, a member of two groups led by Enid Balint so that I can claim some connection with the funding parents.

My first group was led by Michael Courtenay and Mary Hare. This was one of the first groups, perhaps the very first, to have a general practitioner as a leader. We started meeting in 1974 and, two years later, the whole group made an appearance at the International Balint Congress in Paris, so that I found myself Balinting for Britain. This was a somewhat unnerving experience as we were in a fishbowl surrounded by a highly critical and vociferous audience. Happily, my poor understanding of French spared me a lot of the trauma.

When we returned from this adventure we were told that, having been in a group for two years and having represented our country with courage and dignity, we were now entitled to apply for membership of the Balint Society. Since then, it has become somewhat easier to join the Society. Thanks to the reforming legislation of my distinguished predecessor, Jack Norell, only one year of membership of a group is required. Unless, of course, you are a psychoanalyst, in which case you can never hope to be more than an associate member, according to our constitution. Who knows, perhaps one day, even psychoanalysts will be admitted to full membership: it would certainly be nice to see a few more of them at our meetings.

It may be easier for a general practitioner to join the Balint Society, but unhappily it has not become any easier to find a Balint-group to join. Traditional Balint-groups which meet every week and continue for 4 or 5 remain quite rare for a number of reasons. These include a shortage of leaders and, regrettably, a reluctance on the part of many of our colleagues to make the necessary long term commitment. Unfortunately, the Society has been unable to do much to improve this situation. However, I think we can claim some credit for the creation of a new kind of Balint experience: the Balint Weekend. I'm not sure whether we invented the Weekend or whether we stole the idea from the Germans. But they were shown how to do it by Max Clyne, another of my distinguished predecessors as president, so I think we can claim it as a British innovation in any case.

The first British Balint Weekend took place in Reading in 1979. It moved to Oxford the following year and has been firmly established there ever since. Every September, between 50 and 100 people are able to come together for a weekend in the delightful surroundings of an Oxford college and take part in an intensive Balint-group experience. And it really is intensive as well as enjoyable. It's quite remarkable how living together in the college for less than 48 hours can produce a degree of openness and a willingness to share feelings which would take months to develop in a group which meets only once a week.

I think that we owe a lot to two people for the development and continuing success of these weekends. One is the late Cyril Gill, a much loved president, still sadly missed. He started the whole thing off and presided over the first three weekends, setting the style and the tone which have continued ever since. The second person we must thank is Peter Graham who, as secretary of the Society, put in an immense amount of work in organising the weekends and ensuring that everything ran smoothly. Thanks to Peter, we always had beds to sleep in, plenty of good food and wine, and a friendly welcome to Oxford. Peter is retiring from the council this year and I am glad to have this opportunity, on your behalf, of thanking him for his services to the Society over the years.

The Oxford Weekend will happen again this September, in a new college (Lincoln) but otherwise unchanged. For the last three years, we have also had a second weekend, taking place in May, in Ripon, Yorkshire. This is on a smaller scale but is just as intensive and just as enjoyable. The food and wine are probably even better.

The people who come to these weekends include hardened veterans like ourselves but also some absolute beginners. These are doctors who have perhaps read the Balint books, but would otherwise never have had the opportunity to take part in an authentic Balint-group. Some of them now come every year, and although they may have no regular group to join at home, they are able as one of them put it 'to have my annual fix of Balint.' These doctors are able to return to their practices feeling refreshed and with a renewed willingness to try to understand their patients better. In the last few years we have also invited some medical students to Oxford and have been very impressed by their enthusiasm and insights. Here, we hope, are some of the Balint Society members of the future.

Our latest idea is to try to start a group which will meet for several weekends in the year, while retaining the same membership and the same leaders. This is an exciting development and I hope to be able to tell you more about it next year. Meanwhile, I hope to see many of you at Oxford and Ripon. Bring your friends! Give them a taste of Balint: they may find they want to come back for more. Start a Balint Weekend of your own somewhere — anywhere! As our colleagues in the French Balint Society might put it: 'Vive le Weekend!'

From the 22nd Annual General Meeting held on 18th June, 1991

Secretary's Report

The year began with the Oxford Balint Weekend, from 7th - 9th September, 1990, which was attended by 47 delegates and 3 accompanying persons. In addition, 6 medical students, subsidised by the Cyril Gill Memorial Fund also attended, so that each of the groups welcomed one as a member.

The first of the meetings at the Royal College of General Practitioners was on October 16th, when Dr Bryan Lask, consultant psychiatrist at the Great Ormond Street Hospital for Sick Children, spoke about the psychosoma in children; how much it reflects the family and marital conflicts.

On November 20th, Dr. Anthony Ryle, consultant psychotherapist at Guy's and St Thomas' Hospitals, talked about his use of cognitive analtyic therapy. Using limited, structured therapy, he aims to provide *some* psychotherapy for the large number of people in the district he feels responsible for.

We met again on 12th February 1991, when Dr Sotiris Zalidis, departing from the title of his paper, *Short psychotherapy in general practice,* described some *Psychosomatic encounters and the scope for interpretation in general practice.* (see page 16) He gave a fascinating, detailed presentation of a case-history stretching over several years, where psychological help had been given in the course of appointments in normal general practice, resulting in a lively and interesting discussion.

Dr Harold Stewart, recently retired consultant psychiatrist at the Tavistock Clinic, gave the Ninth Michael Balint Memorial Lecture, centring his attention on the importance of *Regression in psychoanalytical pyschotherapy,* one of Michael Balint's areas of work. (see page 5)

The meeting on April 23rd, which was held on Lettson House, the beautiful home of the Medical Society of London, took the form of a demonstration Balint-group, led by Michael Courtenay, and was followed by the Annual Dinner. The meeting was attended by thirty people, together with a Balint-group of 6 visiting general practitioners from Sweden, with their group-leader, Dr Harry Jablonski. The group-discussion progressed very well, with the novelty of the President of the Society presenting a case for discussion by the experienced members in the group.

Nineteen delgates attended the Ripon Balint Weekend from 18th - 20th May, at the College of Ripon and York St John. Two groups did beneficial work. In the plenary session, several delegates expressed enthusiastic interest in the suggestion that a stable Balint-group might be arranged to meet four times a year, with Michael Courtenay as the group-leader. Council in in the process of negotiating this, and will announce the result in due course.

