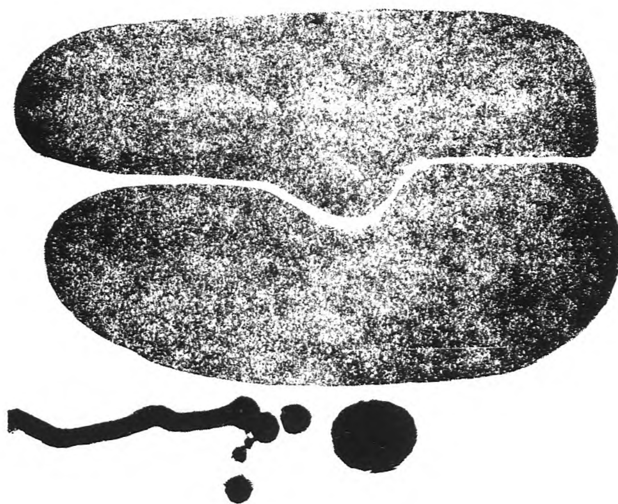
Journal
of the
Balint Society

1994



Vol. 22

JOURNAL OF THE BALINT SOCIETY

Vol. 22, 1994

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Editor: Philip Hopkins

Assisted by Susan M. Hopkins

Photograph by Dr Philip Hopkins

Mrs Enid Balint-Edmonds, B.Sc. (Econ.) Hons., F.R.C.G.P. (Hon.)
At the International Balint Memorial Congress, Budapest, 1986.

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 and residential Balint Weekends at Ripon in May, and Oxford in September each year.

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 27), and the Journal is circulated each year to all members.

Editorial

The mother of the Balint-group, Enid Balint-Edmonds, died on 30th July 1994. There really are no words to express my personal grief and sense of loss adequately, and that which I am sure will be felt by all who knew, admired and loved her. An immediate effect had to be to halt the printing of this issue of our Journal so that this devastatingly sad event can be announced, and as appropriate an obituary as possible could be recorded (page 5).

It makes me feel all the more sad when I remember how, when I last met Enid, she told me how disappointed she was that although more and more doctors are interested in Balint-groups in other countries, there are so few doctors showing any interest in Balint work in the U.K. Even doctors previously known to be committed to Balint work, openly speak about their low morale, due to their having to spend so much time on the Department of Health's dictates, rather than on the personal care which they know that patients need and want. When discussing this with her, I suggested that we might talk at a more suitable time about the possibility of arranging for her to speak to the Society, or to write an article for this Journal, about her thoughts and views on the changes in the doctor/patient relationship in the 1990s, following the Government's current policy of imposing market forces on general practitioners. Sadly, this is no longer possible. But careful reading of her recently published books shows that she was still as enthusiastic as ever she was, about finding out more about what actually happens during what should still be a most remarkable relationship between two human beings – the doctor/patient relationship during a consultation.

Recently I was re-reading some of the transcripts of our St Pancras Hospital group which resulted in *Six Minutes for the Patient,*[1] when I came across a discussion we were having on 14th November 1967. We had been very despondent and puzzled at our slow progress. Enid said, 'I feel that this is the despondency – why is it that we still are puzzled? I think a lot of people still are puzzled when you were talking about what we are trying to do. I would have said that what we are trying to discover is not what one can do, but what one does do, over and above the drug giving, in the five minutes, what in fact *is* the transaction – not to alter it, but to examine it.' Enid showed she was still concerned about the future of Balint work, which as she wrote in the preface to *The Doctor, the Patient and the Group,*[2] 'In a sense this book will be about "Balint Revisited" but it will also be concerned with the future of Balint work. We hope it will illustrate its essential nature, which is to add to the pleasure, satisfaction and competence of doctors in their ordinary work.' Enid certainly did this for me when I attended group meetings with both Enid and Michael, and she continued to do this for me during the group meetings after Michael had died. She undoubtedly did this for very many others too – and we will never forget her.

Surveys have repeatedly shown that patients want above all else, to be made to feel at ease with their doctor, and to feel that s/he is concerned to have sufficient time with their patients for their consultations. Patients want and need to feel that their doctors are interested in, and concerned about them, as people wanting our help – but not to be treated simply as diseased bodies.

The real work of a doctor is neither visiting octogenarians for annual check-ups, nor summoning patients to come to be weighed, have their blood pressure checked, their cervixes smeared and their urine tested . . . All this may be fine when it is clinically indicated, and can be carried out as a worthwhile service, but **our real work takes place in the intimacy of the consulting room or in the sick room, when a patient who is ill, or feels him/herself to be ill, seeks the advice of a doctor whom s/he trusts. This is a consultation, and *this* is the basis of good medical practice.**

It may be that in the present state of our National Health Service, we have lost to some extent this vital focus for our work. Thousands of doctors would not want to retire at 60 years of age, and some even at 55 years, as they appear to be planning to do, if they were still finding their work pleasurable and satisfying, and if they still had the resources with which to use that competence which they had acquired as a result of many years' intensive study and hard work. This would be too much to give up if it had not become such a heavy burden to carry. The government must surely come to see that their policies have failed, and can only continue to fail if they do not take heed of what is actually happening. It may will be too late – the morale of all who work in the National Health Service is at its lowest, and it may never be possible to resuscitate it, but it is worth trying.

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On a happier note, it is time to offer our congratulations to Dr Theresa Dresser, a London general practitioner who has been awarded the 1994 Society's prize for her fascinating account of her experience of *Pain in the doctor/patient relationship,* which appears on page 22.

Also congratulations for Mr Christopher P. Beith, a fourth year medical student at the Royal Free Hospital, London, having previously worked as a social worker in West Yorkshire for eight years. He is only the third British medical student to receive the first prize. He attended the annual international seminar at Monte Verità in Ascona, Switzerland to receive the Award of 3,000 Swiss francs for his enlightened prize-winning essay, *Encounter with a patient* (see page 28). The annual 'Balint' awards are

presented in April every year by the Foundation for Psychosomatic and Social Medicine for the best essays based on students' personal experience of their relationships with patients (see below).

Congratulations too, to Dr Alexis Brook for delivering the Michael Balint Memorial Lecture this year. His subject was of great interest, as it was about the effects disturbed emotional states can have on the eyes. Conditions commonly seen in general practice can be helped more by exploring the patient's emotional conflicts, rather than prescribing eye drops and pills. Sadly, the need for absolute confidentiality prevented him from allowing his paper to be published. Perhaps he might at some time in the future be able to share his experience with us.

PHILIP HOPKINS

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1. Balint, E. and Norell, J. S. (Eds.) Six Minutes for the Patient; Interactions in General Practice. London, Tavistock Publications. 1973.

International 'Balint' Award 1995, for Medical Students

For more than 25 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verita' (the mountain of the truth) in Ascona. With their function as university influence, they are known under the name for 'Ascona-Model' (WHO) and their main purpose consists of Balint teamwork. This means an examination of the doctor/patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. Awards of Sfr. 10,000 will be made to authors of the best description of a student/patient encounter.

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

1. Exposition. The presentation of a truly personal experience of a student/patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. Reflection. 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 specialities, and working routine within different institutions.
3. Action. The student's perception of the demands he/she felt exposed to, and an illumination of how he 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.

Three copies of the composition, each containing the author's name and **full address** should be posted, not later than **January 31st, 1995** to:

Prof. Dr. med. Dr. h.c. Boris Luban Plozza, Collina, CH-6612 Ascona.

The presentation of prizes will take place in Ascona on 8th April 1995, Monte Verità.

All information can be obtained from: Foundation of Psychosomatic and Social Medicine, CH-6612 Ascona, Switzerland.

Obituary

Enid Balint-Edmonds, B.Sc. Hons., F.R.C.G.P. (Hon.)

12.12.1903 - 30.7.1994

Enid Balint-Edmonds died on 30 July 1994. She was ninety years young. At the end of her fascinating book, *Before I was I,* she described in an interview with one of her editors, something of her early experiences when organising Citizens' Advice Bureaux in London during and after World War II in the 1940s. She was trying to look after people who had been bombed out, and became aware of the irrational aspects of human relationships: 'I found that what they were worried about wasn't the being bombed out, but some apparently irrelevant detail about whether their neighbour was pinching their salt and pepper.'[1]

This was followed by three very important events in her development: she started working at the Tavistock Clinic and the newly formed Tavistock Institute of Human Relations, where they set up the Family Discussion Bureau (later to become the Institute of Marital Studies). This was followed by her psychoanalytic traning. When Michael Balint arrived in London and was appointed as a consultant psychiatrist at the Tavistock Clinic she invited him to help her with her work in training social and welfare workers to deal more effectively with their clients with marital problems. Subsequently, Enid and Michael were married.

Enid described this earlier work in some detail in her address to the Society's seventeenth annual general meeting, which is reprinted on page 7 for the benefit of those who do not have the original journal, nor access to it.[2]

Those of us who worked with Michael Balint from the beginning, and in his later groups, well knew the extent to which Enid helped him develop further the training-*cum*-research group method which he first used in the early 1920s, when working with general practitioners in his native Hungary. After Michael's death at the end of 1970, Enid continued to lead the groups they had been leading together, including the one whose work was responsible for *Six Minutes for the Patient.*[3]

Those privileged to have had the experience of having her as a group-leader, either co-leading with Michael Balint or on her own, will feel her loss most keenly. But they will have the consolation of knowing that part of her lives with them. Indeed, many others have also benefitted from the original concepts which she helped to develop, and which have helped so many general practitioners to learn the skills of listening to their patients, and how to apply what they hear and feel, in their clinical use of what happens in the doctor/patient relationship. Initially instrumental in the application of dynamic group methods in the study of patient/doctor interactions in the setting of general practice, she has remained active in defining and refining the ways in which insights gained in the process can be used.

The evolution from the position where general practitioners were encouraged to practise a form of brief psychotherapy towards an integration of psychodynamic insights into their daily work began before Michael Balint's death. Since that time, Enid has filled a crucial role in encouraging further development. Her most recent books have sought both to look back and to look forward, leading to new discoveries in the way doctors respond to patients and how these can be harnessed in helping patients with distress.

Many will testify to Enid's continued efforts to pursue the further development of those original concepts by her work with groups she has led over the years in France, Switzerland, South Africa, the United States of America and elsewhere all over the world (see page 48), as well as with us in the U.K. Fortunately, some of the results of her efforts to show her concern about the future of Balint work, and to remind us that the aim was not to teach a specialty, but to add to the pleasure, satisfaction and competence of doctors in their ordinary work, are recorded in *The Doctor, the Patient and the Group,* the book resulting from the work of one of the last groups she led.[4]

Of course, Enid was primarily a psychoanalyst of considerable merit, becoming a training analyst of the British Psycho-analytical Society in 1963, and occupying many important positions in it. But for those of us in general practice, Enid will always occupy an unique position in the world of Medicine. While not herself a doctor, her contribution from the standpoint of psychoanalysis to general practice and other medical disciplines, has been immense. Her election to honorary Fellowship of the Royal College of General Practitioners in 1980 testifies to that.[5]

Our heart-felt sympathy and sincere condolences go out to her daughters and grandchildren, and especially to her husband, Robin, cruelly robbed of her love and strength.

MICHAEL COURTENAY
PHILIP HOPKINS

References:

1. Balint, E. *Before I was I; Psychoanalysis and the Imagination.* p.222. Eds. Juliet Mitchell and Michael Parsons. Free Association Books, 1993.
2. Balint, E. Address to the 17th Annual General Meeting of the Balint Society. *Journal of Balint Society,* 1988, **15**,27.
3. Balint, E, and Norell, J. Eds. *Six Minutes of the Patient,* Tavistock Publications, 1973.
4. Balint, E. Courtenay, M. Elder, A. Hull, S. and Julian, P. Eds. *The Doctor, the Patient and the Group: Balint Re-visited.* Routledge, 1993.
5. Honorary Fellowship Oration for Enid Balint-Edmonds, 1980. *Journal of Balint Society,* 1981, **9**,10.

Enid Balint-Edmonds
A Message from the South African Balint Society

It was with a deep sense of sorrow that we received the news of Enid's passing. In spite of her advanced years, she was such a vital and ongoing presence that her death has left us with a sense of stunned disbelief and devastation.

Enid made several visits to South Africa to help further the cause of Balint work in our country. In addition to leading workshops, she also initiated a novel form of leadership training by means of supervising transcripts which were sent to her on a regular basis. This was further complemented by an ongoing correspondence in which she continued to give generously of her uniquely inventive mind and profound insights.

But even more memorable than her giant intellect was the person herself; a great-hearted human being whose zest for life and passion for truth was an inspiration to us all. She was a living embodiment of Freud's exhortation, to love and to work!

The pain of the loss of Enid has made me acutely aware of the fact that although I had not had much contact with her in the past few years, there was always the comforting thought that, if the need arose, I could always contact her, and however complicated and insoluble the problem may seem to me, she could be relied upon to respond with an uncanny, incisive clarity at which I could only marvel. But now she is gone, and I can only hope and trust that I can fall back on 'the courage of my own stupidity' which she so fearlessly exhorted us to muster.

We mourn a woman who can truly be described as irreplaceable. But, she has left a rich legacy: all over the world, hundreds of general practitioners and, more importantly, thousands upon thousands of patients have had their lives enhanced by her. For all of us who appreciated her genius and her great humanity, it remains only to stand together and take forward the priceless enlightment we have gained from her.

DR STANLEY LEVENSTEIN
(On behalf of the South African Balint Society)

An address given by Mrs Enid Balint-Edmonds, FRCGP at the 17th Annual General Meeting held on 30th June 1987

The President has asked me to tell you about how the Balint Society was started, or rather perhaps how I started to work in a way which led to the work of the Balint Society.

I suppose I could say that it started during the last war when I was organizing and working in Citizens' Advice Bureaux in the London area. Although apparently hired to help people with practical problems, I continually found myself occupied with what seemed to be quite irrational troubles with people whose real, external reality problems were quite remarkably difficult, but not so upsetting for them when I saw them.

This led me, with a good deal of luck, to a meeting with a remarkable man called Dr Tommy Wilson, and to start working at the Tavistock Clinic with a group of people who were as interested and puzzled as I was about human relationships. Soon, the Tavistock Institute of Human Relationships was formed, and developed some very important work.

I decided to focus my work on human relationships in marriages and, after sitting around and talking to the group of people who were interested in various fields, but all in the same problems, I decided to go around London listening to what people had to tell me about life as they saw it after the war.

During this period I learned, rather painfully, to listen, but, as I had nothing to say, it was not very difficult. However, I learned quite a remarkable lot of things. Amongst them, perhaps the most important, was that listening to problems as people see them, is always different from seeing, or thinking one sees what the problems are.

After some time working like this, and before starting any therapeutic work, I collected some money and got the Home Office interested. A small group of people then began to work together, and in a very tentative way, we started seeing people with marital problems.

Quite a number of very senior doctors and psychiatrists helped us, but finally we met a recent arrival in London, Michael Balint. He agreed to work with us and, in fact, took us over completely and started the real work of studying relationships, and unexpected nature of people's requirements from their marriages – and their therapists.

Quite soon after this, in 1950, Michael thought he would like to work with general practitioners, as he had done in Hungary many years earlier. This, of course, led to the kind of work you all know. In fact, this is where *we* come in. Groups of general practitioners led by psychoanalysists studying doctor/patient relationships, instead of groups of non-medical workers studying marriages.

The interest of this beginning for all of you here, is that so many people want to start something new, but they do not know how to find leaders to help them. Indeed, we had no leaders to start with, and although Michael soon became our leader, I do not think we would have accepted him, or he us, unless we had already started in the way we had, and were prepared to listen to the unexpected, and so widen our horizons and be interested in what at first seemed to be very trivial and unimportant aspects of our clients' or patients' lives.

We did not want someone to teach us, and Michael did not want to teach, but to explore.

It was not the method of leadership nor even the qualifications of the leader that mattered, but his open-mindedness. Perhaps nowadays, when people look around for trained psychologists, psychiatrists or psychoanalysts, they may be lucky to find one who is willing to have a fresh look with them at everything, but the fresh look is the really important thing, and the danger of importing theories the greatest danger.

Balint Prize for the Field of Health and Nursing Care, 1995

To promote relationship-orientated care, based on the Ascona Model (WHO), prizes will again be awarded for papers in 1995.

This model has its foundations in the work of Michael Balint, in whose honour for the first last five years a prize has also been donated in the field of health- and nursing care and annually awarded in Ascona, Monte Verità.

The award of Sfr. 8,000 – has been made available by the Foundation for Psychosomatic and Social Medecine in Ascona and by the Swiss Red Cross.

Papers of max. 20 pages (30 lines per page and 60 letters per line) will be judged according to the following criteria:

1) Exposition. Papers presented give an account of a personal experience within a nursing care relationship to a patient and its possible development.
2) Reflection. The author should take into account in his/her reflections, his/her own feelings, fantasies (which are often suppressed) and manner of behaviour as well as the relationship to co-workers, institutions and to the patient's relatives.
3) Action and Progression. The author points out the knowledge gained by the analysis of the experience and shows how this can be integrated into everyday care.

Closing date for entries: 31st December 1994.

Three copies of each paper in German, French, Italian or English should be submitted to:

SWISS RED CROSS, Department of Vocational Training, P.O. Box 3001, Bern.

The awards will be presented on 8th April 1995 in Ascona, Monte Verità during the Ascona talks on the theme 'the aging person and his/her social environment'.

Handling Hyperventilation in General Practice*

Sotiris Zalidis
General Practitioner, London

Introduction

Hyperventilation syndrome is sometimes dismissed as a symptom of anxiety, but in my view it has a psychological significance of its own with important implications for treatment.

Hyperventilation syndrome is one of the commonest causes of functional symptoms. There is also a suggestion that it may have lethal physical sequelae. It may cause coronary vasospasm leading to cardiac arrhythmias and myocardial infarction in patients with ischaemic heart disease[1]. Hospital based researchers claim that it is the cause of attendance of six to ten per cent of patients in medical outpatient clinics[2].

The prevalence of the syndrome in general practice however, is not known, probably because general practitioners vary in their ability to diagnose and manage this problem.

In a recent paper from general practice it was reported that hyperventilation induced symptoms were common in a group of twenty patients with recurrent functional symptoms which doctors found difficult to diagnose and treat[3]. In my practice I diagnose and treat about one hundred patients with this syndrome each year. In this paper I would like to report on the observations I made on the one hundred consecutive patients I treated in 1992.

What is Hyperventilation syndrome?

The term hyperventilation implies that the ventilatory effort is greater than the body's need for oxygen.

The term hyperventilation syndrome however, refers to a multitude of symptoms which are produced when irregular, sighing, upper thoracic breathing of which the patient is unaware, causes carbon dioxide deficiency. Persistently lowered and fluctuating levels of carbon dioxide in the blood are critical, as they are responsible for most of the symptoms of which the patient complains[4].

The key factor for the initiation of the syndrome is the type of breathing. Upper thoracic breathing is part of the somatic component of emotional arousal. It occures when prolonged intense affective states of which the patient is unaware, such as panic, rage and sorrow cannot be expressed in automatic action such as running to escape, fighting to kill or howling in mourning. These powerful emotions threaten to overwhelm the patient, and create a sense of helplessness.

Once the hyperventilation syndrome is initiated, it can be sustained by several factors other than the original emotional arousal and a vicious circle may set in. Among these factors are secondary anxiety about the significance of the symptoms and the doctor's inability to make the correct diagnosis. John Bowlby has given us a fascinating account of Darwin's life, whose hyperventilation symptoms baffled his physicians and contributed so much to his misery.[5]

Maladaptive health beliefs such as that upper thoracic breathing helps relaxtion, or that the symptoms are due to lack of oxygen, can make the patient intensify his ventilating efforts and make his symptoms worse. A less frequent misconception is that the symptoms are due to too much oxygen. Angela Wilkie, a well informed journalist, gives an excellent account in her book, *Living with Cancer*[6], of her hyperventilation symptoms occurring in the context of her fear of recurrence of her ovarian cancer. She concludes however, by saying that in her panic she started to hyperventilate and getting too much oxygen into her system and making herself lightheaded.

Habitual sighing, sniffing or yawning in an attempt to relieve unpleasant upper chest tightness can also increase ventilation. There is also evidence that chronicity may ensue when central control mechanisms develop which actively prevent the carbon dioxide due to reduction of ventilation, is then opposed by a drive to increase ventilation, mediated by the chemoreceptors[7].

Symptoms of hyperventilation syndrome

In this section I have summarised most of the known clinical manifestations of the hyperventilation syndrome, in order of frequency of presentation in the one hundred patients I treated in 1992[2,8,9].

Respiratory

- sensation of breathlessness which occurs typically at rest or after, but not during exertion.
- inability to take a deep enough breath.
- chest tightness.
- dry irritable cough with frequent clearing of the throat.
- excessive sighing.
- frequent yawning.
- frequent sniffing.
- excessive use of upper chest and accessory muscles of respiration.
- waking up around three in the morning and fighting for breath.

Neurological

- lightheadedness, dizziness.
- sensations of numbness and/or tingling anywhere, but especially at fingertips, toes and around the mouth.
- blurred vision.

*Paper read to the Society on 15 February 1994.

syncope.

migrainous headaches.

intolerance of bright lights and loud noise.

Cardiovascular

palpitations, missed heartbeats, racing heart.

dull upper right or left chest pains.

areas of thoracic tenderness.

fainting due to postural hyotension.

General

feeling tired all the time, weakness.

poor concentration, forgetfulness.

poor sleep, nightmares.

excessive sweating particularly in armpits and palms.

headaches.

cold extremities.

warm feelings in the head.

Musculoskeletal

aching all over.

increased muscle tone with muscle stiffness.

cramps.

tremors or coarse twitching, shivering.

occasionally carpal and pedal spasms.

rarely generalised tetany.

Gastrointestinal

frequent swallowing leading to aerophagy.

dry mouth.

difficulty in swallowing.

sensation of lump in the throat.

full or bloated abdominal sensations.

belching.

heartburn due to oesophageal reflux.

sharp lower chest pains, accentuated by breathing.

Psychological

tension.

anxiety.

depersonalisation.

panic attacks.

phobic states.

fear of insanity.

Presentation of 100 patients suffering from hyperventilation syndrome

Causes

Pfeffer[10] has categorised the causes of hyperventilation into four groups: Organic, physiological, habit and emotional. Organic causes include, drug effects, early stages of alcohol withdrawal and central nervous system lesions. Physiological causes include altitude and acclimatisation, heat and exercise. In general practice however, hyperventilation is most commonly associated with emotional arousal, which was identified in 84 of my patients; only 2 were hyperventilating as a result of taking drugs such as ecstasy or cocaine.