The next Oxford Balint Weekend will take place from September 20th - 22nd, when, because Pembroke College could not accommodate us this year, we will meet at Lincoln College, another even more venerable central Oxford College. PGEA has been applied for. (see page 44)

The committee of the International Balint Federation will also be meeting during this weekend, so we look forward to welcoming a larger number of delegates from overseas.

The Balint-leaders' workshop continues to meet regularly at the Royal College of General Practitioners, with Dr Peter Graham acting as Convenor.

It only remains for me to place on record the Society's gratitude to Mr Arnold Woolf, of Bennett Nash, Woolf and Co. for continuing to act as our Honorary Accountant.

DAVID WATT

Is Balint safe in our hands?

Dr James Carne
General Practitioner, London

When our secretary honoured me with the invitation to address this Annual General Meeting, I felt excited at the prospect of being able to talk to a captive audience, in a didactic fashion, for almost as long as a I liked, on whatever subject I chose and would most probably be praised at the end of it for my efforts.

Not very praiseworthy emotions, but after the initial euphoria, I was left with the task of deciding on what subject to talk about. When I gave the presidential address some years ago, I spoke mostly of some of the funnier incidents that had occurred to me over the years in practice. Somehow life in Stamford Hill is not so funny anymore, or perhaps it is because I do not remember the incidents so well. I felt that a rather more serious topic was called for, and in view of the political issues of the day, it was not difficult to think of a title which would be eye catching and, I hope, suitable. 'Is Balint safe in our hands?' is a good start, but my next problem was that like Pirandell's Six Characters in Search of an Author, I felt I had a title in search of a lecture.

Research done at St Elsewhere (attached to the University of Apocrapha) some years ago, showed that in any lecture, only 10% of the audience actually listen to the contents, while 15% are considering what contribution they can make at question time, and 75% are lost in their own sexual fantasies — so at least I remain confident, and am comforted by the thought that whatever the content, three quarters of you are going to enjoy my contribution tonight.

Over the next few days, two incidents occurred that made me think hard about this subject. The first was a letter in the post folder addressed to my partner and from a neurologist working at one of the most prestigious hospitals dealing with neurological disease. It concerns Joan, a 41-year old divorcee with a two year history of painful torticollis and dystonia. It had started after a period of severe emotional stress in her life. Treatments with Benzhexol, Baclofen, Amitriptyline, Lofepramine, Propranolol, Fluaxol and Fluxetine had all been unsuccessful; she had also had similar failures from treatment by osteopaths, chiropractors, the Alexander technique and then mentioned last, psychotherapy. Up to the date of the referral, the only benefit she had obtained, was from a quarter-bottle of Vodka daily. *Nil desperendum!* The myth of the 'more powerful doctor' survives, and the neurologist continues his letter, and I quote verbatim, 'It is generally accepted now that torticollis (dystonia) is an organic, neurological condition and *not psychological in origin* (my italics). She has clearly failed drug therapy including Benzhexol which is most effective. We have found botulinum toxin injections the most effective therapy for this condition . . .' He goes on to outline the methods by which this is given, including all its side effects some of which are quite horrifying.

The second incident occurred the same day. For the past three years our practice has been part of the local obstetric community care scheme. Based on the Glasgow experience, certain practices run satellite hospital ante-natal clinics within the community, the laudable aims being that mothers have continuity of care, do not have to travel to hospital when they have enormous waits on arrival, and the hospital and community midwives and doctor meet together at the weekly clinics. When the scheme started, I thought that my role as the general practitioner would be very little different from what it had always been when we had participated in shared-care. But I was mistaken because now, I have discovered the 'buck ends here.' Under shared-care, my responsibility was only to check the well-being of the mother and child. Blood tests, repeat tests, scans and all the highly technical pursuits of hospital ante-natal care were carried out at the hospital, but now we have to carry out these tests ourselves, or at least make sure they are done. This has made a big difference to the ante-natal care afforded the patient. As a Balint-orientated doctor, I feel strongly that much of the ante-natal care given by the general practitioner should concentrate on the emotional aspects of the pregnancy. Over the years, I had left the responsibility of the technical side to the hospital and concentrated my efforts on ascertaining that mother and baby were well, and then encouraging the mother to discuss her anxieties, expectations and feelings about the pregnancy. Now, I am so busy with the technical side, there is little time left for this other, very important aspect of care, and I think the patient has become the loser.

These are two remembered examples in a single day of how Balint is in danger of being forgotten, and might concentrate our minds on the question posed by the title of this talk.

So what I would really like to talk about are my theories and experiences of Balint; the effect they have had on my own practice, and how a Balint-orientated doctor copes with the new contract and National Health Service regulations, and finally to say something of what the future holds.

My first knowledge of Balint was when I came out of the Air Force and was doing a year's traineeship in Paddington. My brother-in-law, Henry Stoll, who by then was a firmly established general practitioner in Hampstead, told me he was attending weekly seminars at the Tavistock Clinic, then housed in Beaumont Street, under the leadership of Michael Balint. During my time as a student and then in the Air Force, I had become aware of my own curiosity

about people and how they reacted to their environment, and had automatically drifted towards patient and family care, rather then the rather more blinkered approach needed to study the minutae of disease. One might say I was 'illness-orientated', illness being the feeling that brings the patient to the doctor, rather than 'disease-orientated', disease, in this sense, being what the patient leaves the doctor with. Later, under the Balints' influence, this was expanded into an understanding of the difference between patient-centred and disease-centred. Published proceedings of the first International Balint Conference were, in fact, entitled *Patient-Centred Medicine*.[12] It seemed to me that this type of seminar was what I was looking for to help me understand the decisions and actions I had, until then, been taking at a purely instinctive level.

I was fortunate to be allowed to attend the seminar on a single occasion as a visitor — a privilege which Michael Balint later stopped, when he formulated the 100 miles/3-session rule, which was the minimum requirement for any visitor to attend. For me, that one visit was enough to make me realise that I was in the correct branch of medicine, and there were many pastures within general practice that I could explore and hopefully cultivate.