Age, Sex, Distribution

Of my patients, 69 were women and 31 were men; 23 were in their twenties, 32 were in their thirties, and 18 in their forties. The numbers fell sharply after the age of 50 years and before the age of 10 years. The youngest hyperventilating patient I saw was four years old and the eldest, 83 years old.

Of the 90 patients who came to the surgery, 40 presented as emergencies without having made a previous appointment; 10 patients asked for a home visit.

Presenting symptoms

Forty-one patients presented with respiratory symptoms, particularly chest tightness and inability to take a deep enough breath. Most patients had some difficulty in describing these sensations and used a variety of images in their effort to convey their meaning.

Some complained of a tight elastic band around their chest or a heavy weight preventing their chest from expanding or of thick tenacious mucous preventing it from expanding from inside. Others complained of a sensation of 'blockage' which stopped the air from going into their chest, and sometimes they attempted to dislodge it by coughing or by putting their fingers in their throat to make themselves sick. Occasionally patients used the words 'chest pain' to describe chest tightness and unless they were asked for a detailed description of their symptoms they might have been misdiagnosed. Very often patients thought that they had a chest infection or asthma, and demanded antibiotics. Another common misconception was that they were suffering from lack of oxygen.

There were 27 patients who presented with neurological symptoms, particularly light-headedness, numbness and tingling. Pins and needles or tingling does not have to be symmetrical or bilateral and can occur in any part of the body. When the pins and needles affect the upper arms, they can be confused with the pain of myocardial ischaemia. Chest pains occurred in 14 patients, and 12 patients complained of feeling tired all the time and aching all over. These symptoms suggested a flu-like illness and some patients wondered whether they suffered from M.E. (myalgic encephalomyelitis). Two patients presented with gastrointestinal symptoms such as a sensation of lump in the throat or abdominal bloating. Only one patient presented with tetany which is the symptom many doctors associate with hyperventilation.

Diagnosis

I agree with Lum[4], Magarian[9] and Paulley[11] that hyperventilation syndrome is a clinical diagnosis.

When a patient anxiously complains of frightening physical symptoms such as chest pain or breathing difficulty, the non-verbal communication is one of fear. In order to proceed with the consultation in a constructive way, I have to tolerate my own anxiety that I may be in the presence of a medical catastrophe and critically examine my urge to take immediate action to rule out such a possibility. I have to tolerate this anxiety long enough, until I have asked the patient to describe his presenting symptoms in as much detail as possible. I also ask him to tell me what do his symptoms make him fear in order to help him verbalise this fear.

When I suspect from the way the patient is describing his symptoms that he may be suffering from hyperventilation syndrome I ask whether he has any other symptoms. Patients usually focus on a few symptoms only and they do not volunteer all their symptoms either because they do not consider them relevant, or because they are afraid that the doctor may make an unfavourable diagnosis. For this reason when I suspect the diagnosis, I find it essential to ask in an orderly and systematic way for all the symptoms of hyperventilation syndrome, taking one organ system at a time until I have exhausted the list.

I pay attention not only to what the patient says, but also to how he says it and I am alert to the clues that are suggestive of hyperventilation syndrome such as frequent sighing, sniffing, dry cough, yawning and constant clearing of the throat. The finding of characteristic multiple symptoms is the most useful aid in the diagnosis of hyperventilation syndrome.[12] In fact the greater the number of corroborative symptons, the more likely it is that this is the diagnosis.

Only when I have exhausted the symptom list, do I examine the patient. I listen to the heart and lungs, I check the blood pressure, and record the PEFR where indicated. Then I ask the patient to lie on the couch and I observe his respiratory pattern. Upper thoracic breathing is one more corroborative sign.

A careful history and a physical examination are essential aspects of the management because they give the patient confidence that his fears of organic disease have been taken into account. Also they are essential if the doctor is not to miss one of the diagnoses that hyperventilation syndrome can superficially mimic. For example, a 50-year-old women came to the surgery because she thought she had a chest infection for four weeks and it was not getting better. When I asked her to describe her symptoms she told me that she kept getting stabbing chest pains on walking, together with a sense of a weight on, or tightness in her chest; she also felt that she could not take a deep enough breath. This is the typical way in which patients with hyperventilation syndrome complain of their sense of breathlessness. She was also breathless on exertion. On systematic questioning the only other symptom I could elicit was tiredness. On auscultation, she had diminished breath sounds on the right with normal resonance on percussion. My clinical diagnosis was pneumothorax and I referred her to the London Chest Hospital where the diagnosis was confirmed with a chest X-ray, and her management taken over by the chest physicians.

The explanation of the hyperventilation syndrome to the patient is so different from what he expects to hear that some patients will need to be convinced. This is best done by asking the patient to make himself carbon dioxide deficient in the presence of the doctor by taking fast and deep breaths for about three minutes. Most patients give up after less than one minute, because this manoeuvre reproduces their very unpleasant symptoms in a most convincing manner.

A word of caution is to avoid voluntary hyperventilation in patients with known ischaemic heart disease because of the risk of inducing coronary vasospasm which may lead to arrhythmias and myrocardial infarction.

Pathophysiology

I find that understanding the physiological explanation of hyperventilation symptoms helps me appreciate their somatic nature. I have summarised therefore some of the pathophysiological mechanisms from several major papers.[2,9,13,14,15]

One of the most commonest presenting symptoms, air hunger, or the sense of being unable to take a deep enough breath, is due to the characteristic over-inflation of the chest. Attempting to inflate the lungs from a position which is above the resting one is opposed by the elastic forces of the rib cage and demands extra effort which is interpreted as inspiratory difficulty, evoking the desire for even larger breaths. Overfilling of the upper chest can cause compression of the subclavian artery between the first rib and the clavicle, leading to ischaemic pain affecting the whole arm and hand and also parasthesiae and sensory impairment affecting all fingers.[16]

Carbon dioxide deficiency and respiratory alkalosis develop rapidly after the onset of hyperventilation. Carbon dioxide far from being a waste gas plays a very important role in regulating vital body systems. Carbon dioxide is a major factor in governing cerebral blood flow; cerebral angiography has demonstrated arterial and venous vasoconstriction causing a reduction of the cerebral blood flow as the initial response to hyperventilation, leading to cerebral hypoxia.

The hypoxia is made worse by the Bohr effect, due to tighter binding of oxygen to the haemoglobin in the presence of alkalosis so that it is not easily available to the tissues. The resulting symptoms are dizziness, lightheadedness, disturbance of consciousness, syncope, hallucinations, and visual phenomena such as blurred vision, tunnel vision, flashing lights or even complete black out.

In time the initial vasoconstriction is overcome by the cerebrovascular vasodilatory response to anoxia and the symptoms disappear.

If low levels of carbon dioxide and respiratory alkalosis are sustained, renal compensation occurs through increased renal excretion of bicarbonate in order to maintain the pH of the blood at its normal value of 7.4. When severe, the depletion of the alkaline reserves in the muscles causes fatigue and loss of the capacity for physical effort through diminution of the buffering effect on lactic acid. Common symptoms are fatigue and aching limbs. The unbuffered acid is carried centrally and stimulates further overbreathing. The chronic depletion of the alkaline buffering system that is produced by prolonged excessive loss of carbon dioxide, causes the pH regulation to be sensitive to small changes of breathing behaviour. When the breathing is reduced during the first two or three hours of sleep, an acidosis develops. At a critical point, this reduction triggers an overbreathing response and wakens the subject with hypocapnia. The consequences can include anxiety, panic, sleepwalking, nausea, muscular pains or cramps, and cardiac pain or arrhythmias or both. Also in highly aroused subjects, there is diuresis of magnesium ions. This loss of 'nature's own calcium blocker' reduces opposition to the rise of intracellular calcium ionization that is induced by the respiratory alkalosis of hyperventilation and thereby promotes vasoconstriction.[15]

When a chronic persistent state of hyperventilation occurs there appears to be re-setting of the respiratory centre, allowing for persistence of carbon dioxide tension at hypocapnic levels to allow for the maintenance of a normal pH. This may be one of the factors allowing for chronicity and ready provocation of symptoms. Being chronically carbon dioxide deficient, symptoms may be present much of the time or be triggered by minimal reductions of the already lowered carbon dioxide tension with only occasional deep breaths such as a sigh or a yawn, without an increase in respiratory rate.

Because of the ability to hyperventilate without a visibly increased respiratory rate, hyperventilators are often unrecognised. In the presence of hyperventilation intracellular shifts of phosphorus quickly cause hypophosphataemia with resulting symptoms that can mimic numerous neurological and psychiatric disorders such as aching all over, malaise, dizziness, parasthesiae, decreased attention span and disorientation.

Intracellular shifts of carbon dioxide and calcium cause decreased extracellular calcium and a rise in the intracellular pH of the neurone. This can cause an increase in the neuronal activity leading to parasthesiae, increased muscle irritability and finally tetany. Striated muscle as well as smooth muscle can be affected.

Recent studies of the effect of hyperventilation on the cardiovascular system have shown that it depends on its duration.[9] Hypocapnic alkalosis induced in normal man by voluntary hyperventilation, produces a reduction in systematic resistance and mean arterial blood pressure with an increase in cardiac output and heart rate. These changes are maximal in one minute, minimal in four minutes and completely absent by seven minutes. As the above changes can be blocked by an antihistamine and not by a beta-blocker, it is suggested that the cardiovascular responses to hyperventilation are mediated by histamine release.

Hyperventilation can cause electrocardiographic changes such as T-wave flattening and Q-T prolongation as a result of respiratory alkalosis. It can also cause a more marked S-T segment depression which may be due to hypoxia. There is evidence that hypocapnic alkalosis from hyperventilation can interfere with myocardial oxygen supply, at least in patients with atherosclerotic artery disease, by producing coronary artery vasoconstriction and increasing oxygen affinity to haemoglobin.

Another feature of the electrocardiogram is the markedly increased incidence of ventricular ectopics. The subjective sensation of a single ectopic is uncomfortable and recurrent ectopics are commonly reported as painful. Five causes of chest pain have been identified in patients who hyperventilate. The commonest type of pain presented by my patients, is a dull aching or soreness of the left or right upper chest wall, which may radiate to the head, neck, back, shoulders, arms. When it spreads to the face or limbs it may be described as a numb feeling and may be difficult to dissociate from parasthesiae developing independently. As a rule, the duration of the pain is quite unlike that of angina. Commonly the discomfort is present for hours at a time and sometimes days. The patient may also complain of sharp stabs often punctuating a dull background pain. Tight, constricting or burning sensations are common. The cause of this first type of pain is muscular and is due to over-use of the upper thoracic respiratory muscles, with subsequent fatigue. In addition, extracellular alkalosis increases the tendency of the skeletal muscle to develop spasms. Firm pressure at costochondral junctions or intercostal spaces locates tender areas, the site of muscular spasm.

A less common cause of chest pain is mechanical from aerophagy which produces sharp stabbing low chest pain, which gets worse on deep breathing and results in rapid but more shallow respiration. It is felt that this pain is caused by pressure on the diaphragm by a distended stomach or spasm of the diaphragm itself.

A third type of pain is reported in the left sub-mammary area and occurs when there is high sympathetic tone and the resultant tachycardia is perceived as heavy and uncomfortable. The forceful adrenergic slap of the heart against the chest wall may produce a tender area at the apex. A fourth variety is due to catecholamine myopathy. Chronic high catecholamine levels may induce small areas of focal necrosis and scarring of the sub-endocardium, increasing left ventricular stiffness, reducing compliance and predispos-

ing to pain and even infarction.[14] The fifth type of pain is true myocardial pain due to ischaemia and can be produced in some hyperventilators by a combination of the Bohr effect and coronary vasoconstriction which decreases coronary blood flow.

Low carbon dioxide levels are also responsible for a selective depression of parasympathetic activity so that the patient presents a picture of sympathetic dominance; dilated pupils, cold hands and feet, palmar and axillary sweating and tachycardia, frequency of micturition etc. With very low carbon dioxide levels these signs disappear.[2]

The gastrointestinal manifestations of hyperventilation are due to mouth breathing and aerophagy, leading to dry mouth, sensation of lump in the throat, bloated abdominal sensations, excessive burping and flatus, and sometimes sharp stabbling low chest pain which gets worse on deep breathing.

Hyperventilation and emotions

In order to explain how I understand the relationship between emotions and hyperventilation, I find it necessary to discuss first a new way of thinking about affects.

The modern view of emotions is that they represent information about the relationship of the person to himself and to others.[17] It is useful to think that the information of emotions is carried by certain affective components.

There is a cognitive element of emotions which guides therapists to pay attention to the meaning of the affect, as well as the story behind it. There is a physiological or expressive or somatic component which refers to the muscular activity and the activation of those parts of the body innervated by the autonomic system. There is also a hedonic element which refers to their quality of pleasure or suffering which lends them their motivating role. However, just having an affect does not mean that the person is aware of having it, and is able to name it and use it as information to himself.

The subjective experience of an emotion that is recognised as part of oneself is called a feeling. One can make the observation that one is experiencing a feeling only if all three components occur simultaneously, and free of blocks that cause isolation or dissociation, and if one is capable of adequate reflective self-awareness, or has the capacity for sensitive self-observation.

Being able to determine and consciously recognise that one is experiencing a feeling, makes it more likely that one will be able to utilise the emotion as a signal and as information about the relationship of the person to himself and to others.

It is the mature adult type of affects that are best suited for signal functions. Such affects are minimal in the intensity of physiological components, and are appropriate to the circumstances in which they arise and, for the most part, they are cognitive. However, the cognitive function of the person and his behaviour can become disorganised in two situations. When the intensity of the emotional arousal is excessive, or when the intensity of the emotional arousal is moderate; but the person has poor tolerance for the emotion and easily disorganised function.

Henry Krystal has developed a theory of emotional development, according to which all affects attain their mature adult form after a lifelong development from affect precursors.[18] The newborn baby experiences emotions as internal tensions which are perceived as diffuse excitement on an undifferentiated sensor-motor level. This very quickly becomes differentiated into two general types of affect precursors: a state of contentment, and of generalised distress. Out of the patterns of contentment and tranquility develop the affects we experience as pleasurable and out of the agitated state of discomfort evolve pain and all the painful emergency affects. The emotions mature along two developmental lines. Affect differentation and affect verbalisation with concommitant de-somatisation.

These affective developments take place in the context of the infant's experience with what Winnicott called a 'good enough' mother.[19] Initially, the child's affective responses to the mother are the only mode of non-verbal communication and they are essentially signals for another person. The development of language and symbolisation is the fundamental event in the development of affect symbolisation. As verbal skills and symbolisation develop, the precision and effectiveness of words demonstrate language to be the preferred way of handling affects. The more precise the recognition of one's feelings, the greater their utility as a signal to oneself. However, since the acquisition of language and symbols is a gradual one, subject to lapse and distortion, many infantile memories have to be viewed as non-symbolic non-verbalisable affect memories. When these primitive pre-verbal affective memories are aroused, their somatic component is very strong and they are felt at a sensor-motor level of experience in a vague undifferentiated regressed form, as physical symptoms. The commonest type of affect regression is the persistence of the somatic aspects of emotions without verbalisation or realisation of their precise nature. This is the area of the mind that Michael Balint has called the 'basic fault'.[20]

Affect regression is not the only reason for experiencing the physiological element of an affect as an illness. Regression in the way of handling affects can be another reason. Affect tolerance, the capacity to have feelings comfortably, involves a variety of resources and actions that make possible the conscious experience of emotions.

People who can comfortably experience a feeling, generally feel secure that their state is justified by their experience; that it makes sense; and that having accomplished its purpose or run its course, it will stop. People who recognise the source and meaning of their intense affects, for

example the reaction following a near accident or in bereavement, are much less likely to engage in maladaptive handling of their affects and the emotion runs its natural short lived course.

People who are afraid of their feelings however, engage in a vicious circle of maladaptive handling of their emotions by becoming angry with themselves or frightened or desperate about having an affect, thus perpetuating it. This difficulty occurs more frequently with painful feelings, but some people develop a fear of all emotions even of being in love or becoming sexually excited.

An emotion that was allowed to overwhelm a person at some earlier time, is subsequently experienced as dangerous and is defended against. In the permanent blocking of affectivity by strong defences, the emotions are experienced as physiological attacks and may break through intermittently. Even recurring periods of depression or anxiety are experienced as attacks. During such attacks, the attacks may not be consciously recognised as such. This subjective experience is the cause of the tendency found in both doctors and their patients to experience their emotions as if they were illnesses. The patient's attitude toward an emotion may compound his difficulties with it. The fear of an affect may set up a self-perpetuating circular reaction such as being afraid of being afraid.[21] Those adults who experience affects as attacks, suspend self-regulatory and self-monitoring functions, especially early in the episode.

In the light of the above knowledge, I understand the hyperventilation syndrome to be a consequence of a maladaptive way of handling affects. When a patient panics about the possibility that his magical powers will make the wish contained in the cognitive element of an affect come true, or dreads being flooded with affect precursors which might overwhelm his rational behaviour and disorganise him, he experiences his affects at a somatic undifferentiated level. Upper thoracic breathing is such a motor undifferentiated emotional expression and very quickly causes symptoms due to carbon dioxide deficiency. The patient focuses his attention on these symptoms so that the message contained in the original affect is lost. Secondary anxiety about the symptoms stimulates more upper thoracic breathing and as the self regulating and self monitoring functions of the individual are suspended the patient becomes locked in a vicious circle.

Case Histories

Patients can develop hyperventilation syndrome during an ongoing therapeutic relationship,[22] or they may present with characteristic symptoms for the first time. When I diagnose hyperventilation syndrome for the first time, I offer the patient three consultations of twenty minute duration each, at weekly intervals because I have found that this is the minimum number of sessions I need in order to deal with both the somatic and emotional aspects of the syndrome. Even though I am pleased that 50 of my patients attended for three or more consultations, I suspect that the reason why 25 patients attended only once, and 25 twice, may be related to their basic difficulty in experiencing feelings. It is also possible that some patients are just content to be reassured that their symptoms are not life threatening.

In the following examples I present the initial three consultations of each case to illustrate my way of handling hyperventilation syndrome.

Claire

The first patient is a 32-year-old woman who wanted to be seen urgently. While she was waiting for me I could her her loud, dry cough from my consulting room. When I invited her in and asked her what the problem was, she told me in an annoyed way and with a hoarse voice, that she had a breathing difficulty. I asked her to describe it to me and she told me between coughing fits that her chest got tight and then she puffed away like mad trying to catch her breath. When asked whether she had any other symptoms, she volunteered that sometimes her heart was 'ticking away' as if it was in her head. Then she was silent.

Because the description of her symptoms, and the dry cough, suggested the possibility of hyperventilation syndrome, I started asking her in a systematic way for the presence of characteristic symptoms from other organ systems. When I asked her whether she felt dizzy, she admitted that she felt dizzy all the time, and the dizziness was worse when she stood up. I asked whether she got pins and needles at her fingertips, and she said that both her hands felt 'tingly'. I asked whether she felt tired, and she said that she felt 'tired all the time'. When she talked to somebody for some time she 'got out of breath', and when she walked or did simple things at home she 'felt tired'. I asked whether she slept well at night, and she said that she slept poorly. She tossed and turned and coughed. She woke up at three every morning, feeling that she could not catch her breath. When asked if she had indigestion, she said that she got heartburn, and had the feeling that there was something in her throat that stopped her from getting air into her lungs; she felt that if she poked her finger into her throat she would dislodge it. She also admitted that she was suffering from headaches, muscle cramps, that she was shaky and irritable and that when she felt dizzy, she sighed a lot and when she felt tired, she yawned a lot.

'Why do I have to drag all this information out of you?' I asked. 'Because I am terrified that you may think I have circulation trouble!' she replied.

After I elicited all these symptoms, I felt that hyperventilation was very likely. I checked her blood pressure, recorded the PEFR and listened to her chest. Everything was normal. I asked her to lie on the couch and observed her breathing pattern which was predominantly upper thoracic. I told her that I had good news for her.

Her symptoms were not due to lung disease or circulation trouble, but rather to carbon dioxide deficiency which was brought on by her chest breathing. I explained to her that chest breathing is emergency breathing. 'It is the kind of breathing we do when we want to run or fight or scream or cry. If we breathe in this way without doing any of these things, then we blow off more carbon dioxide than we need to and we develop frightening symptoms. The way to stop this from happening is to start breathing with your diaphragm. Normal relaxing breathing is diaphragmatic.' I asked if she knew what the diaphragm was, and as she did not, I asked her to imagine that if her chest was a barrel the bottom of the barrel would be her diaphragm. It is a flat muscle that separated her lungs from her gut, it moves up and down and maker her breathe.

'It is about here' I told her. I put my hand on her abdomen and pressed down gently and firmly. 'To breathe with your diaphragm you have to blow your tummy up slowly and push my hand away. Try to breathe in and out slowly at a rate of six breaths per minute.' She tried a few times looking rather incredulous and bewildered. This look in the patient's face is usually a prompt for me to demonstrate the effects of carbon dioxide deficiency by asking her to practise voluntary hyperventilation for three minutes.

After 45 seconds of taking rapid deep breaths, she felt so lightheaded and tired that she had to stop. I told her that if 45 seconds of overbreathing can make her feel so ill, I could imagine how ill she must feel when she breathed like that all the time. Because switching from chest breathing to diaphragmatic breathing can be so difficult, I asked her to come again with a 20-minute appointment the following week in order to do some more work on her problem. In the meantime I asked her to practise diaphragmatic breathing for at least 20 minutes twice a day, in the morning before getting out of bed, and at night before going to sleep. Also at any time when she felt her symptoms were coming on. by the end of the session her hoarseness and persistent dry cough had disappeared and she looked much calmer and intrigued.

When she came back a week later, she started the session by complaining about a little nodule on her cheek. She kept sighing and I asked her whether she felt any better since her last appointment. She made a dismissive gesture with her hand and said that she had a lot on her mind. I urger her to tell me what it was and she said that her father had been admitted to hospital. He had had part of his stomach removed in the past because of some growths that could have turned nasty and because he felt very weak recently, he was admitted to hospital for tests. I asked whether she was close to her father and she said that he used to beat her black and blue and she hated him for that. She was the eldest child and he blamed her for everything.

'What about your mother? I asked; 'did she not protect you?' 'She did not dare,' Claire said. He used to beat her as well. When the NSPCC used to call, her mother used to ask Claire not to tell them that it was her father who caused the bruises because they might take her away from home and from her mother. So she used to tell them that she stumbled and fell downstairs. She used to wish him dead. 'So now if he dies in hospital, will you feel guilty about the death wishes that you had as a child?' I asked.

She told me that when she was 14 years old he fell from a ladder and knocked himself unconscious. When the ambulance came to take him to hospital she remembered saying that she did not mean him to die. 'That means that at the time you were worried that your death wishes might come true,' I commented. She said that she knew that wishes did not come true.