I applied for, and was accepted into a group under the leadership of Pierre Tourquet, who was also a psychoanalyst at the Tavistock Clinic, and who had enthusiastically embraced the ideas of the Balints. His death, some years later, in a car accident in France was a tragic loss.

It was Pierre Tourquet who therefore, had the greatest influence on me in those early years. The fantasy that most of us had, on joining a group, that we would after a few sessions, have a full understanding of all the psychological problems presented to us, was quickly dispelled by his actions in never answering a question, which in the early days we had plenty, but reflecting the question back to us in the form of a mini-research programme.

'How do I treat Mrs Jones, whose back-ache appears to be due to her emotional problems?' would be the sort of question we asked.

'Why not go back to her, try and find out more about her problems and then report back to the group,' would be the response.

So we would learn about our patient, her interactions with society, and most of all, our feelings for each other as doctor and patient. Our eyes were being opened to all the blind alleys we had been led up in medical school. 'All patients are the same to me' is a cry still heard today by many doctors, but they clearly are not, when you analyse your feelings about them — and this has influenced me in my own teaching of undergraduate and postgraduate students of general practice to this very day. As part-time senior lecturer in general practice at St Bartholomew's Hospital, I see groups of students when they first return from their attachment to a general practice. I learn a lot about their own feelings, but I learn even more about the doctors to whom they are attached, and more than anything, I note how some of them — a minority I am pleased to say — still retain these rigid, defensive attitudes towards their patients.

Very recently, a young female student was recounting to the group how she had noticed the difference in the treatment patients received, depending on whether the doctor liked them or not. I managed, I think, to help the group see that insight into this 'weakness' was the first thing that had to be acquired, in order to avoid the pitfalls and behave in a more professional manner. The students seemed to understand this, but my colleague, contemporary to me in age, did not think much of the idea at all. His view was that with experience one can teach oneself to treat everyone equally or alternatively, if one could not get on with a patient, one should ask them to leave the list.

The natural development of seminar training and case research, was to arrange to see the patient at a special time — usually after surgery — for a 'long interview.' This was understood to be one hour in length, though I doubt if many of us were able to terminate the consultation in exactly that time, in the way that analysts appear to be able to do. This was the time we willingly gave in order to learn what was happening in the doctor/patient relationship, and come to a better understanding of our own paients, which was, of course the lynch pin of the Balint-approach.

Over a minimum period of two years, we came to a better understanding and underwent that limited, but definite, personality change that was part of the package. I have no doubt that this helped enormously in our understanding and improved our medical practice no end. But there was a price to be paid. The extra time spent with patients, often involving the formation of a close bond with them, meant less time at home, and sometimes, less emotional energy for one's own wife, who in turn often felt excluded. Since Michael and Enid Balint were emphatic in their views — rightly, in my opinion — that the private life of the doctor was not part of the training process, it is difficult to know how serious this trauma was. What I do know is that there were many *cris du couer* from the wives, for a group to be formed for themselves and a few of my contempories had broken marriages at the time.

In only one case that I remember in all the years I attended one group or another, was I given direct advice about a patient. As this happened 30 years ago, and she is still my patient, I think I can fairly say that time has shown that this was probably a mistake.

Anita was 36 at the time and had just returned from living in the United States of America, following the break-up of her marriage and subsequent divorce. She was an attractive, well made-up lady, who made me feel rather

uncomfortable as I was only a few years younger, and she made it clear that she preferred the safety of my older partner, who had been her doctor since her childhood. When he died a couple of years later, I took over his role and quite dramatically Anita (and, I might say, quite a few other patients) put me in the role of a father-figure and accorded me the respect that went with this.

Meanwhile, Anita lived with her mother and continued to do so until she died last year at the age of 94.

I presented Anita at a group-meeting, and as I remember, she was anxious, loquacious and mistrustful, especially of women, and claimed that both her mother and other dominant women in her life asserted too much authority and influence over her. Before discussion could really start, the leader said that she was really unsuitable for general practice psychotherapy as the diagnosis was clearly paranoia associated with conflicts about her lesbianism. As a result, Anita was referred to a group for therapy, whose leader still, at the age of 85, sees his old patients in a group and Anita travels to the other side of London when she feels the need. She complains bitterly that the group only want to discuss their own problems and never listen to hers. In addition she was put on Stelazine and Valium, together with Butobarbitone at night. The dosage has reduced over the years but she remains on small doses of all three drugs.

She has maintained her well cared for appearance, and perhaps, more surprisingly continues to work full-time as a secretary at the age of 67. She still easily attracts men, and although by no means shy or inhibited in her sexual play, has not allowed penetration at any time. There has never been a suggestion of an overt lesbian relationship, but over the years she has had to change her job from time to time when she has found the tensions in the office too difficult to bear. These tensions have usually started, according to her, by an older woman in the office exerting influence on her. She has never overtly broken down, but from time to time I have had to provide certificates of unfitness for work to allow her time to recover, or find a new job.

My role over the years has been to support her when the tensions build up, and on many occasions she has turned to me because she has felt it to be too serious for the psychiatrist. She has rarely had physical illness apart from occasional colds and constipation.

Why then, do I feel that the original intervention of the group-leader was wrong? I have no doubt his diagnosis was correct, but it had the effect of stereotyping her. I have always felt that I could do no more than a holding operation, offering support when needed. I have not had the confidence to explore her as fully as I might have — or is this merely an aspect of her not allowing any men to penetrate her? I feel that I might have offered her more over the years and had I done so, she might not now be the very unhappy — one might say depressed — lady that she has become since the death of her mother last year. I still feel I can only offer superficial support, and recognising this recently, I suggested she might like to see the counsellor attached to our practice. She was quite keen on the idea, but in the event I found myself painting such a bleak picture of her, that he turned her down as being unsuitable. On reflection, I feel sure that I had talked him out of seeing her.

I think without the label of paranoia, I might have been fool enough to rush in where other angels have feared to tread, and might possibly have helped her more.