I suggested that perhaps there is a little bit of her that still believed that they might come true. She accepted that she did have a guilty conscience about the death wishes she had towards her father as a child, but she almost simultaneously denied it and she felt confused.

I encouraged her self-observations and told her that I thought she had put her finger on the problem. I asked her when was the last time he beat her and she said that it was just after her wedding when she was eighteen years old. But then, she went on, he is her dad and despite the past she loved him. Of late he had changed and had become a caring father who showed his affection and invited her to his home for barbecues. She would like him to live as long as possible even though she felt that she was robbed of her childhood. She said that she would like very much to help him now but did not know how.

I suggested that perhaps she would like to take over his illness. She looked at me with tears in her eyes. She had thought that she would like to die in his place. She had such a horrible childhood, not a childhood at all. As a mother she had lost her temper with her children a few times, had shouted at them and smacked them, and the thought of becoming cruel like her father was so painful that she wanted to kill herself. When she married she was praying that her husband did not turn out to be like her father. Fortunately he is a wonderful man. One in a million. Very often she wondered why couldn't her father have been in her childhood the way he is now?

I told her that at the moment the problem was that she felt guilty about the death wishes that she had had for her father as a child. If anything happened to her father now she would feel responsible for his death. There is still a little 14-year-old at the back of her mind who still thinks that her wishes can come true. She told me that she had a dream recently in which she dreamt that her mother had died. She woke up screaming and rang home immediately to find out if she was all right. 'You see; even now you are not sure whether your dreams or wishes will come true,' I commented.

'Don't think I'm mad,' she said, 'but some of my dreams have come true. One day I

fell asleep reading, and I heard voices telling me to look in my children's bedroom. I woke up and went to check and found the bedcovers on fire. The corners of the blanket had touched the electric fire. I am trying not to think of anything in case it comes true!'

She said that she did not not want to talk about her childhood because the bad feelings are coming back. Then she took out of her handbag a form for a barium swallow that one of my partners had given her in an attempt to investigate her symptoms. She asked me whether she should go to have the test. Before I had time to answer she tore the form up and said that she did not want to have it done. 'Why not?' I asked; 'are you afraid about what they might find?' 'No,' she said. 'I am not worth bothering about. I am worthless.'

I disagreed with her. I told her that she is a good mother and that it was very important to tell herself that whatever happened to her father, it had nothing to do with her. She could not take his place so that he lives and she dies. She told me that she did not want to see me again because talking about her childhood brought back all the pain. 'On the contrary,' I replied, 'your guilt affects your breathing and it is very important to talk about the way you feel. The more you talk about your feelings the less frightening the symptoms will become. I invited her to come again with another 20-minute appointment a week later.

When she arrived she looked much more composed. She said that she felt a lot better since she started practising diaphragmatic breathing. She did not feel so dizzy but she still felt breathless sometimes, so that all her symptoms could not be due to her breathing difficulty. 'But are you breathing correctly?' I asked. 'Of course! I am breathing exactly as you told me. I am not stupid.'

I asked her to show me, and she lay on the couch and said she felt very self-conscious. She covered her eyes with her hands and giggled nervously. She said that she felt too nervous to do it when somebody was watching. I encouraged her to try and even though she had made great progress since the first time I examined her there was still some thoracic breathing. I stressed how difficult diaphragmatic breathing can be at the beginning, and that regular practice was needed.

She insisted that all her symptoms could not be due to her breathing and I pointed out to her that it was her guilt that affected her breathing. 'I do not feel guilty!' she said. I was astonished at her denial. What about last week's session? Had she forgotten it? I suggested that she might not feel guilty now, but she used to when she was a little girl and wished her father dead. She said that she had a dream the other day. She dreamt that her father died. She was crying, she ran to tell her mother, and then her father got up and he was well.

She rang her father after the dream to make sure that he was all right. 'There you are,' I said. 'This is what the guilt is about. The dream is like the wishes you had as a little girl. You are still afraid that they might come true.' She insisted that she did not feel any guilt about her father's illness at the moment but that it was probably at the back of her mind. Then she told me that when she went home last time, she thought and thought and then she realised that it was her father who should feel guilty, not her. He wrecked her childhood. She used to feel guilty as a child but the guilt belongs to the past.

I told her that it should stay in the past and asked her whether her father felt guilty? She did not think so. Her father had told her mother that out of all her sisters and brothers, it was her life that he had made hell and yet she was the first to help him.

I asked whether he had ever apologised for the misery he caused her and she told him that this was not his style.

As she had improved considerably since I first saw her I did not give her any more appointments, but left it for her to contact me if she wanted to.

Susan

This 37-year-old bank clerk came to see me without an appointment on 17.5.92. She requested an extension of her sick leave because she did not think that her 'chest infection' had cleared and did not feel ready to go back to work. I asked her to describe her symptoms to me and she said that she had a 'terrible, terrible cough and a dry throat', and when she started coughing, it went on until she felt sick. Then when she tried to catch her breath and could not, she panicked because she felt she might choke.

I asked if she had any more symptoms and she volunteered that she had a tight feeling in her chest. I asked her to describe this feeling a little more and she said that she could only breathe in a certain amount. She kept trying to take deep breaths and it felt like a 'horrible tightness in her chest' and her throat became dry. I asked whether she slept well at night? She said that she went to bed at night and woke after a couple of hours with a tickly throat, her chest felt tight and she started coughing. She managed to go back to sleep but sometimes woke again with the same symptoms around three in the morning. She had also been feeling very tired, her abdominal and chest muscles felt achy and she felt dizzy and lightheaded at times and was yawning a lot. She wondered whether her symptoms had anything to do with giving up smoking but as she had given up smoking once before without any symptoms, it was rather unlikely. Then she wondered whether her symptoms could have anything to do with stress? I asked what the stress was and she told me that her place of work in the City was totally destroyed by a massive explosion caused by an IRA bomb on Saturday 24.4.92. When she visited the scene of destruction a few days later and saw the devastation, she went into a state of shock. She realised that if the bomb had exploded during a weekday she would have been killed. Soon after that her symptoms started with a tickly cough.

She described all this in a quiet reserved manner but I could sense her anguish behind her detached faint smile.

I proceeded to examine her. She was very thin with short dark hair. I checked her blood pressure, measured her PEFR and listened to her chest. Everything was normal. I asked her to lie on the couch and observed her respiratory pattern which was obviously upper thoracic. I told her that I did not think she had a chest infection, but rather her symptoms were due to carbon dioxide deficiency brought on by the way she breathed.

I explained to her the hyperventilation syndrome and taught her how to breathe with the diaphragm, as I have described in Claire's case history. She found diaphragmatic breathing very difficult and I invited her to come again next week with a double appointment because it was very important to get it right.

When she came back a week later she told me that she had been practising diaphragmatic breathing which helped to take the sense of suffocation away, but she was not back to normal. She was still coughing and had an ache between her shoulder blades and her throat was still dry. She still had the chest tightness and woke up at around three in the morning coughing and vomiting at the end of a coughing bout.

Sensing there was a great need for psychological management, I asked her to tell me again about her feelings when she went back to her workplace and saw the devastation. She repeated how the bomb went off on Saturday 24.4.92 and that when she went to have a look four days later and saw that everything was destroyed, she went into a state of shock. The thought occurred to her that if the bomb had gone off during the week, she would have been killed because the desk where she worked was totally destroyed. She thought that if she had been killed, her children would have been left without a mother.

I asked if anybody in her family had similar experiences and she denied it. I asked about her mother's health; and she told me that she was 57 years old and well . . . but not her mother's sister. She had had an operation for carcinoma of the ovary in March 1992 and they were told that cancer of the ovary runs in families. Her grandmother died of cancer of the ovary ten years previously and her mother is under observation for an ovarian cyst. Susan had had menstrual irregularities last year . . . she left her sentence unfinished. She did not dare draw the conclusion. 'So you are worried that if the bomb does not get you, the cancer will?' I asked. She told me that one of my partners had already referred her for a gynaecological appointment, but she had not heard from the hospital yet. In the same breath she said that it is stupid to worry about these things; she should push them to the back of her mind and get on with her work. But then she appreciated that she would feel easier in her mind if she knew that there was nothing wrong with her.

I said that it is perfectly understandable to worry about having cancer of the ovary in her circumstances. The destruction she witnessed, brought the fear of dying very close to her awareness. I promised to arrange for an urgent gynaecological appointment and asked her to come and see me again the following week. When she arrived she told me that she felt a lot better, but she was still coughing a little. I sensed that unless her fear of dying from cancer was lifted, her symptoms would not improve. She told me that when she saw the devastation of her workplace by the bomb, she had become aware of her fear that she might die. However it was only when she talked to me that she became aware that it was not the bomb that she was afraid of, but the cancer. Another bomb, so to speak, ticking in her ovaries. She felt that even if they have to take her uterus and ovaries out, she would not mind if it meant living without the fear of developing ovarian cancer.

I gave her the referral letter for the gynaecologist in which I explained her fears and a few weeks later I learned that she had a laparoscopic biopsy for a tubal lesion shown on ultrasound. The result was negative for cancer but in view of her family history she was to be followed up closely with regular tests.

Anna

This 53-year-old security officer came to see me on 22.2.93. She complained with a dramatic expression that she was not feeling well. She looked remote. She was absorbed in her suffering and was sighing frequently. I asked her to describe her symptoms. She said that her cheekbones and her gums were numb and that she had a pain in her left loin. I asked her if she had any more symptoms and she told me that she felt very hot and clammy that day.

As her frequent sighing and panting suggested the possibility of hyperventilation syndrome, I started asking in a systematic way for characteristic symptoms from other organ systems. To my amazement she denied any breathing difficulties despite her panting and sighing; she also denied feeling dizzy and lightheaded, even though she felt faint on standing up. She admitted however, that her heart was racing, that she ached all over, that she had cramps in her calves, and her muscles twitched. She had headaches, blurred vision and her toes felt 'tingly'. She had a dry mouth, a sense of a lump in the throat, a bloated abdomen and she also felt nauseous. She was sleeping poorly and was waking at three in the morning with a sense of fear and tightness in the chest.

At this point I looked at the problem list in her notes and to my amazement I realised that the following day, 23.2.93 was the fifth anniversary of her mother's death. My excitement on recognising the root of her problem got the better of me, and instead of proceeding in a systematic way, I asked her prematurely whether she realised that the following day was the anniversary of her

mother's death. Her tears welled up and overflowed. 'No,' she said; 'I was not aware of that . . . My symptoms are real,' she protested, 'I am not imagining them.' I assured her that I did believe they were real, and that they were caused by carbon dioxide deficiency, which was brought on by the way she breathed.

I asked her to lie down on the couch so that I could demonstrate to her a healthier way of breathing. I explained the hyperventilation syndrome to her, and taught her how to breathe with her diaphragm. She found it very difficult at first, but after some effort she succeeded and felt calmer and more relaxed. As we had run out of time, I asked her to come and see me again the following week with a 20-minute appointment, in order to explore her feelings further, and consolidate the diaphragmatic breathing.

I first met Anna in 1987, when she was very distressed about her demented mother's failing health. I have described this phase of her treatment in a previous paper.[23] The insight I gained then, provided me with an understanding of the circumstances in which her hyperventilation symptoms had developed. Anna used to be frightened of her mother as a child because she was a cruel woman who regularly beat and threatened her children with abandonment. As her mother's dementia progressed and she became unable to live alone, Anna invited her to stay with her own family in the hope that she finally would get the love and warmth that she always longed for from her mother.

Unfortunately as her mother's health declined she became incontinent and even more abusive. Anna was crying all the time and developed a multitude of functional symptoms such as headaches, poor sleep, loss of appetite, loss of weight, generalised aching and also generalised itching which after a while became localised to her pubic area. No remedy helped, and she kept scratching herself until she bled.

Her mother died on 23.2.88 in hospital and Anna felt very guilty because she had given permission to the doctors to give her some pethidene to relieve her terminal agony. This probably made her die sooner than expected and Anna had the feeling that she had killed her. Her symptoms persisted for several weeks and I saw her through this difficult period until they resolved. On the first anniversary of her mother's death only the itching in the hypogastrium and pubic area recurred but on the second anniversary she developed a multitude of symptoms. She felt tired all the time, too exhausted to continue with her work as a pest control officer, she was aching all over and felt nauseous. She was sleeping poorly and felt that her bones were falling to pieces. She complained of all these symptoms in a relentless and dramatic fashion. When Dr Peter Nixon read my paper[23] he pointed out to me that her symptoms suggested the possibility of hyperventilation syndrome.[24] But at the time I was treating her I did not recognise it. As I could not find any evidence of disease on physical examination and laboratory investigations, she accepted my offer of pschotherapeutic help, and came to see me regularly, but as her symptoms were not improving she took advantage of my absence during my summer holidays and went privately to a nature clinic where she started receiving homeopathic treatment, reflexology and aromatherapy. Her therapists attributed her symptoms to poisoning by the chemicals she was using at work as a pest control officer and they advised her to change jobs. Gradually she recovered her sense of well-being and she stopped coming to see me.

All this information was fresh in my mind when she came to see me on the day before the fifth anniversary of her mother's death, and I could not contain my excitement that at last I was able to make the correct diagnosis. When she came a week later she felt a lot better. She did not find the diaphragmatic breathing easy and was worried in case her breathing difficulty might interfere with the supply of oxygen to her brain and cause her to become demented like her mother. I reassured her that her symptoms were caused by lack of carbon dioxide rather than oxygen and were reversible. I noted her fear of becoming like her mother and encouraged her to talk to me about it. She told me that she was so busy with her housework that she had hardly any time to be with her daughter Rachel.

It felt as if she was on a treadmill. She had to change, and wash the curtains, every week, do the ironing, dust and hoover every day, etc. She did not dare leave it for a day because it would only pile up and next day she would have to do double the work. I asked what her mother was like with housework and she said that she was at it all the time. She used to rail at people whose houses were not clean, and used to call them dirty, awful, with no values, etc.

At the end of the consultation I reinforced the diaphragmatic breathing and she told me that she had never been aware of her breathing before. She asked whether she had been breathing with her upper chest before and I admitted that she must have been hyperventilating for a long time but this was the first time it was obvious to me.

I invited her to come once more a week later with a double appointment. When she arrived, she told me that she had felt well enough to return to work, but that she was itching all over – it was driving her 'dulaly'. I examined her and she did have red itchy blotches on her thighs, the small of her back and her armpits. She did not remember having a similar problem around the time of her mother's death, and she told me that she could not believe that all her symptoms were due to her mind.

I asked her whether she ever thought of her mother and she replied, 'all the time . . .' She was afraid of becoming like her mother. The older she gets, the more fastidious she becomes like her mother and the more she looks like her. Even her toes were becoming like her mother's. She was afraid that her mother was taking over. I asked what particular aspect of her mother she dreaded

most and she said that it was her cruelty. Also, losing her temper and losing her mind and becoming demented.

I reassured her that looking like her mother does not necessarily make her behave like her mother. How she behaved was her choice. Even though I did not offer her any more appointments at the end of the third consultation, these sessions were the beginning of a new phase of her treatment. This time I was able to provide the physical treatment myself in the form of relaxation and breathing re-training and she did not feel the need to seek alternative forms of therapy.

Discussion

Patients who present with symptoms of hyperventilation are anxious about the cause of their symptoms, are not aware of their breathing pattern and have no conscious control over it. They feel at the mercy of an alien force that has invaded their body from outside such as a poison or a virus, or that they suffer from a fatal disease which is out of their control. The first step in their management is to elicit all the symptoms they have and their fears about them.

The second step is to examine the patient. This is the most effective reassurance because the patient feels that his fears about physical disease have been taken into account and considered seriously. It is also a safeguard against making a wrong diagnosis. The third step is making the diagnosis and explaining to the patient that his symptoms are real and there is one factor that can explain them all, namely carbon dioxide deficiency. The fourth step is persuading the patient that this is indeed so. The most effective way of going about it is to ask the patient to make himself carbon dioxide deficient in the presence of the doctor by hyperventilating voluntarily for three minutes at a rate of thirty breaths per minute. This manouevre is also a direct way of helping the patient become aware that he plays an active part in the development of his symptoms. Whereas the first four steps of the management deal with the patient's secondary anxiety about the significance of his symptoms, the fifth step begins to address the primary anxiety which is related to the patient's panic about experiencing affects.

The patient panics because of the danger that he might be flooded, overwhelmed and disorganised by affect precursors and re-experience the helplessness he felt during traumatic experiences in his past. Or because he is afraid that his aggressive and sexual wishes contained in the cognitive aspect of the affect will come true which is a residue of omnipotent primary process thinking.

The fifth step involves making the patient aware of his upper chest breathing by pointing out to him his sighing respirations and teaching him to breathe with the diaphragm only. Affects function as constant, but subliminal signals about our life processes and are usually preconscious. Consequently we become aware of an emotion only seldom, when an affect becomes intense enough to force itself into conciousness. Under these circumstances the expressive, that is to say the physiological and motor element of the emotion, may be so impressive that it tends to be equated with the whole affect experience.

At the beginning of our life the ability to develop intense physiological components of emotion far exceeds the ability to register them and it will be a long time before we become able to recognise them as self experiences. It takes the consistent efforts of both parents and all the resources of the child to prevent the infant from being overwhelmed by his affective responses and to enable the child to establish a secure homeostasis by the age of three months. The subjective experience of relief when the intensity of the affect subsides has given use to the discharge metaphor of affect. When we use phrases such as 'expressing affects' or 'ventilating our emotions' there is an implication of riddance, as if emotions were substances inside ourselves which could be discharged or evacuated outside. This is an archaic notion, a residue of primary process thinking or unconscious fantasy, of affect as substance. Schafer has indicated that affects are a self experience and a way of acting and we can know them by referring to their components.[25]

Emotions are always about doing something and they are expressed in action. Affects that have not matured through verbalisation, desomatisation, and differentiation consist mainly of physiological, mimetic and action tendencies and have an imperious quality dominating and sometimes disorganising the conscious sphere of mental functioning. Unlike facial expressions which are specific, motor expressions of emotional states, upper thoracic breathing is one of the non-specific motor expressions of affect.

Expressive motor behaviours associated with emotions should be thought of as action tendencies which if actualised or fully expressed would result in a behaviour in the world. The accompanying physiological arousal is geared to providing whatever physiological support is required for vigorous physical action. When this action is forbidden, when the patient cannot run, fight or otherwise deal with his enemies both internalised and external in any meaningful, self-saving way he remains trapped in a chronically stressed state, in a posture of mobilisation, with all its tissue destructiveness.

As soon as we free ourselves from the notion that we can help our patients express or ventilate their feelings, it follows that the only real help we can offer is to help them increase the tolerance of their emotions, clarify them, and find the courage to own their affects. The experience that one is thinking his own thoughts and feeling his own feelings is the core of subjectivity. It takes indeed the most fundamental type of human courage to own one's affect and give it expression in private internal discourse, let alone in public conversation.[26]

The fifth step in handling hyperventilation

syndrome therefore relates directly to helping the patient tolerate his emotions better by diminishing the intensity of the physiological and motor component of his emotional arousal. I have learned from respiratory physiotherapists that the most effective way of achieving this in the consulting room during a busy surgery is to help the patient change his emotional posture from one of mobilisation to one of tranquility, by encouraging him to change his breathing pattern, from upper thoracic to diaphragmatic.[27,28] Kestenberg uses a similar therapy involving psychological and tactile methods during which patients are instructed to imagine that the physician's touching palm belongs to them as part of their body. She found that this technique activates diaphragmatic breathing, improves circulation and relaxes the muscles. She emphasised that regular diaphragmatic breathing underlies the attitude of trust the infant conveys when he lies happily in his mother's lap. When an adult puts a hand on a trusting baby belly he feels a pleasure. The tummy seems to cuddle into the softly pressing hand. The trustful attitude of stretching toward the other, of going out of one's boundaries, seeking out and melting into another person she called Transensus.[29]

This physical contact between doctor and patient during which the doctor regulates the breathing of the patient is a form of holding, and is founded on the idea of mutual trust between mother and child.[30] It operates in the potential space between mother and infant where fantasy was active and love could be experienced without guilt or shame.[31]

Graeme Taylor[32] helped us understand the nature of that creative potential space between the mother's and the child's psychic reality by drawing our attention to Hofer's discoveries of hidden regulatory processes. Hofer has shown that the early mother/infant relationship is a relatively open system in which some aspects of the infant's physiology, such as heartbeat, breathing, temperature control, growth, movement, etc, are regulated by the mother's actions and what she provides. The baby in turn with his responses influences the behaviour of the mother.[33]

The calm presence of the doctor who is not overwhelmed by the patient's anxiety about the frightening symptoms of carbon dioxide deficiency and his accepting interest in his patient's feelings and ideas, can lead to the sixth step in the handling of hyperventilation syndrome. This consists in helping the patient to identify and name his feelings and recognise them as a self-experience.

Because there is a reciprocal relationship between verbalisation and somatisation, the greater the opportunity to think and talk about feelings with a skilled therapist, the less intense the expressive element could become and the greater the opportunity to acquaint the patient with his emotions as signals to himself, often unpleasant but manageable and essentially self-limiting. Subjectively experienced emotions are the conscious awareness of synthesis of all three components of an affect and they motivate adaptive behaviour rather than cause automatic, reflective action. Charlotte Balkanyi has drawn our attention to the important function of verbalisation which provides thinking with one of its basic secondary mechanisms, i.e. word finding or naming.[34] The linking of a thing to a word presentation corresponding to it, means that by the instrumentality of the word we differentiate the thing from all other presentations; we separate it from its opposite; we distinguish it from similar presentations; and in doing so we exclude the possibility of condensation and of displacement.

Claire: After I elicited all of Claire's physical symptoms and understood them as the result of carbon dioxide deficiency, I was able to diminish her physiological arousal by teaching her diaphragmatic breathing.

Once the somatic accompaniments of her affects subsided she could direct her attention to their cognitive aspects and talk about them. Since her father's recent admission to hospital, her guilty expectation of punishment for the murderous wishes she had for him became accentuated. Because she was afraid however, to experience and think about her emotions in case her murderous fantasies came true in a magical omnipotent way, she handled her feelings by avoiding thinking about them and became involved in a vicious circle of hatred and guilt.

She also became afraid that her physical symptoms were due to a serious illness, her deserved punishment for her murderous thoughts. She had other feelings as well, such as a longing for a better father, and a particularly painful one which was much less verbalised than the hatred and the guilt. This was her sense of worthlessness that one often finds in abused children. It is as if during the years of abuse an impression is formed that to be treated in this degrading way, must mean that they are worthless. She expressed that feeling in tearing the X-ray form in self loathing. One can understand how such feelings can interfere seriously with the patient's self-care.

During our conversation, I helped her to identify and name her feelings. This process also challenged the remnants of her primary process thinking according to which wishes may come true. Following this she was able to start thinking about her feelings on her own, despite experiencing mental pain and she arrived to the adaptive conclusion that the guilty person was the abusing adult and not the abused child.

Susan: When Susan saw the destruction caused by the bomb, she equated unconsciously her death with the devastation of her workplace and she anticipated a premature, absurd and unacceptable death. The fear that she might have died in the explosion and left her children motherless overshadowed briefly a more unbearable fear that her own mother and herself might die of cancer of the ovary so that both she and her own children might be left motherless. This fear was so strong that it threatened to overwhelm her, and was expressed

in physical symptoms. Her preoccupation with the physical symptoms distracted her from becoming aware of the real danger and encouraged a move towards developing a phobic avoidance of her workplace.[34] My ability to tolerate the patient's fear of death and reflect on the feelings they arouse in me, is essential for engaging in this type of conversation.[35] As soon as I helped her to reduce the intensity of her physical symptoms she became able to discover and tolerate her fear of dying from cancer of the ovary so that we could talk about it openly. This led to adaptive action and realistic management of her gynaecological problem.

Anna: Even though Anna could talk of her fear of becoming like her mother, her behaviour betrayed that she remained identified with her. Identifying with her aggressive mother ensured that separation from her and mourning was impossible. If mourning is to proceed successfully, the two components of grief, anger and sorrow must be experienced and integrated.[36] If the tender feeling of sorrow for losing the loved person is going to have a chance of being felt, the anger for being abandoned must be experienced first. Anna, unlike Claire, was not aware of her hatred for her abusive parent. She was trapped in an impossible situation. To separate from her mother and develop her own identity would involve experiencing the long suppressed hatred whose intensity threatened to overwhelm her and disorganise her. To remain identified with her mother, exposed her to the danger of becoming her mother and therefore losing her identity, losing her temper and her mind, becoming demented and disintegrated. These fears are very close to the fear of going mad and therefore she found the possibility that her symptoms were due to the mind, terrifying. She was desperate to find a physical explanation and treatment for them. One of her symptoms was intense generalised itching which became soon localised at the hypogastrium. Winnicott has stressed the psychological significance of chronic skin irritation which, in emphasising the limiting membrance of the body and therefore of the personality, defends against the threat of disintegration, depersonalisation and loss of identity.[37]

A very interesting interplay between psychological and organic factors, is suggested when we bear in mind that hyperventilation provokes an increase in histamine production and is associated with an increase of allergic manifestations.[4]

In retrospect I wonder whether she would have needed to seek physical treatment in the form of homeopathy, reflexology and aromatherapy in 1990, had I been able to diagnose and treat her physical symptoms myself in the way I described in this paper.

Conclusion

In conclusion, I understand hyperventilation syndrome to be the consequence of a maladaptive behaviour in which the patient handles his affect in a certain way that leads to a vicious circle. It would appear that at least three affective states underlie the irregular upper thoracic breathing that causes carbon dioxide deficiency: an affect that threatens to overwhelm the patient, primary anxiety about having this affect, and secondary anxiety about the significance of the carbon dioxide deficiency symptoms. Upper thoracic breathing is their undifferentiated non-specific motor expression.

The aim of my treatment is to break this vicious circle by addressing all three affective states in six consecutive steps, starting from the most easily accessible secondary anxiety and working towards the original threatening affect. A most important feature of my work is the use of physical touch in order to regulate my patient's breathing and change it from an emergency upper thoracic pattern to a relaxing diaphragmatic pattern. This approach creates in a direct and immediate way an atmosphere of trust and safety. It also minimises the intensity of the frightening physical symptoms and gives the patient a sense of control over his body.

In the safety of this new environment, there is much more chance for the patient not only to identify but also to verbalise his affects. In this way, feeling may be synthesised from its purely physical components to become a psychological experience. Once the person becomes aware of the feeling he should be in a position to take better care of himself.

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Pain in the Doctor/Patient Relationship*

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I know I am alive when I feel pain. In my work, I am so bowed down by pressure of time that several times a day I feel like an animal at bay. My feelings are held rigidly in a nameless box in my chest; it is strange that chest also means a box in which we store items that are seldom used; there is a connotation of fear at opening such a chest; terror at what may fly out. Sometimes, a patient's pain forks through the lid of my box and I dip into the spring of my compassion: then I know that I am alive, and that I am a doctor who can feel for her patient, although I am a general practitioner in the 1990s: a phenomenon which journalists and medical politicians describe and re-describe in appalled tones, in every publication which I pick up. The 1990s general practitioner *is* an animal at bay; the glinting teeth of the threatening encircling hounds, the slavering snapping deafening jaws are the demands, the Dictats which tell us to do this and not to do that; the researchers who find that our Health Promotion programmes which we have reluctantly, and then slavishly, devoted months to perfecting, are utterly useless; patients who have studied the *Patients' Charter* and believe that *Care in the Community* is a properly-funded reality; the Government massacring the loved and valued National Health Service in the face of our impotence. We hear of doctors who are murdered or attacked by their patients, and others who have killed themselves in despair.

There we sit in the consulting room, and the next patient walks through the door. Most are bringing pain to the doctor, and each patient paints his pain with his own particular brush, from the myriad hues and facets of the spectrum of distress.

I see from the pile of patients' notes on my desk that the next patient is Mrs France, a widow in her seventies, who is probably coming in for a repeat prescription for her painful knee, one amongst the usual small assortment of afflictions which life has visited on a person of her age. What do I do about her pain? It is not life-threatening, but it is nagging at her every turn and intention. Her own attitude to her pain is what colours my attitude to her pain; on a good day I am tuned in to her view of her pain as much as to the pain itself. As she is an accepting and uncomplaining soul, the salve a for general practitioner's time problem, I feel a wave of gratitude and affection and allow myself a few moments to show this, and to share in her life. She is short and plump, with a rosy Punch and Judy face, and is wearing her new wig for me to admire, as promised. She says, 'you remember, doctor, when you visited me that freezing night and sent me in to hospital with the jaundice? Well I really thought that I was going to kick the bucket! But I'm glad I didn't – the spring weather is so lovely, and there's plenty to get on with in the garden . . .' I feel the leavening of my spirits, and laugh with her and her pleasure. We both feel better for our encounter; the pain has been acknowledged and cared for, but we also know about joy.

The next patient paints from the black end of the spectrum. Also a widow, also in her seventies, also afflicted with arthritis; tall, thin, with snow-white hair, Mrs Wynne wrings every drop of black from her brush, taking my spirits with her if I succumb. My dear Trainer used to say of such patients, when he spotted their notes at the top of the pile, 'I want to climb under my desk right now.'

The difference between Mrs France's and Mrs Wynne's pain, their attitude to their pain, their ways of living while experiencing the pain, the content of what they say about the pain when they meet a neighbour in the supermarket or when they walk into the doctor's consulting room, may have started when their mothers held them 70 years ago. I am today's mother.

Mrs Wynne's mother may not have been present, or able to hold her baby's pain, and Mrs Wynne has become a person who, down all the years, makes it difficult for me not to want to reject her. It is one of our saddest paradoxes, that the baby who has not been held, and therefore needs more than ever to be held, becomes more and more impossible to hold. She has become the proverbial 'heartsink' patient; someone perceived as a bottomless pit of squandered caring. She cannot use my attempts to share her pain and her feelings about pain. Her eyes narrow with suspicion at the mention of help from the psychologist who works in the practice; it is far too painful to contemplate letting go of the certainty and centrality of her pain and being delivered up to the vagaries of life without a theme.

The next patient has had a good British upbringing, and says when asked how he is, 'Ah well, mustn't complain . . .' I usually invite such patients *to* complain, unless I am *in extremis* for time, but they have often mislaid the key which unlocks the complaints box, and literally *cannot* complain. They and their forebears have endured, in true British style, centuries of unpredictable, hope-drenching weather, deprivation, wars, losses, without ever once giving vent to the howls of pain which Italians treat themselves to daily, for much lesser events such as traffic jams. Ironically, I think I became a doctor in order to hold myself, and to hold my mother, who was not able to see pain in her child, and love it better as some mothers can. I look at a photograph of myself aged five, with my dear friend Margie, in

*The Balint Society Prize Essay, 1994.

a garden far away. We have constructed an efficient field hospital using garden chairs, and she is my patient, lying under a snowy blanket. I look into my five-year-old eyes, and see the competence, the self-care, the decision to become a doctor already present, excluding the mother who says 'Goodness, you are a fuss-pot!' when I wince at the raw antiseptic she applies to a wound on my foot. Although I never stopped hoping, and indeed appealing, to be helped lovingly when in pain or despair, and although my mother was a richly wonderful mother in so many ways, her well of compassion iced over in the face of pain in her children or her husband. She would say, 'people who talk about suicide are not worth bothering about!' If I said that I felt depressed, she would say, 'think about other people!' or 'you haven't got enough work to do, that's all.'

It is, of course, widely known that many doctors have chosen doctoring in order to care for their own pain. Perhaps the high rate of depression and suicide among doctors results not so much from the pressures of work as from a second failure to be taken care of.

After morning surgery recently, I was describing to my partner how a patient's story had affected me. She was a young woman of African origin, and she had just come out of hospital, having miscarried her first pregnancy. While writing out a certificate for her employer, I asked her how she was feeling. She simply said, 'Very sad,' and I could see that she could not go on. I suddenly found that I also could not go on; the threat was only tears, but in the context of a busy Monday morning surgery, tears are not welcome. I managed to convey my wish to help, and to see her at a less pressured time, and wept a little after she had left the room.

My partner looked surprised when I told him how overwhelmed I had felt; then he said, 'Oh well, I suppose it is better to cry tears outwardly rather than inwardly, and end up having a heart attack!' I felt comforted, and kept this wisdom. I also realised that the pain of loss was one of my own deepest distresses.

We puzzle endlessly about why French and Italian people have fewer heart attacks than British people; we promote the 'Mediterranean Diet' as the ideal, and postulate that the wine and garlic somehow help to prevent coronary disease. Perhaps the accompaniments to the wine and garlic, namely the loud voices, the uncensored body movements and flailing of arms in the expression of feelins and pain, are what truly keep the French arteries unclogged, whereas ours are allowed to silt slowly from birth, as we are taught not to inconvenience the world with our pain. What is the English Disease? Not chronic bronchitis, but a culture in which people insult us and we do not complain; our neighbour lets his dog deposit a huge turd in our driveway and quietly we scoop it up although it makes us retch; loved ones die and we do not fuss; partners desert us and we show how calmly we can get over it; a doctor tells us that we have cancer and we do not howl or move our still bodies in protest. Health Promotion could include shouting and gesticulation clinics, encouragement to 'behave like an Italian in a traffic jam', when life causes us pain.

I have some difficulty allowing my patients to express pain, because I am afraid that my own pain will be activated, and overwhelm both of us. It is so much easier to attend to the practical details.

Sally was a vivacious intelligent violinist in her fifties, who used to come to the surgery regularly for her antihypertensive medication. Once she mentioned that her husband had committed suicide many years earlier, but her whole demeanour was of one who was 'getting on with life regardless'. She suddenly found herself unable to find words, and then to read music, and the neurologist who saw her diagnosed cerebral secondaries from an unknown primary malignancy. She underwent brain surgery, and when I visited her after her discharge from hospital, she was sitting in her sunny sitting-room, the yellow spring garden beyond the French windows, with her two daughters who had moved in to take care of her. Her face was moon-shaped from steroids, her head was half-shaved, she had very little strength or movement in her right arm and leg and she could hardly find one word to convey meaning. She said quite a lot, but her words meant something else. Her hands and her shoulders, and her facial expression, said 'look how I find myself! How has this happened?' She would tail off sentences with the word 'ridiculous', and gesture with her empty palms upwards, expressing untold loss. What did we do, we three, who had speech, hearing and movement in full measure? We entered on a discussion of the minutiae of the tablets which were ranged in the centre of the table: what each one was for, when and how they should be taken, placing our faith for the future in the small, mute brown bottles. We made cheering comments to Sally; I told her that she would soon be sitting in the warm sunshine in the spring garden, that her speech would improve greatly with the intelligent help of her daughters and the speech therapist, and that her limb strength would surely increase with physiotherapy, although the fine movements and strength required to play the violin were not likely to be restored. I discovered that she had few friends, as she had been so busy with her music. Her every gesture conveyed the question, 'what sort of future have I got?' but even then Sally was putting on a brave face, smiling and laughing at the absurdity of it all. There was so much pain in that room, but no-one shed a tear. I did try to give her sorrow words a few times, by saying how devastated she must feel, and possibly how angry too, but it was difficult for me to sustain this under her gaze, and I know that we did not explore her pain nearly adequately. I saw how all three of them were looking to me for hope, and I allowed myself to take the easier option of cheering them. This pattern continued on subsequent visits.

Sally had a stormy few months. At first her speech did improve enormously, and she was able to express herself in clear sentences, apart from the odd word which would find its way in from another context. She was able to enjoy the garden and outings; there were the usual hospital visits, with shunts from one department to another.

In the summer her daughters decided to take her to a much-loved spot in France for a week. She had major convulsions while on the cross-channel ferry, was treated by a French doctor and returned home with worse paralysis. I discussed her care with the registrar at the Hospice, and she agreed to visit Sally the next morning. During my surgery on that morning, her daughter Clare phoned to say that she thought Sally had taken all her tablets, including a large number of paracetamols. I found this hard to believe, given her paralysis, and asked Clare to go and ask her mother whether she had taken them, and to look around the bed and floor for spilled tablets. She came back to say 'Yes, Mum says that she did take them'.

Before I had decided what to do, the Hospice registrar arrived at Sally's house, as arranged and admitted her without delay. Sally died a few days later; her death was not thought to be due to the ingestion of the tablets, but to her widespread metastatic disease, and at postmortem the primary tumour was found to be in her thyroid gland.

A friend of mine who is a doctor, and the most compassionate man I know, works with patients who have endured experiences of bereavement and trauma beyond those we usually hear about; torture, witnessing murder of family members, rape by faceless brutalising intruders.

This doctor's compassion was palpable when I met him in 1981; at that time he was a senior house officer in medicine, and one of his great pleasures was to transport a patient or two from the geriatric ward down to the pub at lunch-time, sometimes by wheelchair, for a drink and a chat. When he talked to be about the patients in an African war-zone where he had been working, and described the children whose limbs had been blasted off by landmines, tears stood in his eyes and outrage lived in his voice. That outrage has never left him, and he has become an active human rights worker and writer in addition to his work with patients.

During the last few years, he has puzzled me by saying that he feels doubtful about how much patients really benefit from their sessions with a doctor, and whether it is of any real relevance that the carer *is* a doctor. He feels this very strongly, despite the fact that some patients have said that he is the only person who has really been able to help them. These patients are all carrying a burden of pain beyond that in a usual life, and they bring their pain to this doctor, and he feels constantly uncertain that his work with them will help them substantially.

I began to wonder whether his doubts arose form his own reluctance to seek help; he has never allowed himself the trust to place his own pain about his own life in front of another doctor or therapist; he has never experienced the relief of pain which is given through good, careful, caring help. He is, quite fiercely, his own carer, and when I asked tentatively about his mother's responses to his early illnesses and hurts, he had no very clear memory of these but thought it possible that he had not felt able to trust in her capacity to relieve his pain. He does remember that when his father, to whom he felt very drawn and very close, died, he did not weep at all, but steadfastly kept to unchanged behaviour and reading and reading throughout the bereavement.

When pain has become hard to bear in my own life, I have found myself very actively seeking help.

Although my mother was not able to meet this need, I have fortunately never lost the belief, which has been reinforced by later experience, that my pain can be eased.

Two years ago, I was in some despair about my life. I have my own general practice, and the treadmill had become quite terrifying. I could not see any way to help myself; I had delegated work as far as I was able, and still the blackness in the tunnel continued unlit.

I had undergone many years of psychoanalysis, which I felt had strengthened me rather than deeply relieved me of pain, probably because I always somehow retained a sense that the analyst did not *care* sufficiently; this problem may be inherent in the analytic technique and in the analyst's demeanour as well as in my own baby experience, but this feeling blunted my trust, and disabled the process significantly. I did not want to go back for more.

As so much of my anguish seemed to be centered in my work, my sister asked if it would be helpful for me to talk to a general practitioner she had met, who seemed to enjoy his work, and who had found ways of organising leisure and work in a healthy balance. He kindly agree to meet me, and we talked about my feelings of entrapment, and my intrusive migraines; we also touched on some family pain following divorce five years previously. This doctor had eyes and a soul that saw all the pain, and did not turn aside from it. He agreed to see me again. He left me with the words, 'You don't need help with practice organisation, you need help to understand and deal with your feelings, particularly anger.' My analyst had seldom if ever mentioned anger, and I certainly did not regard myself as an angry person, so I started thinking about this as I went about my life.

I continued to see him about once a month, and experienced the bliss, for there is no other word for it, of absolute trust. Together we could think about the nasty bad feelings as well as the good. His manner was above all gentle, and I had no difficulty in believing that he really really *cared* about me. I cried, which I had never done

in my analysis, and we also laughed; when I thought about him between sessions, I would find myself smiling, sometimes with tears. I have learned so many things from him, and have applied so many of the things I have learned, both in my work and in my personal life. I feel well. I still see him about once a month; it is sometimes very hard to wait, but I have many tools for bad days.

All doctors know of the real and particular difficulties of being a doctor and at the same time a patient. But if a doctor is fortunate enough to have his own pain attended to as I have, he may develop deeper security in his capacity to help his patients' pain. John Berger's A Fortunate Man,[11] was a country general practitioner who suffered bouts of appalling depression and ultimately committed suicide. It seems that he would at times confide in a few known and trusted patients when he was feeling almost crippled by depression. He said, 'Whenever I am reminded of death – and it happens every day – I think of my own, and this makes me try to work harder'. I feel very sad when I read this, and wish that he could have sought and found a doctor, or therapist, who may have helped him with his pain.

There is also a great deal of help, comfort and inspiration to be derived from working in a Balint-group, and from reading Balint's [1,2] and later writings [3,4,5,6,7,8,9,10]. A friend of mine who works as a community paediatrician commented that the experience of being in a group with Michael Balint when she was a medical student in the early sixties, has continuously influenced her interaction with parents and children over the past thirty years. She acknowledges that he was *the* teacher who changed her approach to medical practice, and enabled her to ask meaningful questions.

I know that when a patient comes to me with pain, a careful physical examination, preferably with the patient lying down and relaxed, is therapeutic in itself; if I note that a patient hyperventilates, placing my hand gently on the abdomen, together with the patient's hand, and beginning to teach diaphragmatic or abdominal breathing, bonds us both in caring, to address the deeper feelings when appropriate.

The avenue of touch is used extensively, and very successfully, by a wide range of therapists, who use massage, reflexology, balancing, as well as osteopathy and physiotherapy, to provide access to the patient's pain *and* feelings. Practising medicine in the conventional way, I feel increasingly that our range of approaches is quite limited, and weighted on the diagnostic side, and deprived of many pathways for healing pain.

Some of the pain in the doctor/patient relationship which is hardest to think about, is that which arises when things go wrong in the relationship. This happens most frequently for me when a patient asks me to do something that I cannot, or do not want to do. It hangs in the air between us, and I usually relent rather than resolve the conflict.

I am fairly obsessional, and bless patients who are, at least in part, in control of their lives, who think ahead. I have more of a struggle with patients who live chaotic lives, who do not know whether or why they are pregnant, who take drugs, who request immediate completion of time-consuming reports; with the woman who complained irritably that she was 'too busy trying to run a business' to accompany her eighty-six-year-old demented father to the Casualty Department but instantly implied that I was callous when I offered to send him by ambulance. Perhaps she hoped that I wasn't 'too busy trying to run a business' and would accompany him myself – if so, she must be blissfully unaware of the National Health Service 'reforms' with Business Plans and Charters!

I can recall four patients who have told me outright that an action of mine has upset or annoyed them, and each time I have found it extremely uncomfortable, and needed to mull over the interaction for longer than expected.

One was Miss Meeser, who presented with a tumour just above the symphysis pubis. It was protruding visibly, like a knobbly grapefruit, and she regarded it with the absolute indifference, having been watching it enlarge. I arranged an immediate surgical referral and attempted to answer her questions which mainly revolved around arrangements for her convalescence, because she wanted to exclude all her relatives, whom she disliked. During this discussion I said that there was a possibility that this was a malignant growth. The surgeon telephoned me immediately after examining her to confirm that he was certain that the mass was malignant, but in the event it was a benign, though bizarre, tumour.

She came to the surgery some time later, and said that she thought I had been brutal in telling her that the tumour could be malignant. She said that patients had a right to know about such things, but that patients also had a right *not* to know.

I don't think that I took her point with grace, and I tried to explain why I had felt the need to warn her, calling the surgeon's conviction of cancer to my defence. I expected her to leave my list after this episode, but she did not.

Recently, a young man came in to see me after registering and having a Health Check with the nurse. He said that he had had surgery for a rare condition, familial hyperparathyroidism, and gave me the name of the tablets he was taking, requesting a prescription. While I was looking up the tablets, which were not familiar to me, in the Formulary, he said, 'Have you ever heard of hyperparathyroidism?', and again, 'Surely you know about hyperparathyroidism, don't you?. This needling happened to take me back to an occasion when, as a medical student, I had endured a grilling at the Open Clinical of the hospital, by a brutish consultant who was enjoying his power to humiliate, on the subject of hyperparathyroidism! I refused to be drawn by

this patient, and as he was leaving, he said, 'With respect, I have never been treated so curtly by a doctor!' I should probably have replied, 'With respect, I have never been needled so by a patient', but in the event, I simply said, 'Oh', and he left. I noted that he was a barrister in training! He has, indeed, been importunate on further occasions, demanding to be seen after surgery hours, and I worry about his presence on my list. We do not have a good, comfortable doctor/patient relationship, although recently we became a little easier with each other when he had an episode of illness which involved my caring for him physically, examining him carefully, and seeing him on several consecutive days.

Mr Clarkson, a patient with whom I have seemingly had a good relationship for many years, recently asked to see an insurance report, in relation to a mortgage application, which I had completed on his behalf. He read the report and then asked to see me. He told me that he was angry because I had answered one of the questions regarding a referral to our practice psychologist, as being provided for 'personal stress'. I had used this term to include his recent divorce, which I had not specifically mentioned to protect his privacy. He said that the insurance company knew all about his divorce anyway, because that is obviously why he was applying for a mortgage! I felt that 'anger' was a very strong term to apply to my choice of words, but he told me that he is a Counsellor himself, and therefore in touch with his feelings. I did, of course, alter the report to read 'recent divorce' rather than 'personal stress', and he seemed quite content with this, and proceeded to thank me at some length for my care over the years, as he was moving away and would have to change to a new general practitioner. I saw him in the Supermarket the following Saturday, and we smiled a greeting. But the word 'anger' still sits in the air between us, for me at least.