Since the early days of Balint-seminars, I have seen the movement grow and watched with admiration as the influence of Balint-orientated doctors have changed general practice for the better. First, there were the books which were written as a result of the seminar-work. The first and best known being, of course, *The Doctor, his Patient and the Illness*,[2] first published in 1957. This is now, of course, the bible of general practice. Other publications provided an important contribution to this advance in thinking. Aaron Lask's *Asthma,*[16] Max Clyne's *Night Calls*,[6] and *Absent* (the study of school refusal),[7] Michael Courteney's *Sexual Disorder in Marriage*[8] and Leonard Friedman's *Virgin Wives*,[10] were all written within an astonishing ten years or so during what must be considered the hey-day of Balintism. In the '70s and '80s, a new generation of books was published and these were mainly group works written as individual contributions under a similar theme, and as a result of research done within the groups. *Six Minutes for the Patient,*[1] *Repeat Precriptions,*[5] *While I'm Here, Doctor*[9] and other titles hopefully, soon to be completed, *Surprises within the Consultation,* although I do not believe the title has been settled yet.

In 1972 a very definitive college publication was introduced to the profession, *The Future General Practitioner*.[14] The authors of this work included John Horder, Marshal Marinker, Paul Freeling, Conrad Harris, Patrick Byrne, and Donald Irvine, at least half of whom to my knowledge had been staunch supporters of Michael Balint and had, mostly, worked with him. It is not surprising that with the standard of work being produced, the influence of Balint permeated to the depths of the profession. If any one would have asked the question at that time is Balint safe in our hands?, there would have been a resounding 'yes.' Has this momentum been sustained? Obviously there must be some doubts in my mind, otherwise this lecture would have no point. What, if anything, has gone wrong? Or possibly, how have attitudes of the profession changed, so that some doubt has to be recognised?

I think that many things have occurred over the past decade which have changed the practice of medicine. These changes began by being self-inflicted, and climaxed over the past

two years into being imposed upon us by a government who felt frustrated at their failure to show improvements in a service to which they had committed themselves as loyal advocates, and who subsequently launched a public relations exercise on the profession, based on a very suspect market research, in which a highly selective group of consumers and providers were asked their views, and an even more selective set of criteria were chosen. I believe, strongly, if not passionately, that had a group of Balint-trained doctors been asked, the contract would have looked very different. Why, therefore, were we left out? I think the answer lies in the sad fact that we remain a devoted but reducing number of practitioners with influence in the right places. Balint has remained safe in our hands, but perhaps being ignored in the hands of others.

Some years after the surge of Balintism, another movement emerged, and over the years has gained momentum, and at the present time appears to have a much greater influence over medical practice. Paradoxically, it was the climate created by Balint in which self-analysis and motives were encouraged to be questioned, that allowed this movement to grow. I refer of course to so called alternative medicine. Many of the ideas that originated within Balint-seminars were eagerly taken up by the protagonist of this discipline, and in my view it was these ideas that attracted it to the populace. I remember working in a group when I first head the word 'holistic' used. Whether the word owes its derivation to that period, or was rediscovered, I'm not sure, but I do know that it was used to describe a means of examining a patient in a holistic way. By this was meant how a human being related to his environment and the effect this had on his symptoms; how the interplay of the doctor/patient relationship and its subsequent understanding, would help in the relief of our patient's discomfort. How one should differentiate between the so called traditional diagnosis and the overall diagnosis, expressed as a statement descriptive of the patients condition.

I stand to be corrected, but it seems to me that the term is now used in the sense of 'all types of treatment should be considered in an individual case.' I do not argue against this sentiment, but it has allowed a lot of mumbo jumbo to become popular and commercially successful, without any adequate research first being applied. Of course, this idea appeals to many people, and especially to vulnerable patients who are looking for magic and an easy way out of their misery. It is not surprising that they have turned to this easy option, rather than the harsh discipline imposed on them by a true 'Balint' approach. Perhaps the same can be said of the doctors who can attend a weekend course (PGEA approved!), learn the techniques and then offer them to their patients at a series of health clinics, paid for by a grateful government pandering to the needs of their constituents.

Following a serious illness or operation, a patient usually asks, in one way or another, one of two basic questions. 'What are you doing to make me better?' or 'What can I do to get better?' We all know which one will recover soonest, and I have sometimes had to spend quite a lot of time and even skill to convert the former way of thinking to the latter. I am not too surprised when many of my patients seek the easy option, but are we right as a profession, to encourage this state of affairs to continue? Should we not demand a much higher level of training and accreditation from our alternative (or as they now prefer to be called, complementary) colleagues, before we associate freely with them. No doubt the old regulations of the General Medical Council, in which a doctor could be struck off for referring a patient to a non-medically qualified practitioner, went too far, but have we allowed the pendulum to swing too far in the other direction? So far, in fact that a patient can refer themselves to a non-medical practitioner and then seek our agreement, usually in retrospect, so that they can claim back their fees from the insurance company.

Increasingly, I become more angry, when I hear on the radio, watch on television, or read in the newspapers or magazines, that general practitioners have very little to offer, and if you have an identifiable disease you should demand to see a specialist and, if you have a set of symptoms for which no specialist can be bothered, use alternative methods. Michael Van Stratten, an osteopath, has become the new guru on health matters. I have listened very carefully, and I have very often heard a media-doctor advice a caller to seek the help of an alternative practitioner and to extoll their virtues in an effort to show that they are eclectic in their ideas, but I have seldom heard an alternative practitioner advice a caller to seek the advice of his general practitioner, (other than to ask for a letter for a hospital specialist). And yet, I find that patients I see outside my National Health Service practice, very often need desperately to seek the advice of an understanding general practitioner to sort out their problems. It is my belief that many people have money burning holes in their pockets, and desperately want to spend it on their perceived health needs. Since they are not allowed to spend it on seeking advice within the health service (this would be a heinous crime!), they look elsewhere, so what we are now witnessing is a deterioration in the services that can be provided under the National Health Service and millions being spent elsewhere.

Perhaps the enlightenment we, as Balint-doctors gave to the world, allowed us to strip away the artificial layer of magic that we ourselves inherited from the apothecaries and alchemists of former centuries, but perhaps, too, the alternative we offered of hard work and the discomforts of self-understanding, were too much for many of our patients and they have

looked for their magic elsewhere. Maybe we failed to get our message across fully, but is the cause irretrievably lost? I do not think so. Active Balint-groups are thin on the ground, and difficult to maintain outside certain active centres. But the Balint movement continues to gather strength abroad, and there are active groups and conferences worldwide. Only last years, while on holiday in Estoril, I noticed there was an international conference on family medicine and a whole afternoon session was given over to Balint-training. I was even more surprised to see Jack Norrell's name as leading it, and was pleased to be invited to join him in his demonstration-group. The work done in that group in one afternoon showed me that the problems facing family doctors in helping their patients are universal. The cases presented — even after translation into English from the Portuguese — were identical with cases we see every day in our work. Even the ubiquitous 'pregnant nun' syndrome was one of the cases presented! The mixed reaction of the group and their acceptance or non acceptance of the glimpses of insight that were revealed showed beyond doubt that Balintism is still very much alive. Like the man in Moliere's *Malade Imaginaire* who discovered he had been speaking prose all his life but had not realized it, Balint is part and parcel of general practice, the need in the future is to see that it is taught properly, so that it can be used properly. As long as doctors have treated patients, the principles of Balint have always been there.

Michael and Enid Balint were the discoverers who showed how it could be utilized for maximal benefit. Like radio waves that have always been in the atmosphere, the important discovery was in the harnessing of these waves and their translation into sound. Over a period of a century, vast improvements have been made in the utilization of these sounds — and not all for the better. It was not enough for mankind to leave it at the stage of the crystal or battery sets. Equally with Balint, it is not enough to leave it at its infantile stage, but if it is to be safe in our hands, we need new discoveries and workers to advance the concept to meet the challenge of every-day life. It is not enough to fossilise it at the point where it was all the rage. We must distinguish between pure Balint and applied Balint. The purists will find it very difficult. Doctors entering the profession now do not want to find the time for long cases and two year seminars — an absolute essential for true Balint-training. The new contract has no time for Balint, and it does not seem to figure in the new targets promulgated by the Government and which will take up so much of the profession's time. The discipline needed for book-writing is not very forthcoming.

So, it seems to me, we must look to applied Balint for the future. As I have said, we cannot deny its existence. Those of us who have benefitted from it, know how helpful it is. Continuing to use it in our work, the Society continuing to hold meetings and courses, members continuing to hammer home the message of the benefits that this approach to medical practice brings, are some of the means that will ensure that Balint will remain safe in our hands. I have every confidence it will remain safe, but let us make sure that we harness it in the right direction, and not be afraid to speak up for it at every opportune time.

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Balint Weekend at Ripon

18th to 20th May, 1990

This is the second time a week-end has been held in Ripon by the Balint Society. There were 21 participants, the same number as last year. We worked in two groups, of ten and eleven members which met five times: on Friday night, three times on the Saturday and once on the Sunday morning, ending with a plenary session together on the second half of Sunday morning. Group A was co-led by myself and John Salinsky, and after initial introductions including the type of practice we worked in, and a short discussion on the way we would be working, we plunged straight into cases.

In the course of the weekend everybody presented at least one case. All were cases which the presenter had found difficult to manage. All the cases had a distinct 'heart-sink' feel about them; the presenter having had problems in management in regard to their relationship to the patients and their demand for time and attention and sometimes vis-a-vis other partners in the practice. The material in the initial cases was very florid and the group sometimes found it difficult to keep to the work in hand i.e. looking at the relationships between the patient and doctor, and not to get side-tracked onto the fascinating byways of speculation.

Nevertheless, by the end of the second session the groups were working well together, allowing space for each other and making thoughtful, constructive contributions. By the third session, the nature of the cases presented changed and they became much more recognisable, as the cases that we are all familiar with in our surgeries day by day. They remained, of course, cases which had presented particular difficulties to the presenting doctor but because they were recognisable it was easier for the other members of the group to see what was happening between the doctor and the patient and to reflect this back to the presenting doctor.

There was a recurrent theme of loss running through the session. Loss of loved ones, of children, of organs, of youth and of our own difficulties in staying with these feelings of sadness to enable the patient to work their way through them. I felt the group worked well, progressing to a much more realistic level in the course of the five sessions.

Great enthusiasm was expressed for continuing to work in this way and much of the plenary session was taken up with thoughts and ideas as to how this might be organised on an on-going basis in more convenient geographical areas. As always at such gatherings, a great deal of useful information was gained during the breaks, between sessions and during meals. Living together in one house, a very comfortable house, facilitated this considerably.

ERICA JONES

(It is regretted that the report on the Balint Weekend at Ripon in 1989 was incorrectly attributed to 1990, in Volume 18 of the Journal, p. 23. It is hoped that Council's decision to delay the publication of the Journal until after the Annual General Meeting each year, will help to prevent such errors in future issues. Ed.)

The American Balint Society

4th May 1991

On 4th May 1991 the American Balint Society held an all day workshop entitled, 'Starting and Running a Balint-group,' in the Wyndham Franklin Plaza Hotel, Philadelphia. This was followed by the second Annual General Meeting of the Society. The workshop was attended by about 90 people, most of whom were teachers of Family Medicine who were either running or planning to start Balint-groups in their training programs for family doctors. Some were medical doctors and others were clinical psychologists; but it was quite hard to tell the difference between MDs and PhDs, unless you looked at their name-tags, because everyone seemed to be talking the same jargon-free language.

The workshop began with an introductory talk by Dr Laurel Milberg, the secretary/treasurer of the American Balint Society. Dr Milberg has been running a Balint-group for Family Medicine residents in Monroeville, Pennsylvania, for 14 years, although she scarcely looks old enough to have been at it for so long. She showed us a video-recording of her own group in action and invited us to observe it from the differing points of view of the presenting doctor, the other group-members and the leader herself. It was fascinating for me to watch a group of totally unknown people from 3000 miles away, struggling with the mysteries of the doctor/patient relationship in exactly the same way as my own group of general practitioner-traineers at home. I felt like an astronaut who has just discovered human life on another planet.

After a coffee-break, we watched another tape of a different group led by Dr Paul Scott from Pittsburg. This time we divided up into three groups with each group watching a separate screen, so that it was possible to stop the tape at intervals and try to decide what we thought the leader should do next.