The fourth patient was a well-known artist in her seventies, whose lifelong heavy smoking eventually produced a probable lung cancer, visible on her chest X-ray. I invited her to the surgery after hours, to talk about the diagnosis and the options, and to arrange a referral as she wished. We had coffee together and spoke at length about the likelihood that she had cancer, and about her feelings. She had few friends. I gave her my home telephone number and invited her to phone me if she wished to, and she did so two days later, on a Saturday morning. We talked again, and I mentioned that, by coincidence, I had noticed a long article in the Saturday colour supplement of the newspaper, by a writer who had lung cancer, describing his experiences of treatment. I said that I had not read the article yet, but she was very keen to pop out and buy the paper. A few days later I received a typed letter from her, saying that she was 'not at all grateful' for my suggestion that she read the article, because it had only served to upset her, and in any case it was not certain that she even *had* cancer.

Her cancer was subsequently diagnosed with certainty, and operated on, and after a while she changed to another local general practitioner, writing to say that she had no reason to fault my care, but that it was a case of 'personality differences'.

What have I learned from these direct complaints, made by patients courageous enough to face me with their pain? And what of Sally, who died with thyroid cancer and secondaries, her emotional pain not cared for? How far can I change my reception of open criticism? As far as my own pain is concerned, I think I will always need to go away and lick my wounds, talk it over with a friend or colleague, and then come back to it with the patient.

Miss Meeser was right in saying that a patient has a right not to know, and it was probably my own horror at her self-neglect which blunted my sensitivity to her needs.

The young barrister in training was right that I had treated him curtly, although there may have been good cause on this occasion, but his comment pulled me up to remind me how often I get away with curt behaviour towards patients, especially when I am feeling rushed or out of harmony in my own life; I can only tell myself, again, that no doctor, ever, has a right to treat patients in this way, and try to keep this knowledge always presents in my mind (but forgive myself if I sometimes fall down on perfection).

My act which angered Mr Clarkson was, in my view, a difference of emphasis, and did not justify anger, but I accept that 'stress' must carry more frightening implications for him than I had realised.

I was interested to hear from my neighbouring general practitioner that my artist patient with the lung cancer and the grievances has become one of her 'heartsink' patients; I know that being her doctor would always entail negotiating a minefield, and I am not sorry to be relieved of her care, although I was hurt by her leaving my list.

My dying patients; I need time for them, and may need to use time after Surgery, however impossible this feels in the face of the Paper Mountain. I have a patient at the moment who has cancer of the pancreas, and whose pain and jaundice are overtaking my attempts to talk to him about what is happening, especially as he has always been a loner, and dismissive of close enquiry. But I am managing to give him time, to think together about his situation and his feelings about his care.

I started this essay, 'I know I am alive when I feel pain'. I will end by saying that I know I am alive when I feel joy. Perhaps one year we can be invited to write on 'Joy in the Doctor/Patient Relationship'.

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The Balint Society Prize Essay, 1995

The Council of the Balint Society will award a prize of £250.00 for the best essay on *Joy in the doctor/patient relationship.*

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume,* and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

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

The prizewinners will be announced at the 26th Annual General Meeting in 1995.

Entries must be received by 1st April, 1995, and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS

Encounter with a Patient*

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In this essay I have attempted to describe an encounter with a patient, Peter and his partner Angela that took place during spring of last year. I have first outlined my recollection of the relationship and then moved on to discuss my reactions to it.
Peter was admitted to hospital under the care of a general surgeon after gastric cancer was diagnosed with the help of endoscopy. This had followed a period of illness where Peter had felt increasingly tired and lost weight.
The description has been made from memory and I have attempted to remain as faithful as possible to what actually happened. In so doing I have attempted to avoid journalistic licence or poetic excess, so some of the description may seem a little mundane. I have not included any detail that does not somehow help to reflect the essence of our encounter or the changes it invoked in me.
Memory may have coloured some of the incidents but I hope not many.
Names of the individuals involved have been changed.

Peter and I met for the first time one evening in May. It was the evening before the first major operation of his life. It was the second week of my first surgery rotation in my first clinical year. The registrar had told me that there was a gastrectomy in bed eleven and I might like to see him before surgery the next day. Peter was lying on the bed, fully clad reading a magazine. He was an amiable looking man in early middle age, rather thin with a worried look between smiles. He spoke with an accent I could not place but he later told me that he was born and had grown up in England but had lived in Canada for many years. He seemed curious and amused that he had engaged the attention of a medical student. I also suspected he was rather bored as he seemed keen to participate in what ever it was that students were supposed to do. As I began to explain to him the manner of student history taking and examination, his wife Angela appeared with some take out cappuccino coffee and profiteroles. She immediately struck me as an energetic individual, some years younger than Peter, perhaps in her mid to late thirties. Seeing that her visit had a sense of occasion I offered to take my leave. I asked Peter if I could see him tomorrow morning and with a warm nonchalance he agreed.

I arrived as promised the next morning at 8.30 a.m. Peter was less at ease than the night before but he remained agreeable to indulging me in the opportunity of a student clerking. He did warn me however that Angela was coming to see him on her way to work and he would appreciate it if I could leave when she appeared as she did not have much time. So I began with his history and then as I was about to begin to examine him Angela appeared. Seeming to contradict his earlier condition he suggested to Angela that as I had been turned away yesterday evening I might be allowed to continue. She conceded this. So imposing on their private time and with my self consciousness increased I conducted a hasty abdominal examination.

As I neared the end of my routine they began to ask questions about what I was doing and why. At first the questions were straightforward enough but soon we were immersed in conversation around Peter's illness at many levels ranging from personal experience to causality and blame. Angela, whose expressiveness contrasted with Peter's reticence, was at pains to assure me that she and Peter had always eaten a good diet and Peter had always been capable of expressing his emotions. 'We have read that people who do not express their emotions can get this, can bad diet cause it?' I side-stepped the issue feeling overwhelmed and out of my depth and tried to bring us back to the here and now.

'Well at least it has been detected early with the endoscopy so if we operate now there will be a good chance of getting rid of . . . . .' I hesitated.

'Of the cancer?' Peter offered and smiled kindly.

'Yes' I said, irritated by my own caution of directness with two alarmingly frank people.

This had taken place before 9.00 a.m. Within a few minutes of beginning a routine student clerking I had found myself in the whirlpool of two other people's emotional distress and then being called upon to explain the cause of disease and misfortune and perhaps pass comment on the moral worth of the people involved. Although these themes were only briefly mentioned I was unaware that morning that they would form the substance of much of our subsequent conversations.

I remember suddenly finding myself being quite annoyed at the suggestion that Peter may have been somehow blameworthy and wanted to reassure him that this was surely not the case. In short I found myself quite confused about what I actually thought. Our discussion was rapidly diverging into all manner of themes and onto all kind of levels. Then suddenly I remembered Peter's gentle hint earlier that his time this morning was not all hospital property. I made my exit saying to Peter that I would be in the theatre and would see him there. 'Will I see you?' he sniggered, once again managing to trip me up.

I explained that I would probably see him just before his operation in the anaesthetic room, if not, then on the ward afterwards.

I was not able to see Peter in the anaesthetic room as I had been delayed in a clinic. The

*Essay awarded 1st prize by the Foundation for Psychosomatic and Social Medicine, Ascona, 1994.

operation had began and a sub-total gastrectomy was soon under way. I was not actually scrubbed up for the operation as the registrar and house officer were present and wishing to assist the consultant, Mr Walters. The consultant had decided to try and keep me occupied, perhaps because floating observers can be a little irritating. When the stomach was removed it was handed from the table to me and Mr Walters asked me to dissect out the tumour. I remember feeling the warmth through my gloves and as I opened the stomach along the lesser curvature, the tumour was revealed, about the size of a fifty pence piece. I remember also how hard it felt. I completed the dissection and the specimen was sent off to Histology.

As the operation progressed, it became evident that several lymph nodes were affected. These were also removed and sent off to Histology. I clearly recall at this stage that the glib camaraderie and repartee between members of the surgical team quickly seemed to dry up. The mood then began to vacillate between irritation and sullenness. Perhaps at this point the poignancy of an active man in his early 50s with a wife twelve years younger than himself had begun to settle over the team. Gone too was the optimism that they had managed to transmit to Peter and Angela.

I saw Peter the next day in the special observation area of the ward. He said he was experiencing far less pain than he had expected. He was pleased that the anaesthetist had agreed to site an epidural. Beyond these details, Peter did not seem very keen to dwell on his present predicament, he seemed to want to talk, but of things other than his illness. I already knew that he worked as an accountant and that until about a year ago, he and Angela had been living in Canada. They had come to England so that Angela could work on an epidemiological project. Two days later I was on in the hospital fairly late in the evening. My surgical team was 'on take', receiving emergency referrals. All was quiet so I called into the ward to see Peter. He was lying in bed with the sheets pulled up to his face in an almost foetal position, or as much as his wound would allow. His face was moist and he was shivering, and said he was cold. I asked if I could help. The nurses were busy, but I fould out that the house officer had been contacted and told of Peter's condition. I fetched a blanket to cover him and stayed, resting my hand on his shoulder, and wondered what else I could do. We talked, our conversation flitting between fear and death and what was becoming our own special brand of small talk and diversion. It turned out that Peter and Angela had a flat around the corner from the house where I had lodgings. At first, I felt I should be more purposeful with the conversation but I refrained and let Peter determine the course.

When we returned to talking of death, Peter said that he knew that the operation had been successful and he was trying to 'focus' on this and exclude other worries from his mind for the time being. However tonight he could not do this. He told me that Angela was very religious, a committed Christian and this gave her a great deal of certainty in belief about existence after death. Peter said that he was unable to share her faith and had no recourse to such comforting certainty.

At first I wondered if he wanted to talk to see if we could find any reassuring ideas about death and the hereafter. A little conversation revealed that this was not what Peter wanted to dwell on though it was important to him. He tentatively ventured that he could cope with the idea of his having the disease whilst those around him were well. But his having the disease and the uncertainty whilst others had health and faith seemed doubly unfair. It seemed unsurprising that he should focus his reluctant resentment on those closest to him. However this seemed to cause him great guilt as he knew that Angela was under much pressure to seem positive and cheerful when she visited. He knew that whatever help Angela's religion gave her, she must have been frightened and anguished too.

I had little religion or any great certainties to offer Peter. What I could offer at the moment of terrible aloneness that he was experiencing was some fleeting companionship in his doubts and some help to pace his thoughts, so that he could try to work through them without panic setting in. Peter was worried too about how his illness would affect their physical relationship. Would Angela still want to make love with him? I remember trying to persuade Peter that their relationship was obviously of great depth and what there had been before, there would probably be after. Either way, help and advice would be available if they wished for it. This conversation reminded me in later dealing with Peter to try to reassure him about his own view of his body and self after surgery.

I had stayed for a while and Peter had seemed to tire so I left him to rest. On the short walk home in the May evening rain, I pondered on what had taken place. It seemed in the quiet of the evening, with his morale dented by the onset of infection, Peter's thoughts had turned to mortality more than he had wished for at that time. I felt that I was beginning to understand Peter's way of dealing with his predicament. When he could, he seemed to filter adversity somehow and to try and deal with one problem at a time.

My next encounter with Peter's world was to be the following evening when I was walking onto the surgical ward and met Angela as she was leaving. I knew she had been to see Mr Walters earlier that day. I asked how she was and as she began to answer tears welled up in her eyes and she turned and quickly walked away. I felt as clumsy as I did on my first meeting with her and her husband.

It was the morning allocated to students for 'ward work', which meant that we were not required in a clinic or an operating theatre, so we were free to catch up on seeing patients newly admitted to the ward. Having seen my quota, I

called to see Peter. Initially our conversation would as usual begin with various pleasantries. Peter would ask about our training, my life and what I had done before medical school. After a while he would allow me to talk about him, and eventually his illness and operation. He told me that he knew that the report had come back from Histology and that Angela had discussed this and other things with Mr Walters. I knew that the malignancy had been confirmed but that the highest lymph mode had not shown malignant change. Before I could add anything he did not wish to know what the histology report had said, as he felt that he was not yet ready for such matters. I was surprised. Without realising it, I had categorised Peter as an informed patient who wanted to know as much as he could. Perhaps seeing the quizzical look on my face Peter began to explain. He told me that he was in hospital in an alien environment having too mooch around all day in pyjamas.

He used the word 'dehumanised' to describe what was happening to him. Peter became angry at this point and I remember feeling this as unpleasant. He added that he wanted to get out of hospital and 'take the news on his own terms'.

I saw Peter again the next day and after talking a short while, he told me that he had noticed that some of the nursing staff were being kinder towards him than to other patients. He said that one student nurse was being particularly earnest and over concerned, frequently exposing him to a syrupy smile. He seemed to be reading other people's expressions and allowing his impressions to feed his fears of the worst.

Adjuvant chemotherapy had also been offered and Mr Walters had suggested that Peter might like to discuss this with Dr Brown who had a special interest in oncology. When he mentioned this I was immediately enthusiastic. I was eager at this stage to say something 'positive'. I had met Dr Brown and he had impressed me. A kind, gentle and thoughtful man, a good role model for a student I had thought. Peter gently managed to stop me. He did not wish to see Dr Brown yet, not until he was out of hospital, for the same reasons as not wanting to know the histology report.

This began to introduce tension into our relationship. On the one hand, Peter was carefully reading the reactions and manners of those around him and was becoming increasingly convinced that they were nothing more than sham kindness towards a dying man. At the same time he was placing a moratorium on any member of the team including myself from giving him a thorough appraisal of the stage of his illness, or allowing us to arrange any further discussion of treatment that might, in our view, improve the prognosis. I felt that we were being placed in a double bind.

The wound infection that Peter had suffered continued to be problematic. The surgeon said that it was one of the worst in his experience. The effect on Peter's morale was diminishing. He was very upset at the way in which one of the staff had handled him the previous day. Peter said that he had changed the dressing with little gentleness and had hurried away without explaining how the wound was healing. Peter asked if he should have been given analgesia for this procedure, such was the pain. I had known by this time that Peter was very stoical and this must have been unpleasant. I was uncertain at first how to deal with criticism of other members of the team. I did not wish to be disloyal, but neither did I wish to invalidate his grievance. All I felt I could do was apologise on their behalf and talk to Peter about it in terms of staff being overworked.

A few days later saw an improvement and Peter was spending more time out of bed and preparing to leave hospital. That week I saw Peter and Angela by the lifts. Their initial greeting was warm but the irritation of their mood soon came through. Peter had been given 'permission' as he described it to go home for the best part of the day. The consultant was reluctant to discharge him because the wound, though improved, was not entirely free of infection. So he had gone home to spend the day there, but about half an hour after arriving they had received a telephone call, asking Peter if he could return to the ward immediately. A scan had been booked but they had forgotten to tell him. The disappointment was intense, but Peter now had his mind so firmly set on going home that he had started to respond to mishaps such as this with a mild resignation. The next day saw Peter achieve his first goal of a full day away from the hospital taking in a visit home and a picnic on Hampstead Heath. 'It's Spring and it's so good to be out there and be part of it all', he told me that evening with a childlike smugness, almost as if he had cheated the hospital by having a day's fun. Peter left the hospital about three days later, though I was not aware of his departure until the next day. He had managed to persuade Mr Walters to discharge him two days earlier than planned. About a week or so later I met Peter and Angela by chance, when they had called on the ward to say hello to the staff. They seemed quite bright, almost effusive. We talked for a short while and Peter said that I should call round for tea some time. I thought I sensed a little hesitancy on Angela's part but then she gestured to affirm the invitation. So an arrangement was made.

I arrived at Peter and Angela's and the welcome was warm. The flat had the definite feeling of being home despite the transitory purpose that it served before they returned to Canada. Peter and Angela finished preparing the meal and engaged me in sporadic conversation as they flitted in and out of the room and I arranged the table. Angela, being religious, wished to say grace with all three of us holding hands. I found this a little embarrassing and I believed Peter sensed that I was not accustomed to this as he made some joke about the strangeness of their evangelical ways. Peter seemed in good spirits. His assessment of the effect of hospital life upon

him was accurate. Here, sitting in his own home, dressed and in control, with me as his guest, he seemed augmented and unafraid.

I wondered if it was going to be a little difficult for Peter to eat a large meal, without his stomach yet he obviously wanted to partake in this meal and seemed also to want to impose a sense of occasion, however informal we were appearing to be. I remember feeling concerned that Peter was subjecting himself to discomfort on my account. A little vain perhaps, as eating must have been a common occurrence for him despite his recent surgery.

I had decided in advance to let Peter set the agenda for our conversation, thinking that I would not mention medicine or the hospital unless he or Angela did, as they might want to forget illness at least for the evening. It was soon made clear to me what an absurd notion this would have been. When I had arrived at their home a few polite comments were made to whether I was still working in surgery, was I enjoying it, and similar themes. Within a few moments of beginning our meal such reticence was cast aside. Angela launched straight into territory that I thought Peter might have wanted to avoid at least for a short while. They had seen Dr Brown, the oncologist, and had been very disappointed.

Peter and Angela thought that the idea had been to have a reasoned discussion about the pros and cons of chemotherapy, and that he would help Peter to make a considered and informed choice on the basis of possible risks and probable benefits of the treatment. Peter and especially Angela had felt that Dr Brown had strong preconceptions and had assumed that Peter would be anxious to start chemotherapy as soon as possible. The only matters that had to be arranged were which drugs and when. Angela who had a background in life sciences and now working as an epidemiologist had felt insulted by this. I felt surprised by all this after my sterling recommendation of Dr Brown. I felt let down or that I had let Peter and Angela down by too hasty an endorsement which raised expectations and led to disappointment. Peter remained fairly quiet. He agreed with what Angela was saying, but added little to it. I also began to feel a little anxious. The conversation then moved to Peter's decision to consult a practitioner of Chinese herbal medicine. I had long been curious about such matters and later in the evening Peter showed me some of the mixture he had been given. I asked what the mixture contained, and what the properties of the different herbs were. Neither he nor Angela knew. I heard much that evening of the short comings of various doctors with whom they had both had dealings. Both told me also that they felt physicians were a very privileged section of the population and that after training they should work for at least two years for low wages in 'poor' areas. Many of the sentiments were in keeping with some of my own ideas but I was not used to hearing them expressed with such vehemence. I began to feel somewhat beleaguered by this onslaught although it was directed at other individuals. I did feel a good deal of it personally.

Perhaps they noticed this or perhaps the conversation took a turn of its own and Peter began to talk about Mr Walters. At first they had found him aloof, a paragon of surgical detachment and, Angela especially, had found this frustrating particularly in that he would not admit to being affected by the illness and suffering that he dealt with every day. So on one occasion she had taken her church minister to an appointment with Mr Walters and on this occasion the facade she felt, was abandoned and he had talked freely of being upset by having to deal with fatal diseases. His admission of vulnerability and capacity for empathy drew their approval. Talking of this must have prompted Peter and Angela to think of other members of the team. The registrar, brusque, outwardly gregarious, but with no depth of kindness. The first house officer, sensitive, diffident but with a great potential for skill and empathy. The second house officer who took over the job two days after Peter had his operation, friendly but already showing signs of detachment and indifference. Though it was interesting to listen to these observations and compare them to my own. I did not wish to be disloyal to those who were not there to defend themselves. It was clear however, that they were not indulging in malign or even casual gossip, but that it was important for them to give voice to their experience of these characters.

I explained my dilemma so instead, I was gently questioned about my ambitions in medicine and my motives. Suddenly Peter brought our talk back to the particular and asked what I had done at his operation. I remembered the dissection and, rightly or wrongly, I became evasive. I said that I was not actually assisting whem he had surgery, and this was true. I then added that I had felt uneasy about discussing operation details whilst we were eating. This was part of the truth, but the other part was my uncertainty about telling Peter about the dissection. I suggested that we return to the topic later. In fact we did not. Although I like to think that I was prepared to tackle the question if I was asked about it again.

After exchanging what must have been the salient points of each of our life stories, and talking of other things, the evening came to an end. When I left, all three of us agreed to meet again soon, as Peter and Angela were going back to Canada. This had been their long term plan but they had decided to bring it forward several months.

I bumped into Peter and Angela about a week later as I was walking home early one afternoon. They were in a hurry as they were going to see Mr Walters for an out-patient appointment. Again, without really meaning to, we agreed to meet again but no firm arrangement was made. A few days later I was walking home by a long route over the south end of Hampstead Heath, when I chanced upon Peter and a friend walking in the

oppposite direction. Peter suggested that I call round that afternoon for tea. 'When I arrived, Peter explained that Angela and he were leaving for Canada in two days' time. Angela was working late that evening, so he had arranged to see this friend, whom he had known since their school days.

After some routine talk of life at the hospital and the work that Peter expected to do when he arrived back in Canada, his friend brought up the matter of the chemotherapy. He seemed concerned that Peter had declined this option and wanted me to confirm that Peter could think about having the treatment when he returned to Canada. But I felt I had to support Peter's decision, although I did feel that Peter's friend was right.

I knew that Peter had much to do that evening and I also had a later appointment, so after a short while I took my leave. I tried to treat my farewell to Peter as any other, but I felt it was loaded with unspoken thoughts of what the future held for him. I left it open to Peter and Angela to contact me again if they wished but, I would be surprised to hear from them again. It did seem that whatever the statistical prognosis of Peter's condition and whatever the actual outcome, he left for Canada with a strong sense of the future.

There are many concerns that I would like to reflect upon as a result of knowing Peter and Angela, and having been involved in their medical care.

Firstly there was an inevitable sadness that I felt. Though some have argued that gastric cancer may well be more curable than it is often perceived to be in Western Europe[1] people in the team seemed to accept the conventional wisdom that the five year survival rate is about 5%. Its occurrence in a relatively young man with a younger partner seemed to force me and others in the team to think of our outlook if we found ourselves in that position. At the same time it is necessary to be sensitive to Peter's and Angela's intention to adopt an active and positive approach to the whole problem and support them in this.

Looking back over the narrative written, I have wondered why I have remembered so much of the detail of what took place. It seemed that Peter and Angela invited me to share in what had happened to them at almost every possible level and this made the emotional charge of what was happening so accessible, that it was inevitable that much of what took place would lodge in my memory.

I learned much from Peter and Angela by their expressed desire for openness. I remember Peter's question about what part I had taken in his surgery and that I had tried to defer answering and found that we never returned to the topic. Until this time I had thought that the matter of patient information was black and white. Patients are not given enough information, therefore to right this wrong, all questions should be answered when they are asked and nothing should be withheld. This experience showed me that such matters are not always so simple. Was Peter ready to be told all the details of what I saw at the opeation? Perhaps, but not right then. By not wanting to know the histology result or see the oncologist until he was discharged. Peter was suggesting to us that one has to be ready for information before one received it. This later made me consider that I should have been more structured in my contact with Peter, and that I had left too much of the timing and content of our discussions to chance. I hope that setting a balance between structure and flexibility becomes easier with experience.

Peter and Angela also seemed to hope that the staff would give much of themselves not in time but in honesty. The most obvious level of honesty is in information and decisions. Beyond this is, perhaps the honesty about the emotions that our work evokes. Peter and Angela knew that they were frightened but they wanted the staff with whom they came into contact, to admit that if they were involved at all they might be scared and uncertain also. This seemed to form the basis for their liking Mr Walters, who was able to treat them in this way.

This made me ponder why some do not work in this way. Some perhaps, simply do not experience very much of an emotional response to the suffering they see in others. Others perhaps do feel, as well as see, but respond in an aberrant way. Doctors are sometimes criticised for wanting to appear invulnerable. Often the criticism may well be justified but it may also often be wrong to assume that doctors chose this role out of vanity. Vulnerable doctors will, from time to time, want to make sense of the sorrow that they see around them and perhaps failing to do so, or finding themselves isolated, they will try to rise above their confusion with a sense of detachment and an illusion of resilience. A patient distressed by his illness may find comfort from such an appearance of certainty and steadfastness, and unwittingly reinforce the doctor's view of themselves. The deception thus grows without our being aware.

In these thoughts I recognised the luxury of my own role. As a student few calls for certainty were made upon me. Rather I could wear my uncertainty on my sleeve. I also felt very fortunate that I could talk to the consultant Mr Walters, but regretted that there was less dialogue with the registrar and the second house officer.

In addition to encouraging me to think about honesty in relation to information and feelings, Peter and Angela also implied they wanted people to help them with meaning. I recalled that on the morning of Peter's gastrectomy, Peter and Angela had asked whether his diet and his ability to express emotion had been significant in the causation of his disease. These questions raised issues of blameworthyness, guilt; very fundamental questions to me. One could very easily dismiss these ruminations as being centred around the inevitable question 'Why me?' but I felt that an attempt to put everything in some kind of context was Peter's way of trying to set an attitude that he

would adopt to his disease. It is not perhaps unreasonable to suggest that this attitude may have a significant influence on a cancer patient's chance of survival. Although I took refuge in honesty and admitted to Peter that I did not have certain answers to many of his questions, I felt that I had tried to do two things. Firstly, I thought that I had shared with him a sense of the importance of these questions and in later discussions after his operation I had not been dismissive of them. Secondly, I thought it important to do everything possible to relieve any sense of guilt or self-recrimination that might have crystallised around any of his ideas. To be beset by such nagging doubts as one is forced seriously to contemplate mortality, perhaps for the first time, seemed unkind. I tried to do this by emphasising the uncertainty and unproven nature of many of the ideas around the aetiology of cancer and to point out to him that even people with blameless life-styles become seriously ill. I also suggested that such ideas may help healthy people feel good about the way they live but should not allow us to return to the mediaeval idea of equating illness with sin.

The whole encounter also made me think of boundaries. A student colleague suggested that I should have declined the invitation for dinner at Peter and Angela's home. To get too 'over-involved' in this manner was unprofessional and by making myself too accessible to someone with such a poor prognosis was bound to be depressing.

I must admit that I was a little irritated by these suggestions, but then stopped to think that there might be something in them. Was I blurring the boundaries and was I being fair to Angela and Peter: I do not really have a full answer to some of these questions. However I do feel that I would not really have learned as much if I had stayed within the narrow boundaries of seeing Peter on the ward and confined our discussions to his symptoms, signs and laboratory results.

It does also seem that if one wishes to strengthen the simple power of the human relationship in the practice of medicine to counsel, console or perhaps just entertain, then one must learn to accede to and learn to recognise when boundaries have outlived their usefulness. After all, like any rules, they are there to protect us until we think of some better ones.

After Peter had been offered chemotherapy, there was a shared assumption in the team that he would want to accept it. I remember a sense of anxiety when he refused and also a sense of frustration when he plumped for Chinese medicine but would not subject the practitioner's claims of efficacy to the same intensity of scrutiny as he had the conventional treatment. This reaction was instructive. Peter and Angela had gone to considerable lengths to look at the available literature on chemotherapy and gastric cancer, and suggested to me that the evidence of efficacy was not strong.

This prompted me to consider that my anxiety about Peter's refusal may have been due to a wish to intervene, or see something active done, rather than the result of reasoned and informed appraisal of the best thing to do. My lingering doubts about the relevance of Chinese medicine perhaps centred around my suspicion that Peter was rejecting the known limitations of chemotherapy in favour of accepting the unknown possibility of Chinese medicine. By pointing out that we simply did not know about Chinese medicine, Peter both curtailed debate and gave himself a reservoir of optimism. Peter had made his decision and it was obvious that he derived hope from the alternative that he had chosen. It seemed right therefore to back him in this and in our two conversations on this topic. I tried to stress the positive possibilities of his choice. Some may argue that this was a dereliction of medical duty as one should make a definite recommendation and attempt to persuade the patient to one's point of view. I really felt that this would only have made Peter anxious about a decision he would not anyway reverse.

Instructive also was Peter's and Angela's reaction to my choice of gurus. I did wonder if they had been quite correct in their interpretation of Dr Brown's attitude but if one puts such reservations aside, then I felt that I had done Peter a disservice by enthusing over someone that I happened to like. Perhaps being a student in a teaching hospital makes one hungry for examples of excellence. However a patient seeing a doctor for the first time when in the turmoil that serious illness and surgery brings, will see things through very different eyes and judge those he or she meets by very different criteria to the impressionable student. There was little I could do to make amends for raising hopes, but a lesson for the future nonetheless.

This whole episode was educative in how to deal with patients in relation to the other people in their life. When I first met Peter inadvertently, I was seeing him as 'my patient' and Angela as his wife, someone who visited and needed to be kept informed. The falsity of this approach soon became apparent as the degree of Angela's involvement was obvious and as I began to understand the effect of Peter's illness on her, and I found myself involved with both of them. Throughout this I became aware that the way in which I saw them, changed during the course of our contact. At first, I had tended to see Angela as being more expressive and the former of opinions but Peter as being more malleable, almost passive in his acceptance. When I held with this perception I thought this may have been due to Peter assuming the role of the patient, which he alluded to, or it may have been a long standing trait. In time it seemed that many of Peter's ideas were quite strongly formed and discussed, but he was merely more prone to be reticent about them.

Whatever the dynamics of the relationship, it brought home ot me that it may be a risk for the less experienced to fall into treating a couple as a single functional unit with two halves

that one has to deal with similarly. In time I reminded myself to treat them as two very individual people with a special link. Though this may seem a little obvious, I felt it to be an important lesson for the future. How does one maintain the trust of a couple and the confidence of individuals?

Peter's comments about the hospital being dehumanising and his various criticisms of medicine did evoke a mixed response from me. Frequently I found myself being left irritated by them, yet at the time of our discussions I remember agreeing with him and thinking that his ideas concorded with much of what I felt about hospital life. The explanation for my sensitivity may not be difficult to arrive at. We may invest much of ourselves in our work and derive much of our identity and even status from it. It is perhaps almost inevitable therefore, that our sense of self will overlap a little with those doing the same job or the institutions we work in. If anyone impiniges on them we can unintentionally feel that they impinge on us. An analogy may be the individual who says insulting things about members of his family but castigates any outsider who dares to agree with him. The complication is perhaps how to deal with this contradiction. Too hasty a defence because of dented pride could result in ignoring a wrong that needs to be corrected. It could also place a barrier between a patient with a problem to disclose and an otherwise sensitive doctor. Perhaps indeed the more sensitive the doctor, the greater the likelihood of this occurring. In my dealings with Peter and Angela I tried my best to keep an open ear to all they had to say and tried to let any residual irritation wash away through talking to students of a similar mind.

Peter's 'case' reminded me to be mindful of the emotional stretching to which all health care workers are exposed. At one point I was being required to cut a tumour out of a freshly removed stomach with the detached attitude of the pathologist, and another time I was trying to be friend, and confidant, and comforter to this man. It may be said that one becomes hardened to this and learns how to deal with it. I feel this to be false. There should always be time and permission to admit that this is difficult and perhaps one day we will be able to share this with patients.

As a student, one is tutored and advised by patients in many ways. One is told of characters one should emulate and others to avoid. One is told to maintain some habits and discard others. Perhaps there is a wider responsibility to consider the things that our patients say and the lessons they teach us, without articulating them and distil from them some thoughts about the way we work and train. Peter and Angela tended to see certain individuals in the surgical team as being amenable to the sort of contact that they wanted and yet would be critical of others. Perhaps rather than dwell on personal characteristics of individuals it may be useful to consider the immediate environment that they work in and also the wider cultural context. Some aspects of the environment can be influenced by the team members, particularly the team leader, others are to do with the larger organisatin and the society beyond. Wider change that will hopefully come about by public dialogue on medicine and the doctor/patient relationship is beyond the scope of this brief discussion.

Perhaps specialists and general practitioners sympathetic to the importance of the doctor/patient relationship could set examples of excellence by ensuring that time and encouragement is available for the discussion of these issues. However, failure to acknowledge that many individuals will work in disciplines where this be ignored or actively discouraged may lead one to overlook how intimidating and alien such practices could seem. Perhaps some more basic and practical guidelines might be required to establish some core values required. It is easier to pontificate and judge, than it is to begin to make changes. Some pragmatic guidelines might take the following form:

i) Morale is important to a patient's physical recovery and this can be influenced by sensitivity to all a patient needs, including provision of information and the reassurance of participants in decision making.

ii) Many patients may quickly perceive staff who evade their own fears and vulnerabilities and this may be unhelpful.

iii) It is useful and a sign of maturity for staff to admit when they feel defeated or frightened.

iv) Possessiveness over professional territory between disciplines is demeaning and should be avoided.

One can freely accept that many professionals working in large organisations that may be becoming increasingly commercialised, may find such suggestions embarrassingly idealistic and not over original, but it may be that adoption of these or similar ideas as the basis of working could make contribution to making the doctor/patient relationship more of a 'resource' in its own right. Furthermore the fact that many patients continue to complain of the absence of evidence of such guiding principles suggests that much work remains to be done.

In an ideal world, principles would be incorporated flexibly into everyday behaviour but in the real world formal structures would be needed to bring them about. For example, arrangements could be made so that formal feed-back could be sought from patients as to whether they thought these matters were being addressed. In addition to this discussions of matters of patient relationship could be made a recognised part of working practice as are, for example, in ward-rounds or practice-meetings. These are only very basic suggestions perhaps, but such measures could help towards influencing the immediate culture of a hospital team or a general practice and make an initial contribution to improving the poor practices that persist in many places.

Another influence on the behaviour of doctors is their long term socialisation. Wider cultural factors alluded to play their part in this, but so does education.

Much of what has been discussed involves the development of empathy. It may be argued that this is an innate characteristic and cannot be taught, or that it is a skill or capacity that can be learned. If it can be learned it is not altogether clear how. The introduction of communication skills teaching into the curriculum of many medical schools is laudable. Moorhead and Winefield[2] point out, however, that there is no evidence to support the suggestion that such coaching bring about an increase in empathy as they defined it. They go on to suggest that individuals who were prepared to relinquish the role of the doctor as 'problem solver' and substitute what they refer to as a patient-centred style of practice were more likely to enhance their score. Evans et al[3] draw attention to problems inherent in attempts at the measurement of empathy.

Whilst one has to accept that there are many difficulties surrounding defining and teaching empathy something surely needs to be done. Spiro[4] suggests that the opportunity to extend the art of history taking into developing and sharing anecdotes of the patients experience of illness may enhance the capacity for empathetic understanding. This he refers to as 'pathography', that is the story of persons with disease. Perhaps encouragement could be given to enable students to form supportive relationships with patients and later reflect on narratives formed around them.[5] It may, of course, be said that this might only formalise what many students do already, but incorporating this into training requirements and perhaps even including efforts in this regard in course assessments, may contribute to widening the practice.

Much of what took place between Peter and Angela and myself may not seem particularly unusual or even important to the seasoned practitioner. For me however, the exchanges were important. The pace at which they placed demands on me, and the emotional intensity they attached to them, helped me unfold some of my previously unformed ideas and feelings.

Whether or not I was useful to Peter and Angela, I do not know, but the experience taught me that in future encounters it may be useful to ask whether one's influence is helping to move people to that which they want to achieve to start life again, or simply carry on in the prospect of physical and psychological loss.

As a purveyor of ideas or insight, I think I was of little use. There was little I could suggest to Peter or Angela that they had not thought of themselves or derived from wiser minds. As a buffer between their tenderness and some individuals and a health care system they saw as being harsh I was perhaps useful, as were Mr Walters and many of the nursing staff. It seemed important that Peter and Angela felt they could make suggestions that might influence my future work, and that I might share this with others and thus they could influence a small part of the future of medical practice however humble.

Whatever effect we had on each other, I do feel a debt to Peter and Angela and hope that I encounter many more such instructive people in the course of my training and work.

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What is a Balint-group?

Michael Balint developed a unique type of case-discussion group. Today, nearly 25 years after his death, groups bearing his name exist all over the world. No group can be exactly like these led by Balint himself. Nor can the circumstances in which the groups are held, be the same as they were in the 1950s or 1960s. Yet there is much about many of today's groups which Balint would surely have recognized and applauded. He would probably have been surprised and delighted, at the widespread adulation which his work has attracted and at the use of his methods, admittedly in diluted form, in the training of many general practitioners. On the other hand, some so-called Balint-groups are clearly nothing of the kind.

Following a discussion at the 1993 Balint Society Oxford weekend, the Society's Council decided to produce a statement on the characteristics of Balint-groups today. The purpose of this statement is primarily to encourage the formation of new groups and to offer some guidance as to how they may be run. We hope it will also provide reassurance to existing groups that their work is valuable and important. At the same time we hope that our statement will help those whose groups bear no resemblence to a Balint-group to rename them. (Not because we decry the work they may be doing, but merely to avoid confusion.).

This statement has been prepared by Paul Sackin on behalf of the Balint Society. Balint Society Council members and Andrew Elder made many useful suggestions which have been included in the statement. The Council does not see this as the final word on this vital subject and we would welcome comments and criticisms.

It is in two parts. Firstly, we consider those aspects of Balint-groups which are fundamental. Secondly, we list a number of features which, if present, help the group to work better. Without these less essential aspects, however, the group would still be recognizable as a Balint-group and could do useful work.

Essential characteristics of a Balint group:

1. A small group.
There are no absolute rules, but groups with less than six or more than 12 participants are unlikely to work well.

2. Defined group-leader who is one of the following:
a) A general practitioner who has attended Balint-groups and has had some training in small group leadership, ideally to include co-leading with an experienced Balint-leader and/or attendance at the Balint Society group-leaders' workshop.
b) A psychoanalyst, psychologist, counsellor or related professional who has attended Balint-groups and has had some training in small group leadership. Such a leader would need to have an interest in the clinical area of the participants (e.g. general practice).

3. Group members are in clinical contact with patients.
Members are usually general practitioners or general practitioner trainees, but groups have been run perfectly well for medical students, nurses, psychosexual counsellors, etc.

4. The material of the group is based on the presentation of current cases giving the presenting clinician cause for thought.
The cases may have given rise to distress, puzzlement, difficulty or just surprise. Random cases have occasionally been used (even in groups led by Michael Balint) but we would not recommend this for starter groups.

5. The discussion focuses on the relationship between the presenting doctor and his patient.
Matters of 'fact' may need to be cleared up at points during the discussion but only those that have a bearing on the doctor/patient relationship are relevant. Discussion of general issues is also not relevant.

6. Case notes should not be used.
The presenting doctor may prepare himself with reference to the case notes. In the actual presentation and discussion, relying on memory is crucial. Slips of memory are not considered as signs of poor doctoring, but as vital clues to the understanding of the patient and his doctor.

7. The groups are not for personal therapy.
Self-awareness will increase as a result of attending a Balint-group but the discussion is firmly focussed on the patient and the doctor/patient relationship. Discomfort or distress in the doctor are not ignored but are worked through in the context of the needs and problems of the patient rather than of the doctor.[1]

8. Standard rules for small group working apply.
Confidentiality, honesty, ownership, respect for other group-members etc. are essential Group-members should be arranged in a circle, preferably on chairs of similar size. Each group session should normally last for between one and two hours. Usually the discussion of each new case lasts between half an hour and an hour.

9. The purpose of the group is to increase understanding of the patient's problems, not to find solutions.[1]
Participants are therefore encouraged to speculate on how they see what might be going on. Questions are discouraged. Advice is discouraged even more.

10. The leader takes ultimate responsibility for trying to ensure that the group functions as described above.
Group-members should also have a responsibility (see 8, above). The leader must above all ensure that group-members, particularly the presenter, are not unduly hurt. (Some increase in anxiety, on the other hand, is an almost inevitable concomitant of learning).

Desirable characteristics of a Balint group:

1. The group is 'on-going'.

The original Balint-groups used to meet weekly in term time over several years. Nowadays this is usually unrealistic, but a commitment to regular meetings is important. On the other hand, even a single session can be enough to experience the method and attendance at, say, a Balint Society weekend can lead to some useful learning.

2. The group is closed.

It is best if the group membership is unchanged for much of the time. On the other hand, in the real world of, say, general practitioner training, carousel groups may be better than nothing.

3. There is a co-leader.

Joint leadership by a general practitioner and an analytically orientated leader, or by an experienced leader and a leader in training, gives added value to the group.

4. The leader preferably has psychoanalytical training.

Common sense suggests that a leader with a facility for understanding the unconscious is likely to help participants more effectively to understand the doctor/patient relationship. On the other hand, good small group leadership skills are probably even more important than analytic training. Experience of co-leading with an analytically orientated leader is obviously useful too.

5. The group does not have to include all-comers.

Ideally the leader(s) should interview potential participants beforehand, but groups of 'conscripted' trainees, for example, can work very well. It could be argued that those with insufficient flexibility to contribute usefully to a Balint-group may have major problems with clinical practice.

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Postcard from Oxford, 1994

The 1994 Oxford Balint Weekend finished, as often before, with a lively plenary session at which impassioned views were exchanged: "Doctors don't really know what 'Balint' means" "Balint doesn't seem relevant to the doctors of the 1990s – they have no time" "Why can't we call Balint-groups something else in case the name puts people off?" "Other people run Balint-style groups under a different title anyway."

Over lunch, I perused the current BMJ. Professor T. Cheng, of Washington DC, stated in his guest editorial that eponyms are out of fashion and acronyms are 'in' instead.

So – why not spread the word that BALINT is an acronym for something like **B**asic **A**nalytic **L**earning **I**n **N**ormal-length **T**reatment?

Further ideas for promotional acronyms to the Editor, please!

SUE HOPKINS

Reference:

Cheng, T. O. 1994. Acronymophilia. Editorial. *British Medical Journal*, **309**, 683.

Assessment of a Balint-group

Jim Lawrie
Assistant Course Organiser, Homerton Vocational Training Scheme

The vocational training scheme includes eight group sessions each term, devoted to the doctor/ patient relationship. A clinical psychotherapist runs the group which lasts for just over 1 hour. The trainees are invited to present a case which is then discussed with an emphasis on the psychological interaction between doctor and patient. This illustrates that many cases that may present with physical complaints have an underlying psychological or emotional cause.

It is fairly straightforward to ask if anything has been learned at the end of a traditional lecture or presentation. The knowledge gained during the case discussion group is less concrete. It develops a way of thinking about problems over a period of time and the benefits may not be apparent for months or even years. Assessment of each session or group of sessions is difficult since the value may not be immediately apparent. Some trainees find the group difficult at first but appreciate its value greatly towards the end of the scheme.

We decided to evaluate the overall response with 5 questions on one sheet of A4 paper:

1. What do you like most about it?
2. What do you like least about it?
3. Do you find it helpful with your consultations in general practice?
4. Do you find it helpful in hospital work?
5. Do you find this type of work difficult?

Unfortunately the last three were closed questions and many of the trainees answered with 'yes' or 'no'.

The following term, the closed questions were amended, and this resulted in a large number of useful and interesting comments. The problem was to present this data in a form that enabled useful discussion. It was decided to list, under the heading of each question, all the different comments which had been made. The comments were weighted so that those mentioned most often were listed first and those least often, last. This failed to quantify the importance of some comments, or to distinguish between comments made the same number of times. It did give some indication however of the relevant importance of the various answers to each question.

The results of the assessment were presented to the trainees at the first Balint-session of the new term. The discussion was extremely helpful and addressed many of the difficulties were mentioned. It was decided that:

1. New trainees would have an introductory explanation of the group and its function.
2. The hospital based trainees would be actively encouraged to present cases from their work.
3. There would be a regular opportunity for follow-up of cases presented at an earlier date.

The assessment enabled the trainees to comment on the change this teaching session. The group has been more lively and effective since changes. Assessment is interesting, what is important however is analysing the results and acting on them.

The Case Discussion-Group

1. What do you like most about it?

a) Reactions of others to particular problems.
b) Opportunity to share inner conflict.
c) Support from others.
d) Time to consider cases.
e) Opportunity to open up in a 'secure environment'.
f) Expression of weakness and inadequacy is possible.
g) Brings the group together.

2. What do you like least about it?

a) The silence.
b) Too little from hospital.
c) Uncomfortable setting.
d) Group too large.
e) Don't know what it is all about when you start.
f) Fear that someone else needs to present more than you.
g) Complaints about the group from one's peers.
h) Lack of humour.

3. How does it affect your consultations in general practice?

a) Insight into patients' feelings.
b) Aware of social context and the patient as part of a family.
c) Awareness of one's own feelings.
d) Awareness that all can not be sorted in one consultation.
e) Helps with after effects of consultation.

4. How does it affect your hospital work?

a) Too early to tell.
b) Not applicable.
c) Awareness of lack of emotional support for people working in the hospital.

5. Comment on your experience in the group?

a) Stimulating and therapeutic to discuss feelings.
b) Feelings of support from friends and 'mummy and daddy'.

c) Stressful at first, wary of the psychoanalyst.
d) Difficult to find appropriate hospital cases.
e) Growing confidence with seniority.
f) Feedback at end of case is useful.
g) I often have cases I would like to discuss but feel unprepared for a presentation, or I feel I could only tell half of the story.