The discussion was very lively and many familiar themes were brought out: How far, for example, should the leader try to 'push' the group-members to reveal their feelings about the case? Should the leader offer his own interpretation of what's going on, or would it be better to keep quiet and let the group find its own way to a different conclusion, or perhaps no conclusion at all? Should the leader permit or even encourage discussion of the doctor's own personality? I was relieved to find that most people thought that the Balint-group was not the place for personal therapy, although the expected 'small but significant change in personality' was greatly to be welcomed.

I was very impressed by the enthusiasm and committment of my American colleagues, and full of admiration for the insight and sensitivity which they showed in discussion the recordings of groups that we looked at together.

In the afternoon, we had an excellent talk on 'Empathy in the Doctor-patient Relationship' by Dr Clive Brock who teaches in Charleston, S. Carolina, and is one of the founders of the Society. This was followed by a demonstration-group led by Dr Brock and Dr Frank Dornfest from Santa Rosa, California, who is the Society's president. The presenting doctor told us about a difficult old lady with multiple illnesses who was driving him near to despair by constantly asking him when he was going to do something to make her feel better. The doctor was at first very dissatisfied with the group's response to his predicament and felt that they were doing very little to help him. After a while, we all realised that his feelings of discontent and frustration exactly reflected those of his patient! The workshop concluded with a panel discussion on the subject of 'Deepening Leadership Skills.' While this was going on, I retired to another room with six 'beginners' who wanted to have the experience of taking part in an ordinary Balint-group without an audience. Dr Gail Jones provided valuable support as my co-leader and I think that we all found this hour of 'private' Balint-time particularly rewarding.

At the end of the day, the Society held its AGM with Dr Dornfest in the chair. There are plans for local events in the next 12 months, including tele-conferences to try to overcome the communication problems in this vast country. Next year's national Workshop will be held in St. Louis, Missouri and any visitors from Europe can be sure of a very warm welcome if they make the trip across the Ocean. We are also hoping to see some American delegates at the Oxford meeting of the International Federation in September 1991.

JOHN SALINSKY

Report from the South African Balint Society

The SA Balint Workshop: 8-10 February 1991

A record number of 30 participants, including John Salinsky, President of the British Balint Society, and Secretary/Treasurer of the International Balint Federation, and Clive Brock, Vice President of the USA Balint Society, met under the leadership of Stan Levenstein. We are also joined by Jane Eyre of Durban, Naomi Arnheim of Johannesburg and Basil Michaelides of Port Elizabeth. Dr. Furman invited each member to introduce him/her self, read out the guidelines for the weekend and stressed that:

the workshop would take the form of case-discussions, not necessarily 'psychiatric' problems, (from participants' own practices) in groups.

the group-discussion would focus on trying to *understand* the difficulties in the doctor/patient relationship and the best ways of addressing them. All discussion would be 'case'-orientated.

Members should confine themselves to expressing their views as to what they regard the nature of the problem to be.

Dr. Levenstein's ongoing group presented the first case on Friday evening, that of a 27-year old female who was referred to the general practitioner by her psychologist, as she had fallen out with her previous general practitioner who, she felt was not looking after her properly. The patient was anorexic and engendered a lot of anxiety in the presenting doctor, who was very worried that the patient wanted to starve to death.

The first case on Saturday morning was presented in a group led by Dr. Clive Brock, with Dr. Jane Eyre as the co-leader. The presenting doctor, a male doctor, presented a male patient in his 40s who was unmarried and made his doctor feel very helpless. His patient was very anxious and had seen numerous cardiologists, gastro-enterologists and respiratory physicians all over the country. He found him to be a most manipulative patient but despite this, the doctor found him very pleasant and 'liked him very much'. The patient wanted the doctor to make him a happy person which the doctor felt he could not do. The presenting doctor was always scared he might miss a carcinoma or ischaemic heart disease in the patient, and that one day the patient would commit suicide.

The second group on Saturday morning was led by Dr. John Salinsky with Denise Rubinsztein and Saville Furman as co-leaders. The presenting male doctor presented a young mother who had been battered and once raped by her husband. She had three children and the doctor was very concerned for her.

The third case of the day, in a group led by Dr. Levenstein, was presented by a male doctor of a young female who was in her late 20s. The patient presented asking for a pregnancy test despite having had her tubes tied previously. She was a very large, fat, jolly, endearing patient. The presenting doctor was concerned about her preoccupation with death and felt she was a management problem. She had previously had a severe motor vehicle accident and when in crowded places constantly thought about death.

A cocktail party, sponsored by Fisons, was held on the Saturday evening. Dr. Furman welcomed everybody, especially overseas quests, and Professor Eleanor Nash of UCT and Rose Jonker of the Academy of Family Practice. Dr. Basil Michaelides proposed the toast to the International Balint Federation and Dr. Clive Brock, after a humorous but from-the-heart speech, proposed the toast to the South African Balint Society.

Dr. Stanley Levenstein announced that Dr. Naomi Arnheim of Johannesburg, was to be the fifth recipient of the S.A. Balint/Fisons Travelling Fellowship Award, which she will be using to travel to the annual Balint Weekend in Oxford, in September 1991.

Dr. Furman paid tribute to Fisons who, although they make no psychotropic drugs or any product that could be promoted through the Balint movement, continue to support the Society, which is in keeping with their policy of helping to improve the quality of life of people, which is also one of the aims of the Society.

Jenny Price, the Product Manager from Fisons, Johannesburg, spoke of her warm feelings towards the Society and wished us well in all our endeavours. It was also announced that Fisons would continue to sponsor the Weekend Workshops for the next five years.

On Sunday morning, the first group was led by Clive Brock. A lady doctor presented a 40-year old female patient who was married to an obsessive/compulsive man. She had undergone a growth experience in her life and now was regressing and presented as a problem to her general practitioner, of not coping with her success in her job and her ability to cope with her home.