6. Would you prefer a different format? What changes would you like?

a) Group is too supportive – needs to provide more constructive criticism.
b) Need to facilitate hospital based trainees to present – must accept there will be less information on the family. Less follow-up.
c) Need to ask anyone from hospital if wants to present a case this week?
d) More comfortable chairs/surroundings.
e) A written description of the group's work and aims.
f) Smaller groups/2 groups.
g) A theme to carry on from one week to the next e.g. Eating disorders, marital problems, racial problems, etc.

7. Would you like an opportunity to discuss this questionnaire?

a) Yes.
b) Only if brought to the group as a whole.
c) No.

A Balint Day for Course Organisers in Ripon, 1994

Every year, the Association of Course Organisers holds a conference in Ripon. This year, the main conference took place in June, and was preceded by a one day workshop on Balint-group leadership run by members of the Balint Society. The aim of the workshop was to provide an opportunity for Course Organisers who are already running case-discussion groups for their trainees, to learn about the Balint style of group-leadership. The workshop was attended by 21 doctors, led by Paul Sackin with assistance from Heather Suckling and John Salinsky. Some participants had had previous experience of being in a Balint-group, perhaps as a trainee, while for others this was their first contact with 'authentic' Balint.

The proceedings started with a 'fishbowl' group led by Paul and Heather. The case presented was discussed by the inner group of eight, after which everyone else joined in to discuss what they had seen and heard in the small group. Those in the outer circle were each asked to focus on one of three aspects: the work of the group-leaders, the experience of the presenter, and the dynamics of the group as a whole. The workshop then split into three small groups which met in separate rooms. In each group, members took turns to act as co-leaders, in pairs, while cases were presented and discussed.

After each session, there was a discussion about the aims and tactics of the leaders, and to what extent they had succeeded in what they were trying to do. Differences in style were readily observable but there was a remarkable consistency in general aims and methods. Each group had one of the three facilitators to provide general advice and appraisal and to represent the Balint Society's view on what makes a group a Balint-group. (see page ??).

It was apparent that one of the chief benefits of the day was the opportunity given to the course organisers to present their own heartsink patients, instead of having to suppress their own problems while they listened sympathetically to those of their trainees. It occurred to me that the experience of simply taking part in a Balint-group is itself the most potent form of group-leader training. The workshop ended with a short plenary session in which an attempt was made to summarise some of the features of the Balint-group which distinguish it from other kinds of case discussion-groups.

Several people made the point that Balint-style leaders always try to deflect questioning away from the presenter, once he has told his story, and to encourage the other group-members to do the work themselves by using their awareness of their own feelings about the doctor/patient relationship. The organisers received a lot of very warm and positive feedback about the workshop as a whole, and there was strong support for the idea of repeating it next year.

JOHN SALINSKY

Spotting Clues in the Opening Case-presentation of a Balint-group: Insight from a Meta-Balint-group

Clive D. Brock, Alexander W. Chessman, Alan H. Johnson
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The opening statements of a case presentation in a typical Balint-seminar contain clues that help the leader understand the particular doctor/patient relationship under discussion. This process closely parallels clinical problem-solving for the family physician. A physician typically generates the significant hypotheses during the early phases of an encounter.[1 2 3 4] Therefore, a primary reason for studying the opening presentation in a Balint-group meeting is that the process of hypothesis generation parallels the encounter with a patient. This paper identifies some of the important clues in the opening statements of a Balint case presentation.

This paper is based on our observations as participating leaders in Balint-groups and from a review of our work as leaders at weekly meta-Balint-group meetings. The opening presentation in Balint-group meetings were studied, to assist leaders in determining the potential direction of the group as quickly as possible. The sooner the leader grasps the issues arising from the doctor/patient relationship the better he/she can guide the group members towards gaining similar understanding for themselves.

A Meta-Balint-group: A Supervision Group for Leaders

This group presently consists of five Balint-group leaders. The leaders' responsibilities are divided among three Balint-groups (PGY2's, PGY3's and medical students). We meet weekly to evaluate tapes (audio or video), written transcripts and oral presentations of a recent Balint-group seminar. The meta-Balint-group members consist of three family physicians, a psychiatrist and a counselling psychologist. Former members included a double certified family physician and psychiatrist and a social psychologist. Typical issues for discussion include interventions and why they are made (spotting clues); attendance (group membership and participation); how leaders establish credibility (medical cross-training); co-leadership (roles, purposes and communications); groups' failure to progress (being stuck); judging normal group development (professional time line); non-productive group participants (resistances, scapegoating); meta-messages (overall themes and the messages they convey); how leader projections affect the presenter and other group members (Balint-seminars for leaders); and how the relation between co-leaders affects group process (spitting). The timing of these issues is somewhat dependent on the meta-group members' sense of comfort and trust in one another. In our earlier meetings we focused on spotting clues. Now, after two years of group meetings we are discussing the relationship between co-leaders and how this affects group processes. In this paper we will start at the beginning and describe our work in spotting clues.

Each meta-group session lasts one hour. During a typical 'clue spotting' session, one co-leader presents a videotape or audiotape of a recent Balint-group meeting. The tape is stopped when anyone hears or sees a significant communication. We then discuss the significance of the communication and use this understanding to generate hypotheses and then stipulate plausible leader interventions and attempt to predict the issues that may arise later in the presenation. As the tape proceeds more information becomes available, we confirm or amend the initial interpretations and predictions accordingly.

Background Theory Assumptions

The major role of the Balint-group leader is to identify clues in the presentation which are manifestations of the presenter's identification with the patient. The leader directs participants' attention to these clues, so that while the discussion remains open and free the focus is on the doctor's unconscious connection to the patient (i.e. on the doctor/patient relationship). This format teaches participating physicians how to recognize clues; and, more importantly how to interpret their meaning: (a) in the context of the Balint-group session and (b) in their ongoing clinical interactions with patients.

Let us consider for a moment how this works: When a resident presents a case for discussion in a Balint-group, the presenter is stuck between unawareness and awareness. In the unawareness phase, the doctor may assume the patient's feelings or become the personification of a significant person from the patient's past (transferences).[5] This event occurs spontaneously/unconsciously just like the reception of all other sensory phenomena (visual, tactile, etc.). The awareness phase requires training. The doctor learns how to develop an explicit appreciation of his/her spontaneous, unconscious identification with the patient (countertransference). Enid Balint regards identification with the patient as having a biphasic structure: 'first identify, and then withdraw from that identification, and become an objective professional observer again.'[6]

Greenson describes the state of being stuck between unawareness and awareness as 'uncontrolled empathy'[7] meaning that the resident is over-identified with the patient. This identification without understanding is a troubling experience and will cause him/her to 'turn a blind eye' and defend against the emotional state identified. At this point the doctor and patient have formed an unconscious alliance (relationship). In this regard, Enid Balint pointed out that the work required in a Balint-group seminar is 'based on the idea that human beings whether doctors or patients, unconsciously defend themselves against certain thoughts and feelings.[6] Now the doctor is resisting, as is the patient, the very insights the patient most needs.

Because of the presenter's discomfort with this identification, the presenter unconsciously distorts the presentation. He/she does this by using only indirect and subtle clues. Sensing and 'exploring' these clues leads to an understanding of the doctor's countertransference and, in parallel fashion, a truer understanding of the patient's transference and emotional state.

Clinical Observations

From these meetings, we were impressed that most of the clues to the important issues arising from the doctor/patient relationship appear at the beginning of the presentation. In other words, to develop hypotheses about the relationship, we rarely needed to advance beyond the presenter's opening statement. We were often impressed how soon into the presentation diagnostically significant clues were given – even as early as in the opening sentence. Occasionally, we noted clues even before the formal presentation began, when the group members were busy assembling and talking freely. The theme of the informal chatting would reappear in the theme of the resident's presentation.

The Nature of clues

We take notice of verbal and non-verbal clues. A significant verbal clue can appear as a metaphor, a slip of the tongue, a second thought, a contradiction or an omission. Metaphors are particularly helpful to us, because a figure of speech relates to the wakeful state, as a dream relates to the sleeping state. A figure of speech leads down the Freudian 'royal road to the unconscious', soon to connect to the highway of consciousness.

The non-verbal clues appear to the leader and group participants as feelings, which in turn are expressed directly as verbal statements or indirectly through body language, voice intonation and group process or ambience.

Transcripts from a Meta-Balint-group meeting: Focusing on spotting clues

Transcript 1

The case is presented by an infrequent participant who makes an unexpected appearance in an established group. The presenter is out of phase with the group's development and the case closely reflects his own professional predicament. The clues are derived from the first seven sentences of the opening presentation. What follows is an excerpt on the meta-Balint-group discussion based on an audiotape review of the presentation.

Presenter: Basically she is a patient I've had since starting residency here. She's a 44-year-old white female with severe COPD. She's got a history of possible manic-depressive disorder. On and off follow-up over at mental health. She has a history of IV drug abuse in the past. She has a severe or had a severe smoking problem which is responsible for her COPD. And basically has been seeing me for 2½ years, mainly for . . .

CDB: Well, that's the opening statement.

AHJ: 'Off and on'. That off and on became terribly metaphoric for me, very powerful and predicting of what I expect her presence in his practice to be like.

CI: Yeah! What struck me was that he'd been seeing her for 2½ years. That was his statement. I wondered why he had now decided to bring her to the group.

AWC: It is the end of his residency training. After 2½ years he is just about done with residency training. He's a complete doctor and he should understand everything. I can hear him saying well, things haven't changed or they haven't got better. Do I trust the group now?

CI: What could I do with her now? I'm graduating.

AWC: Maybe he doesn't want to really feel happy about leaving his patients!

CDB: He's bringing up an impossibly difficult case and this is one of his few attendances in the group in 2½ years. Is he trying to find out whether there is anyone without limitations in the group who can deal with such a difficult case or what?

AWC: That's going to be the problem for the group. Does he imagine that the group might be able to perform some magical function or other?

CI: This man has a difficulty in sharing, hasn't he? That's what I hear you saying. You say it's the first time he's shared at the group.

AHJ: Yes, he's 'on again, off again', with the group just like his patient is 'on again, off again.'

AWC: Yeah, what's the sharing – I mean, I sense you're right but what does that mean?

CI: What's the sharing? Well, he wants to keep this patient. It's his patient and although as you point out other opinions are needed he's not sought them, has he?

CDB: What do you make of that?

CI: Now he's faced with a real problem because he's leaving and he's got to share, doesn't he?

CM: There's a confusion about boundaries and responsibilities. It's about who I am as a family physician. What can I treat effect-

ively? Then he refuses to let go of this patient that he clearly feels confused by and not particularly effective with.

AWC: Is he asking, 'What are the limits between me and this person?'

AHJ: If I have to share her more fully then I would be sharing my inabilities or my shortcomings with the group. I can't be all things to her. I haven't been all things to her. But nobody else is going to know that. Until today.

CDB: So here we have a person 2½ years into training with the same unrealistic expectations of himself as a beginner.

AWC: And still not fully integrated at all in his professional self-concept.

The meta-groups discussion centred on the significance of two clues as seen in the context of the opening statement. Namely: 'On and off follow up with mental health' and 'seeing me for 2½ years' 'on and off' evoked a sense of imagery which helped us see the doctor and patient in a different light.

Verbal and non-verbal clues represent to us the clinical manifestations of the case; they provide a framework from which insights and hypotheses about the doctor/patient relationship and, specifically, the doctor's countertransference can be generated. We see the leader's task to identify meaningful expressions of the countertransference in the form of clues and then to direct the group's attention to understanding their significance. This will enable group participants and, most importantly, the presenter to understand: (a) the exact nature of the countertransference, and (b) how it affects the doctor's ability to understand and treat the patient.

Transcript 2

The following transcript illustrates how a significant verbal clue may be spotted even as early as in the first sentence of the opening statement.

Presenter: I had a patient encounter that was uncomfortable. I don't know if there was a real dilemma.

CDB: I'd stop it there.

GS: An uncomfortable encounter?

CDB: Yeah.

CI: You want to stop it there?

CDB: Yeah, it's that first, the first line. I mean, an enounter that was uncomfortable.

AHJ: I think that's a potent descriptor.

CDB: It wasn't easy.

GS: Just a minute now.

CI: Yeah, it wasn't easy.

GS: When you say you would stop the next, that means you have formed an opinion about what's going on?

CDB: Well, I've heard something that I'm not going to disregard. I don't know what to make of it.

GS: It doesn't mean that you would make an intervention.

CDB: No. In my own mind, I've registered, 'I had a case that was uncomfortable' and I won't get stuck thinking about what was uncomfortable. I'd let the case go on but I would register 'uncomfortable' and later on in the presentation it would become clear to me what the discomfort was all about. But my first re-frame is, it wasn't easy.

AHJ: Well for me what happens is that I immediately think of something sexual, as opposed to anger or annoyance or sadness or technical incompetence, and I didn't know what to do, to be in a quandary or frustrated. All of those things. But when someone says they're uncomfortable to me, that means either their life is threatened physically or that they're sexually assaulted. So that's what went through my mind.

Later in the presentation it became clear that the 'uncomfortable' patient encounter was due to a sexually laden doctor/patient relationship. In the resident's own words: 'It's sort of embarrassing, though, a little, in a male audience' (referring to the fact that she was the only female group member). 'Anyway, this young guy, patient, young male, came in very attractive and I was very uncomfortable examining him.'

Discussion

We have described how a group of Balint seminar-leaders come together to work on sharpening their diagnostic and leadership skills by investigating material from Balint-group seminars. The meta-Balint-group is comprised of people with diverse professional backgrounds which reflects the composition of leaders nationally.[8 9 10 11 12]

A meta-Balint-group allows leaders to come together to make explicit the internal process of recognition and interpretation of significant verbal clues. We think that it is essential when something significant occurs in a Balint-seminar, the leader will first recognize the event and then decide what he/she thinks and feels about it. The leader uses the empathic process to reach an objective understanding of the patient, by developing what Hogan describes as an 'imaginative or intellectual appreciation' of what has been recognized/identified as significant.[13]

We have illustrated a method for how other Balint-seminar leaders can examine and evaluate a recording of the opening presentation. While there remains conceptual space left for expressing the art of Balint-seminar leadership, we believe we have provided one model of assessment which frames and directs the behaviour of the leader. We have been impressed that significant clues to developing hypotheses about the doctor/patient relationship are usually contained in the opening statements of the presentation. We have found figures of speech, silences, and contradictions to provide rich clues. When these clues are openly discussed among the leaders in a meta group each gains new insights to

their possible meaning and alternative ways of broaching those insights with the group.

We wish to thank Will Miller and Frank Dornfest for helping to prepare this manuscript, and also Margaret Porcher and Marcel Williams for doing all the typing.

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From My Bookshelf

TRANSCULTURAL MEDICINE: DEALING WITH PATIENTS FROM DIFFERENT CULTURES. Bashir Qureshi. 2nd Edition (Hardback, pp. 243; £29.95p. ISBN 0-7923-8836-4). Kluwer Academic Publishers, London, 1994.

This is the second edition of Dr Qureshi's book, based on the up-dated collection of his articles which have been published in leading medical journals, linked together in a very readable, humorous style, together with a number of amusing cartoons each of which tells a story, to provide a fascinating review of this important aspect of medical practice.

As he rightly points out, most general practitioners today will have patients from multiple ethnic backgrounds, making it important that they and indeed, all health professionals should concern themselves with the ethnicity, religion and culture of their patients as much as with their age, sex and social class.

The book is beautifully produced, well designed, clearly printed and written in a clear succinct style. It is divided into three main parts: I. General aspects, with sections on diverse topics from how to avoid problems with communication and diagnostic traps related to customs, to ethnic terminology and occupations. The article on psychiatric disorders is especially interesting, as it explains the need to have some knowledge of not only the incidence of psychotic illness, but also the effects of the cultural background.

In part II, special considerations are given to a wide range of topics, starting with the problems which are becoming increasingly common, such as those arising as a result of cultural conflicts in mixed marriages. Again, the importance of the stresses arising in these difficult situations often lead to illnesses which bring the families to the doctor. Dr Qureshi's store of observations about all manner of the ways in which cultural influences can affect our patients' health, and also their attitudes to it, is remarkable – each page containing a mass of useful information, and helpful tips on how to treat them.

Part III consists of a number of short extracts from his articles on multi-cultural medicine, a series in the British Medical Journal. Finally, there are useful Appendixes, the first on available resources for the doctor who needs help with specific problems, such as the disposal of the dead, and mourning customs, and finally, examples of topics for examination essays and multiple choice questions, complete with answers to help the readers to test their knowledge.

The index is comprehensive and quickly guides the reader to the subject of his enquiry. Altogether a very useful addition to any Practice Library, where it should be available for all members of the health team.

PHILIP HOPKINS

The Doctor, the Patient and the Future

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To many, it feels as if the Balint movement is in decline. Health promotion, audit, guidelines and care management seem to be the fashionable aspects of general practice. The intimate interpersonal trinity of the doctor, the patient and the illness is in danger of being forgotten. The founding fathers of the Balint Society have reached, or are approaching retirement, and there are few enthusiastic heirs to take their place. Numbers at the meetings, the Annual Dinner and the society's weekends are declining, and the mood at the 1993 Annual Dinner was pessimistic.

In such a situation of apparent decline there are two options. One is to keep proclaiming the message in its original form even if it falls on deaf ears, in the hope that in time the tide will turn and renewal occur. The other is to do some hard thinking about the essence of our message, what are its essentials and what culturally conditioned trappings which are no longer relevant, in order to determine how the core message can be made relevant to the situation which now faces us. This may involve a radical change of direction or even the end of an institution which has fulfilled its purpose in favour of regrouping in other ways. The position of the Balint Society is no different from other movements with a message such as religious groups and political parties.

In religion and politics those groups which follow the first course tend to continue in their decline towards oblivion, because when the tide does turn it is always a new flood, never a return to that of yesterday. History is scattered with vestigial groups who once had great influence but which are now small and ineffectual sects.

Sometimes a movement no longer attracts support because its battles have been won and incorporated in the mainstream. Its task is over. In other situations its message has been rejected and it is necessary to think why this was and how it can be presented more attractively, and in a way which speaks to the current generation.

What is the essential message of the Balint movement? There are I would suggest four main points:

1) that patients' experience of illness cannot be fully dealt with in a mechanistic bio-medical franework because:
   a) Life causes illness, and often dealing with illness involves interpreting and changing life
   b) sometimes illness is not merely a result of life but a way of dealing with it
   c) patients come to doctors not merely to be cured but to understand their illness.
2) the doctor's feelings are an important part of the consultation. They can contribute to it with great benefit, for example as a diagnostic tool, and interfere with it with disastrous results, as when the doctor fails to understand or to control her feelings.
3) the doctor/patient relationship can be an effective therapeutic tool if we learn to use it rightly – the 'drug doctor'.
4) the Balint-group is an effective method for improving our understanding of 1 and 2, and our skills in 3).

The Balint movement began at a time of bio-mechanical triumphalism when it was necessary to make points 1 and 2 loud and clear. This time has passed and to a considerable extent these points are now part of the mainstream of general practice wisdom and are even beginning to impinge on other branches of medicine. To the extent that this has occurred the Balint movement has worked itself out of a job, and should rejoice, not lament that its services are no longer needed.

Whilst there is no doubt that the Balint-group remains an effective tool for achieving insights into the doctor/patient relationship, our situation is very different from that of the 1950 and 1960's. Almost all trainees and most general practitioners have the opportunity from time to time to work with their peers in groups to understand their problems. Then most practitioners were single-handed, and the weekly group perhaps was the only opportunity many had to discuss patients with a fellow professional. Now many of us can and do discuss our problems with our partners, with practice nurses, counsellors or health visitors as and when they arise. We no longer have the burning need to give up our half-day to do so, and we should feel pleased, not guilty that this is the case.

The threat to our values now lies in the increasing emphasis on doctor-centred health promotion activity, with absolute targets for cervical smears and immunisations. These and other 'performance indicators' which concentrate on what can easily be measured, rather than what is important, are major threats. Our response must be not to seek to attract more doctors to traditional Balint activity, but to work with all doctors, whether particularly influenced by Balint or not, who value the interpersonal relationship with their patients to develop measures of these factors so that what is important can be audited as well as what is easily measurable.

There are, no doubt, new audiences for the traditional Balint-group, although not necessarily in its traditional form. Practice nurses currently seem to experience the isolation that was the general practitioner's lot in the fifties, whilst hospital doctors under increasing attack for their poor interpersonal skills[1] are another important

potential market. We need to continue to explore ways in which general practitioner trainees can become more sensitive to their feelings, and those of their patients in the consultation in an increasingly crowded medical curriculum.

If the Balint Society is to have a future, it must be in identifying and pursuing these current needs, rather than lamenting over the failure of doctors to support its traditional activity.