The last case of the weekend, presented in the group led by John Salinsky, was that of a very demanding, highly anxious woman who presented numerous times with each illness, convinced that she would either die of choking, a haemorrhage or of cancer. She could not keep to any boundaries and even hounded the doctor at his home. The doctor had tried many different techniques in trying to contain this patient but up till the time of the Workshop they had all proved a failure. After lunch a feedback session was held, when some doctors felt that it is very difficult for a new group to get going straight away at a Weekend Workshop like this, and suggested that instead of ongoing groups, new groups should be formed. This was supported by Dr. John Salinsky, but Dr. Brock felt that he

preferred the format of the Weekend, as it gave him a chance to see leadership styles of other doctors. Dr. Salinsky agreed that it was good for the leaders, but not always good for the participants. It was suggested we should re-consider the aims of the Weekend, as if we tried to model it on the Oxford Balint Weekend, we would have to use a venue with more rooms. Dr. Salinsky explained that the main aim of Balint Weekendsk in the U.K. was to give people a 'taste' of Balint, and to encourage new people to join.

In summary, Dr. Levenstein said there are obviously different needs for different people. One of the new participants felt threatened to present a case after seeing the other groups present so well, as she felt that her case may not ge 'good enough'. Another newcomer expressed the feelings of being daunted and intimidated after seeing established groups, making him feel inadequate. One participant mentioned that she found there was more intensity this year in the outside group than in previous years. Stanley Levenstein made the point that the outer groups often 'hear' things differently. From further discussion it became obvious that there is a need for new groups for many of the young general practitioners.

Much discussion centered around how and when future Workshops would be run. Members were requested to fill in the feedback sheets, and these would be studied before any final decisions were made.

The feedback session was followed by the 12th Annual General Meeting of the South African Balint Society. The following office bearers were elected:

President:	Dr. S. Furman	*Regional Representative for Natal:*	Dr. J. Eyre
Vice President:	Dr. B. Michaelides	*Additional Member:*	Dr. S. Levenstein
Secretary/ Treasurer:	Dr. N. Arnheim		

SAVILLE FURMAN

PROMOTING PATIENT-CENTRED MEDICINE:

The Ascona Model to further the doctor/patient relationship

Award for Medical Students 1992

Medical students are invited to submit an essay based on their personal experience and relationships with patients. An award of 6000 Swiss Francs, donated by Pharmaton Ltd., Lugano, will be made to authors of the best entry, as judged by adjudicators drawn from the Psychosomatic Societies of Austria, France, Italy, Switzerland, West Germany; the International Balint Federation, as well as student representatives.

The essays will be judged on the following criteria:

1. Exposition: The fresh presentation of a truly personal experience of a student/patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. Reflexion: A description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialties, and working routine within different institutions.
3. Action: The student's perception of the demands he/she felt exposed to, and an illustration of how he/she then actually responded.
4. Progression: A discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Four copies of the essay, each containing the author's name and address, should be posted, **not later than December 31st, 1991,** to the following three representatives:

1) Prof. Dr Boris Luban-Plozza
Piazza Pedrazzini
CH-6600 Locarno, Switzerland
2) President Dr J S Norell
50 Nottingham Terrace
London, NW1 2QD, G.B.
3) Prof. Dr Paolo J. Knill
Lesley College Graduate School
11 Mellen Street
Cambridge, MA 02138, USA

The presentation of prizes will take place in Ascona.

All information can be obtained from: Documentation Center Balint, CH-6612 Ascona, Switzerland.

From My Bookshelf

Again, it was only the availability of space which reduced the time spent in agonising over which books on my current bookshelf to bring to your attention. The most recent addition, just off the press, is a must, not only because it was written by an old friend who has previously presented a most interesting paper to us,[1] but also because he is a family doctor who has practised as a psychoanalyst as well for many years.

NINE LIVES: The Emotional Experience in General Practice, Kenneth Sanders. (Paperback, pp. 156; £8.00p. ISBN 902 965 28 X) Strath Tay, Perthshire, Scotland. 1991.

In this, his second book based on his experience as a family doctor with psychoanalytic training, and still working in general practice, the author continues his attempt to 'transform into words' the inner world of conflicting feelings. And very well he succeeds, just as he did in his first book.[2]

It will come as no surprise to readers of this Journal that *'general practitioners have to think and act before all the information they need, is available to them.'* And that *'No-where does this cause so much frustration as in emotional and psychosomatic illness . . .'*

Indeed, with Balint's help, many of us have come to understand that 'treatment' starts from the way in which the doctor welcomes the patient as s/he walks into the consulting room; indeed, the more enlightened might say, even from the way in which the patient is welcomed by the doctor's ancillary staff whose behaviour must reflect his/her philosophy of what s/he thinks medical practice is all about.

I knew I was going to enjoy reading Kenneth Sanders' second book when I read on the first page of the first chapter that, *Psychoanalytic activity requires the courage and the imagination to permit a marriage between art and science. When they are separated, both remain sterile. In combination, they complement one another in an enhanced desire to find meaning in the experience of being alive.'* Not that I have experienced a personal analysis, but because Balint training brings with it some understanding of psychoanalytic concepts.

In this first chapter, Dr Sanders describes how his early experience in general practice left him puzzled, together with the gradual realization which many of us have felt, that our traditional medical training leaves us ill-equipped to deal with much of the illness presented to us.

During the course of our training in hospital, we *'. . . learn to listen to the patient, examine the outer surface, then proceed to the inside.'* In psychoanalysis it is the 'interior structures of the mind' which are examined, and the importance of the link between these and the internal structures of the body, and their relationship to early experiences of the child with the mother, are emphasised.

So, with reference to Freud, Klein and Bion, Dr Sanders continues with a beautifully concise description of the need to try to understand and deal with the emotional tensions and conflicts which underly, or are associated with so much of the illness encountered in general practice. He compares the analysis of the mind with investigation of the body which, he points out, unfortunately frequently become confused with one another.