Reference:

1. Woodham, A. The healing touch that hurts. Independent on Sunday Review, 14.11.'93, p.89.

THE BRITISH PSYCHO-ANALYTICAL SOCIETY

PSYCHO-ANALYSIS IN BRITAIN TODAY

A SERIES OF INTRODUCTORY LECTURES AND SEMINARS

At 63 New Cavendish Street, London, W1M 7RD

Chairman: **Dr Jennifer Jones**

PART 1: BASIC PRINCIPLES

AUTUMN TERM 1994: Wednesdays 5th October to 7th December 5.30-7.45 pm

Month	Day	Lecture	Speaker
October	5	PSYCHOANALYSIS: STARTING POINTS	**Dr D. Duncan**
	12	THE INNER WORLD OF THE CHILD	**Dr R. Anderson**
	19	THE PARANOID/SCHIZOID POSITION AND ENVY	**Dr G. Fornari Spoto**
	26	THE DEPRESSIVE POSITION AND DEFENCES AGAINT IT	**Dr M. Johns**
November	2	THE OEDIPUS COMPLEX IN PSYCHOANALYSIS TODAY	**Dr R. Britton**
	9	THE EGO: NEGOTIATOR OF SOLUTIONS	**Mr D. Campbell**
	16	SUPEREGO, GUILT AND ANXIETY	**Mr D. Tuckett**
	23	TRANSFERENCE AND COUNTERTRANSFERENCE	**Mrs M. Burgner**
	30	HISTORY OF PSYCHOANALYSIS IN BRITAIN	**Dr M. Pines**
December	7	CONCLUSION: PLENARY DISCUSSION	

PART 2: DEVELOPMENTS: THEORETICAL AND CLINICAL IMPLICATIONS

SPRING TERM 1995: Wednesdays 11th January to 15th March 5.30-7.45 pm

Month	Day	Lecture	Speaker
January	11	SOME PSYCHOANALYTICAL ASPECTS OF DRUG ADDICTION	**Dr E. Hopper**
	18	UNCONSCIOUS PHANTASY: THE MEETING POINT OF INTERNAL AND EXTERNAL REALITY	**Miss P. Daniel**
	25	PROTECTIVE IDENTIFICATION	**Mrs P. Roth**
February	1	HIV AND AIDS	**Prof P. Hildebrand**
	8	FEMALE SEXUALITY	**Dr D Birksted-Breen**
	15	THE MIND OF THE ADOLESCENT	**Dr M. Laufer**
	22	MALE SEXUALITY	**Dr R. Hale**
March	1	TRAUMATIC EVENTS AND THE INTERNAL WORLD	**Mrs C. Carland**
	8	CONTEMPORARY PSYCHOANALYTIC VIEWS ON DREAMS	**Dr H. Stewart**
	15	CONCLUSION: PLENARY DISCUSSION	**Dr H. Stewart**

Each lecture will be followed by discussion in small group seminars. To ensure continuity of discussion participants are requested to attend the entire series of lectures and their accompanying seminars. The Group seminars leaders will include **Mrs J. Boswell, Mrs S. Budd, Mr M. F. Davids, Dr F. Dirmeik, Mr L. Kleimberg and Dr. J. Peringer.**

A Balint Weekend in Slovenia

25th-27th March, 1994

The Slovenian Balint Society held a Balint weekend meeting at the Hotel Zlatarog, which is beautifully situated beside tranquil lake Bohinj and surrounded by the magnificent Julian Alps. The meeting was attended by general practitioners, psychiatrists, medical students, social workers and penologists (prison social workers). One of its aims was to develop the skills of new group-leaders, and three of us from Britain, Erica Jones, Jack Norell and myself, were invited to assist in this process by leading groups with Slovenian co-leaders. At the initial plenary session, some of the social workers expressed their doubts about the wisdom of having 'mixed' groups of people from different disciplines. They felt that it might be difficult to relax and be honest about their uncertainties in the presence of the doctors who they thought might have a superior and censorious attitude towards them. Happily, once the groups had started, this was never a problem. The small group setting worked its usual magic and group members from different professions quickly realised that they all had the same difficulties and human frailties. Everyone seemed to feel accepted and supported and inter-professional rivalries were completely forgotten.

My own group was conducted in Slovenian which at first, was quite a shock to my system, as it was my first experience of taking part in a group whose language was completely unknown to me. Fortunately, I had the help of Dr. Alenka Peter who sat beside me and rapidly translated everything that was said into whispered English. At first, I still fèlt like a detached observer, as if I could hear and see the rest of the group but there was a glass screen between us. Part of the problem was that once I had decided to say something, unless I wanted to interrupt rudely, I had to wait until the previous speaker had finished. If the group was lively, as this one certainly was, by the time I had the speaker's words whispered to me in English, someone else has started speaking and it was too late to get in. After a while, I learned the trick of starting to speak before my interpreter had finished and so opening a space for myself. This was important as I was, after all, supposed to be the group-leader and although the discussion was moving at a lively pace it wsa not always in a direction I was happy about. As is often the case with new groups, there was a good deal of searching for more information and trying desperately to solve the presenter's problem by advising him about what to say, what to do and whom to consult. My interventions were aimed at encouraging people to consider and express their feelings – and then to use them to reach a better understanding of what was going on in the client/helper relationship.

Our first case, presented by a family doctor, was a village farmer, shame-faced husband of an alcoholic wife, who irritated the doctor by asking for a certificate for time off work rather than wanting to enlist his medical or therapeutic skills. The second, presented by a social worker who looked after the welfare of bank employees, was an unhappy woman who was the lone parent of a 10-year old boy. Her social worker had spent a lot of time helping her through several episodes of psychiatric illness and had managed to get back to part-time work in the bank. Unfortunately, she did not get on well with the other bank clerks and was talking of giving up the job, to her social worker's dismay and disappontment. Our third case was presented by a penologist, a social worker in the prison service. He explained that he and his colleagues had to cope with very stressful working conditions. They felt as if they were being crushed between opposing pressures from the prisoners, who wanted chiefly to get out and the prison authorities who wanted to keep them in and to punish them. He described the case of a 29-year-old man with a severely deprived childhood who had been sentenced to a year in prison for fairly trivial thefts. The social worker had negotiated a day at home for the prisoner, but he had spoiled everything by returning to the prison late and drunk. The privileges and remission which had been painstakingly earned were immediately lost. The social worker was very cautious about allowing himself to feel any empathy with his client because his outlook seemed so hopeless. It was as if his own human feelings were imprisoned within his ribcage: hopefully he was able to give them a day of freedom too.

The other groups were led by Jack Norell, Erica Jones and Dr. Dusan Zagar, who is a psychiatrist and Balint-group leader in Ljubljana, the Slovenian capital. There was also a fifth group for the children, aged from 10 months to 8 years. They were ably entertained by their own 'leader'. Perhaps not yet a Balint-group, but they seemed to be having a lot of fun nevertheless.

At the final plenary meeting, everyone seemed to feel that the experience of the weekend had been a valuable one, and the co-leaders were pleased to have been able to improve their skills. The natural beauty of the lake and the mountains, the fresh, sparkling air and the tranquility contributed greatly to our enjoyment, as did the excellent food and the hospitality of our Slovenian hosts. Our thanks go to them, and especially to Dr. Zlata Kralj who is to be congratulated on bringing so many people so successfully together in such a lovely setting.

JOHN SALINSKY.

The International Balint Federation

The Federation now has active affiliated Balint Societies in 14 countries: Belgium, Croatia, Finland, France, Germany, Hungary, Italy, Poland, Romania, Slovenia, South Africa, Sweden, United States of America and Britain. Switzerland is represented by the Swiss Psychosomatic Society. We are also in touch with Balint enthusiasts in a number of other countries where Balint-groups are active, but there are no Balint Societies yet.

These countries include Austria, Denmark, Holland, Israel, Norway, Slovakia and Spain.

Representatives of the national Societies meet twice a year and individual members from countries without Societies are also welcome to attend. The last meeting was held in Brussels in February 1994, and was attended by 18 people from 10 countries. The new president of the Federation, Dr Frank Dornfest (USA) chaired a discussion on the subject of the training and accreditation of group-leaders. Most people took the view that qualities and experience were more important than qualifications, but there were interesting differences to be found in the situations in different countries.

Two new Societies, those of Poland and Romania, were welcomed and admitted to membership of the Federation. We also had a pleasant dinner together, and a demonstration of 'Balint Psychodrama' by Dr Michele Lachovsky (France).

In April of this year the Swiss Foundation of Psychosomatic and Social Medicine awarded its annual Balint essay prizes for medical students at a ceremony in Ascona, on Lake Maggiore in Switzerland. The first prize was won by a British student, Christopher Beith, from the Royal Free Hospital (see page 28). This competition will be held again in 1995 (see page 4).

In November 1994, the Federation will be mounting an International Balint Congress in Charleston, South Caroline, USA. This should be a most exciting and rewarding experience and we are hoping that as many people as possible will be able to attend. (See page 48 for details).

Another International Balint meeting will be held in Lausanne, in 1995 (27th-29th April) the latest in the series organised for medical students as well as qualified doctors, by Professor Boris Luban Plozza of Ascona, Switzerland. The theme will be *'Balint: comment continuer?'* These meetings have groups conducted in different languages, including English, if desired, and the presence of so many enthusiastic students gives the whole event a youthful and festive mood.

In 1996, the 100th anniversary of Michael Balint's birth, the Hungarian Balint Society will be arranging a special Memorial Congress in Budapest, the city of his birth.

We in Great Britain often feel disappointed that there are so few Balint-groups in this country, and we wonder why more doctors here have not wanted to be involved. As general secretary of the International Federation, I have been very cheered and encouraged to find that there are so many kindred Balint spirits in so many countries in Europe and beyond. I would like to remind everyone in our British Balint Society that we belong to an International movement which is alive and flourishing. So brush the dust off your passport, go to your local travel agency, and go and take part in a Balint-group in a different country. Best of all, come to Charleston in November, where you will find you have friends from all over the world.

For further information about the International Balint Federation, please contact the General Secretary, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex HA9 9SG. Telephone: 081 904 2844.

John Salinsky
General Secretary
International Balint Federation

The American Balint Society will host the 9th International Balint Federation Congress

Balint Training in a New World

Purposes: To provide a forum for interaction between Balint trained physicians, qualitative researchers and international faculty. To provide new directions in the day to day practice of Balint methods in primary care.

Objectives: Participants will leave the conference with new skills in:

- **Personalised Patient Care**
- **Group Leadership**
- **Utilization of the Balint Method**
- **Evaluation of Outcome**

9th to 13th November 1994

at The OMNI, Charleston, South Carolina, U.S.A.

Full details available:
Dr John Salinsky, General Secretary, International Balint Federation, 32 Wentworth Hill, Wembley, Middlesex HA9 9SG

This event is the first International Balint Congress to be held in America. Yes, in the United States, contrary to everything we may have heard, there are real family doctors who care about the doctor/patient relationship and gather together in Balint-groups to worry about it, just like we do. But being Americans they have a vigorous and dynamic approach to researching what it is all about. Balint enthusiasts are working in Family Medicine training programmes, just like here, and they want to convince the deans and the professors that Balint-training is important and actually capable of transforming doctors and their patients.

They have proposed the application of Qualitative Research, which has developed ways to scrutinise and analyse in a scientific manner the process that go on between people in therapeutic relationships. At the Charleston Conference three highly respected qualitative researchers, who know nothing about Balint (yet) will observe our work and discuss with us their conclusions about its scientific validity.

Each day two keynote speakers will give us their thoughts about the critical issues: leadership, assessing outcome, the future of Balint work. Then there will be fishbowl-groups led by leaders from different countries, for you to join in or watch, in the mornings. In the afternoons there will be a rich variety of individual papers to choose from; or you can dive into your own Balint-group and stay there every afternoon presenting and listening to cases with a small International group who will soon be your friends for life.

Then there's the city! Most visitors to America go to New York or Disneyland or San Francisco. Relatively few find their way to Charleston, a well kept secret. If you come, you have a treat in store; street after street of elegant eighteenth century wooden houses with shady verandahs screened by classical colonnades and surrounded by luxuriant gardens. Further downtown the atmosphere is lively with seafood restaurants and bars and the sounds of music. There are museums, there are antique shops and tours of the historic buildings of this Southern city, spared by the Civil War and without a skyscraper anywhere in sight. It was here, by the sea and the waterfront, where Gershwin set Porgy and Bess.

Our American hosts will be delighted to see us and show us their Southern hospitality. There will also be Balint doctors from all over Europe and further afield, looking forward to meeting us and telling us about their patients who, strangely enough, are exactly like ours, although they live in Paris, Brussels, Stockholm, Helsinki, Vienna, or Cape Town.

So come to Charleston for the experience of a lifetime. OK, it's a little expensive, but you're not short of a bob or two and you've got to spend it on something. I'll meet you in the cocktail bar of the Omni Hotel and we'll relax over a couple of mint juleps while we whet our appetites for the greatest Balint show on earth!

J.V.S.

From the 25th Annual General Meeting held on 14th June, 1994

Presidential Address given by Dr Peter Graham

It was the best of times and was the worst of times. I wonder which of these statements most accurately reflects this current year, when history will audit our achievements.

To start with the good news, the number of books and articles published has grown, and the understanding of Balint and the doctor/patient relationship is slowly being completed. A group led by Paul Sackin has managed to produce a working definition of what a Balint-group is, which will be a Mission statement to all and sundry (page 36), as a kind of landmark in response to my initiative here last year.

Our relationship with the Royal College of Psychiatrists began a new era when we met with Dr Ann Dean, their Education Officer, at our day-meeting last month at the Hospital of St John & St Elizabeth, entitled *Recapture the Joy of General Practice,* which was a first class meeting, and where she was palpably impressed by the two Balint-groups she observed. The psychiatrists have stated that their juniors in training should have Balint-group experience. No doubt this will affect us in the future, and will call for some increase in our resources.

Also, as suggested in the Editorial in last year's issue of our *Journal* (page 3), it appears that a number of practice nurses will need help which might well include training in Balint-groups, in order to understand better their developing role in the field of general practice, and we are commencing talks with Dr Dean about possible future programmes to include them.

John Salinsky and Graham Curtis Jenkins have written a model Leader in this month's *British Journal of General Practice,* on our relationships with counsellors in general practice.[1] This is an excellent pathfinder on the way ahead for the further expansion of Balint-work. There is no doubt that we are at the centre of a vast armada of activity which will become more important in the future.

The Society's evening meetings at the Royal College of General Practitioners this year, were of an excellent standard, particularly the one devoted to *Hyperventilation in General Practice,* which was introduced by a most comprehensive lecture by a member of our Society, Dr Sotiris Zalidis (page 28). We are grateful to our secretary, David Watt for organising them so well.

The meetings at Oxford and Ripon continued the high standard which we have come to expect of them. The Ripon meeting was unusual, in that it was arranged as part of the annual meeting held by Course Organisers, to give them an opportunity to experience participation in a Balint-group.

Some of us went to America to the Balint Leaders' Intensive Workshop in Charleston, which confirmed the benefits of the exchange of ideas, and we look forward with great anticipation to the next International Congress which takes place there in November (page 48).

The bad news is that there are very few new members joining the Society, and there are no new groups starting. Even those at the Tavistock Clinic where a meeting was held recently, are under threat. Future recruitment also looks bleak, as most doctors are increasingly burdened with so much paper-work that they have less time with their patients. In Cambridge, Dr Jon Sklar may have to resign.

I must repeat what I said last year, we are rushing like lemmings to the cliff edge, and unless we can find a way of defining the value of Balint-work and training, and at the same time raise the status of our group-leaders, the loss of interest will continue. We know that it works, but we need to demonstrate that it works for others to see.

Last September in Oxford, I was shocked when we heard that someone had tried to set up a Balint-group without an experienced group leader, nor even a member of the Society. I propose that we should appoint a committee to set minimum standards of accreditation so that in future, everybody will know the minimum requirements, and how to acquire the title, Accredited Balint-group leader, and how to obtain it.

I know that this may be controversial and that many will say it is unnecessary, but in the past we have taken so much that is unsaid for granted, that we must now make it crystal clear, speak out loudly and call a spade a spade, and speak out for patients and other doctors.

Reference:

1. Salinsky, J. Counselling in General Practice. *British Journal of General Practice,* 1994; **44,** 194-195.

Secretary's Report, 1994

The Society's year began with the Oxford Balint Weekend at Lincoln College from 17th - 19th September 1993. Forty-one participants attended. Unfortunately we did not attract any medical students, but I will publicise the next meeting more widely. I think that the word of mouth is very important; looking back to two years ago, the five students who attended had known one another through various connections. I also hope that members will encourage their friends and colleagues to come along. We had four groups, including the on-going research-group.

The meetings this year were much better attended than for some time, averaging twenty people at each. The first was on 22 October 1993, and was introduced by Dr Andre Tylee, on the current important topic of recognising depression in general practice. At the second meeting, on 16 November 1993, we welcomed Drs Rob Hale and Nollaig Drake, consultants at the Tavistock Clinic, who spoke about their intention to continue the general practitioner seminars there, and to try to work more closely with the Society. Further communications with them have taken place, and I am glad to be able to report that they have announced next year's seminars in a renewly phrased advertisement which is more positive and explanatory.

On the 15 February 1994, Dr Sotiris Zalidis spoke about the incidence, aetiology, diagnosis and practical management of the hyperventilation syndrome in general practice. I am sure that we all took away from that evening, some new ideas they might apply in their practices.

The eleventh Balint Memorial Lecture was given on March 15 this year, by Dr Alexis Brook, who fascinated a well attended meeting, with an account of his work in hospital and in the Well Street Group Practice, with patients suffering from eye disease which seemed to respond to psychotherapy. Lastly, on April 19, Rabbi David Freeman, who is also a practising Jungian analyst, compared some of the effects of the holocaust experience, he has observed in patients, and on those involved in the Arab/Israeli conflict. He vividly described how some of those who had perceived themselves as having been victims, could become the victimisers. He described how the repercussions of this type of experience can be seen to affect some of the patients we see in general practice, as for example, the victims of child abuse who can victimise their own children later.

Following the decision made at last year's Annual General Meeting, I duly sent out questionnaires to members of the Society inviting them to say whether they would consider it worthwhile holding a Day Meeting in London, and how much would they be prepared to pay for attending it? There was also a question about their willingness to have the annual subscription raised to cover the cost of paying speakers who agree to attend our evening meetings. Just over 20% responded, and provided sufficient information to allow us to plan ahead.

A good number thought they would attend a Day Meeting in London, so this was arranged, and took place on Thursday, May 19, at a very pleasant venue, the Hospital of St John & St Elizabeth, in St John's Wood. Eighteen doctors attended the day, which started with a short introduction to the Balint movement by Dr Philip Hopkins, followed by two sessions of the two groups which were both well appreciated. Finally there was a lively plenary session led by Dr Andrew Elder. There was a good mix of experience in those who attended, and we hope to arrange another similar day next year, with a larger attendance.

In their answers to the questionnaires, people were quite equivocal about whether speakers attending the evening meetings should be paid, being evenly divided between yes, no and don't know. Interestingly, a large majority of those who replied, stated that they would be willing to pay an increased annual subscription, though I suppose that this might not reflect the view of the less keen members who did not reply to this survey.

I am very pleased that I can end my report on a happy note, and tell you that Council decided that there is no need to increase the subscription rate at the present time.

DAVID WATT

The Balint Society
(Founded 1969)

Council 1994/95

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Bodily Empathy

Address by Michael Courtenay

It is sometimes useful to look outside the traditional field of Balint work, and I should like to pay tribute to a Swedish Balint colleague who has taken a long hard look at the work of the general practitioner, having been under pressure from specialist colleagues who have not appreciated the special nature of the setting. Carl Edvard Rudebeck wrote the Supplement 1/1992 for the Scandinavian Journal of Primary Health Care setting out four papers addressing the unique kind of demands and responses which the work of general practitioners makes.

The study was undertaken in the context of the virtual disappearance of general practitioners in Sweden during the nineteen-sixties, and whose resurgence had led to confrontation with specialists who doubted whether general practice was coherent or 'safe'. He reviewed the history of a possible theory of general practice medicine, starting with Keith Hodgkin's seminal book *(Towards Earlier Diagnosis in Primary Care, 1963),* and continuing with Fry, Morrell, McWhinney and Bentsen. He criticised the working parties endeavouring to clarify the general practitioner's role, considering that both WONCA and the Leuwenhorst Group (of which he served as a member), had failed to identify what is the essence of general practice.

They shared a principle of inclusion of tasks and fields of knowledge without any logical structure of hierarchical priorities. The general practitioner is left as the sole source of specific expertise in the field. The specialists' question 'what is specific about general practice?' had to be taken seriously. By making doctors conscious of what is 'unorthodox' in the setting, the emergence of its specificity became more likely.

From his Balint-group experience, he saw that patient-centred medicine and the findings of clinical epidemiology had to be integrated in order to achieve clinical competence. He also saw that Morrell's concept of 'symptom presentation' had implications beyond the vision of its authors, in that it involves the patient's response to the symptoms in addition to the symptoms themselves. In general practice, thousands of doctor/patient contacts covering a wide spectrum of symptom presentations can generate a special skill.

Over-reliance on bio-medical knowledge tends to make clinical work a purely cognitive matter, but reality is more complex. Unfortunately, the imprinting of orthodox medical education may lead doctors to ignore their own experience, undermining their capacities and self-esteem. Only observation in working with patients in general practice can lead to the resolution of apparent anomalies dictated by theoretical considerations. As communication between doctor and patient is fundamental to the work, only by reconciling the patient's and the doctor's agendas can the latter fulfil his task.

Rudebeck has explored the philosophical literature widely, and came to see that the body considered in medicine is rather de-humanized. We have no other access to our bodies other than our own experience of them. This is the common factor for patients and doctors in looking at things bodily. He then drew on the phenomenologists to put forward the idea of the 'Lived Body', made up of the 'Body-as-nature' and 'Body-as-self'. He realised that symptoms change the view of the patient about his body, becoming something apart and out of control; 'other-than-me'. As a human being is actually undivided, the patient's agenda is determined by his/her reaction to disease.

This view led to his seminal of 'Bodily Empathy'. The doctor's understanding of his/her own body is special, integrating the experience of the lived-body and the knowledge of medical science. Even though the doctor cannot experience all possible symptoms, 'bodily empathy' can develop through the special understanding of bodily experiences. While empathy has been generally understood as a professional way of understanding emotions arising in the patient, the bodily effects of these can become part of the process by which the emotional dimension is communicated to the doctor through 'affective resonance'; and a similar resonance can be developed through the experience of the lived-body because the doctor has the capacity to view his/her own symptoms in a unique way. Bodily empathy is essentially the understanding of other people's bodily experiences and this can resolve any discordance between the patient's and the doctor's agendas.

It is then no longer necessary to abandon the patient who presents symptoms which do not fit into the traditional taxonomy of disease, which is precisely the Balint doctor's stance. Additionally, physical examination can be enhanced by adding this bodily dimension of empathy to the traditional methods of examination. Physical examination displays the patient's bodily expression of distress more clearly than words, so that the combination of verbal and bodily responses can deepen the clinical interaction. This is precisely in accordance with the findings of Balint doctors who developed methods of reaching diagnoses in patients with psychosexual problems through the use of vaginal examination thirty years ago. Altogether Rudebeck's work has illumined the nature of Balint work by approaching the work of general practice from another direction.

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

1994-95

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

Dr ALEC FRANK, General Practitioner, Sussex. 'A Very Peculiar Practice'.	18 October 1994
Mrs C. B. GARLAND, Clinical Psychologist & Psychoanalyst, London. Surviving a Disaster: the Longer Term Picture.	29 November 1994
Dr PAUL LAUNER, General Practitioner, Edmonton. The Doctor, the Family and the System.	21 February 1995
Dr DAVID SCHARFF, Psychotherapist, Washington, D.C. Relationship between Psychososomatic Aspects of Sexuality and the Issues of Emotional Engagement.	21 March 1995

(Non-members are welcome, free of charge)

Other Events:

LONDON DAY CONFERENCE at the Hospital of St John & St Elizabeth	18th May 1995
THE ANNUAL GENERAL MEETING AND DINNER Will take place at the Royal Society of Medicine, at 7.30 p.m.	29 June 1995
THE OXFORD BALINT WEEKEND, 1995 Will take place at Lincoln College, Oxford: From Friday, at 6 p.m. to Sunday, at 1 p.m. (Dates will be announced)	September 1995

All meetings are PGEA approved.
Further information available from the Hon. Secretary, Dr David Watt.

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.

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

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

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

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