He explains that in spite of the need to grapple with emotional problems, *'. . . there are times when the experience becomes unpleasant . . . There is conflict about getting acquainted with feelings. If sufficiently intense, they hurt. The alternative is to evade the emotional experience, to hold the transaction at a commercial or even mechanical level. In medicine, that happens when the patient is thought of as one machine that can be investigated by another. Both doctor and patient may fear the capacity to feel, while agreeing that it is a sign of life.'*

Sanders brings out this very important point which underlines that absurdity of the government's current attempt to convert our patients into 'satisfied customers.' In spite of being offered effective treatment, the patient may well become a dis-satisfied 'customer', and be tempted to seek 'less painful' help elsewhere. The more alternatives open to her/him in the market-place, the more easily will it be to give in to that temptation.

In stressing that this is no 'how-to-do-it manual', Sanders describes an approach to the human problems met by all family doctors, by relating in a delightful way in the chapters that follow, the stories of nine patients, and providing what he calls, *'Navigational guidance . . . for the use of those who are interested in this method of engaging imagination as well as hospital-training in the art-science of general practice.'*

The last chapter consists of an imagined group discussion between the patients whose stories have been told, as they voice their opinions, conflicts and hopes concerning their experience as patients.

References:

1. Sanders, K. A Matter of Interest. *Journ. Balint Soc.* 1987, **15**; 12-17.
2. Sanders, K. *A Matter of Interest: Clinical Notes of a Psychoanalyst in General Practice.* ISBN 902 965 22 0. Paperback. Strath Tay, Perthshire, Clunie Press. 1986.

SOMATIZATION: Physical Symptoms and Psychological Illness. (Ed.) C M Bass. (Pp 339. ISBN 0 632 02839 4) Oxford, Blackwell Scientific Publications, 1990.

Dr Christopher Bass, senior lecturer and honorary consultant in psychological medicine

at King's College School of Medicine and Dentistry and Institute of Psychiatry, London, is to be congratulated on producing and editing this beautifully printed volume. This represents a much needed study of the interactions between organic, psychological and social processes and events which produce physical symptoms and signs and illness behaviour.

In his preface, Dr Bass tells the reader that the purpose of the book was to describe some of the more common somatoform syndromes. A chapter on taxonomy compares and contrasts ICD-10 and DSM-III classification, and proposes a multiaxial system of assessment of these disorders. Many aspects of somatisation are covered by Dr Bass and ten contributors — nine psychiatrists and a professor of gynaecology — in 13 chapters. Although written primarily for psychiatrists in training, the sections on management of these conditions will be of interest to other clinicians, especially those in general practice who may still be searching for explanation of the problems involved in the interplay of the emotions and physical symptoms.

In his introductory chapter, Dr Bass refers to the failure of psychiatric nosology to *'accommodate patients with physical symptoms that lack an organic basis and in whom, psychological factors are thought to be aetiologically relevant.'* He follows with a fascinating account of the use of the terms 'neurosis,' which was introduced by Cullen in 1769,[1] 'neurasthenia' and 'functional disorder.'

He then describes the more recent use of the terms 'somatisation' and 'somatoform disorders', which was introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III).[2] Strangely, the term 'psychosomatic' is not to be found in the index, and it is mentioned only once in the text, in a reference to one of my favourite books, Flanders Dunbar's *Emotions and Bodily Changes.*[3] Nor is there any explanation for the choice of the new term, somatoform instead of psychosomatic throughout the book, which is all the more surprising considering that Dr Bass is currently President of the Society for Psychosomatic Research, and an Assistant Editor of the Journal for Psychosomatic Research.

PHILIP HOPKINS

References:

1. Lopez-Pinero, J M. *Historical Origins of the Concept of Neurosis,* Cambridge University Press. 1983.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edn, (DSM III.) Washington, D C. 1980.
3. Dunbar, F. *Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships: 1910-1953.* New York, Columbia University Press. 1954.

Programme of Meetings of the Balint Society for the Twenty-Second Session

1991-1992

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

MS IRENE BLOOMFIELD, Honorary Consultant Psychotherapist, University College Hospital, London and,
DR PETER SHOENBERG, Consultant Psychotherapist, University College Hospital, London:
The Student Psychotherapy Scheme at University College Hospital and its Role in Helping Medical Students to Learn about the Doctor/Patient Relationship. 29 October 1991

DR ERPYS CHRISTOPHER, Medical Officer, Psychosexual Clinic, University College Hospital, London:
Institute of Psychosexual Medicine Seminar Training, contrasted with training with the British Association of Psychotherapists (Jungian). 26 November 1991

The following meeting will take place at the Medical Society of London, Lettsom House, 11 Chandos Street, London, W1M 0EB. on 4 February 1992, at 8.30 p.m. preceded by coffee at 8 p.m.
Joint Meeting with the Institute of Psychosexual Medicine: Stresses and Strains in Living with Others.
(Speakers to be announced later). 4 February 1992

DR SALLY HULL and DR PAUL JULIAN, General Practitioners and Lecturers in Academic Department of General Practice, Joint Medical Colleges of St Bartholomew's and the London Hospitals:
(Title of address to be announced later). 10 March 1992

(Details of further meetings in April and June 1992, will be announced later.)

The Oxford Balint Weekend, 1991

will take place at Lincoln College, Oxford:	on Friday at 6 p.m.	20 September 1991
	to Sunday at 1 p.m.	22 September 1991

The Ripon Balint Weekend, 1992

will take place at the College of Ripon and	on Friday at 6 p.m.	8 May 1992
York St John, Ripon, North Yorkshire	to Sunday at 1 p.m.	10 May 1992

(Oxford Balint Weekend, 1992 — dates to be announced)

Weekend Balint-group

Doctors attending the Society's Oxford and Ripon Balint Weekends often express disappointment that they cannot continue to participate in a Balint-group during the rest of the year.

We are therefore proposing to offer such doctors the possibility of a continuing Balint-group which would meet for approximately four weekends per year. It is envisaged that the meetings would take place at a pleasant, central location as conveniently places as possible for the majority of participants. The group will be led by an experienced leader probably working with an associate leader. It is anticipated that the weekends would be approved for the PGEA.

It would greatly help Council in planning this venture, which will probably start early in 1992, to have some idea of the likely level of interest. We should be glad to hear from society members who might be interested in taking part, or who know of others who might wish to do so.

We should also welcome comments and suggestions about this venture. Please contact: Dr David Davidson, 85 South Hill Park, London NW3 2SP. Tel: 071 794 8921.

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.

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