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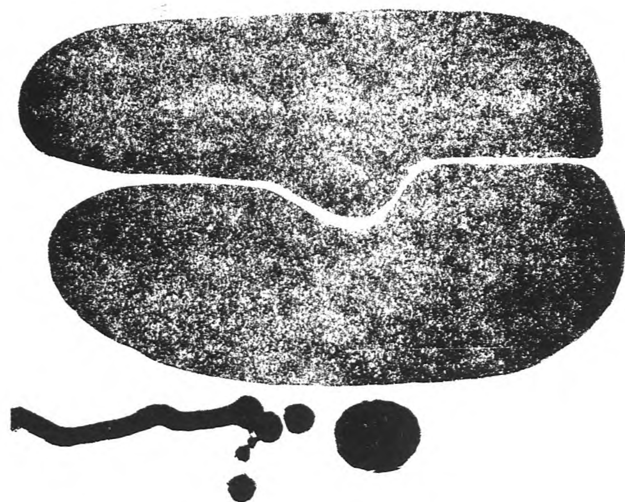

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The Balint Society:

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

Editorial

The general practitioner and the depressive patient

There has been increasing concern about the alleged failure of general practitioners to recognise depressive illness in their patients. Some authorities have put the figure as high as 50%. As a result, the Royal Colleges of General Practitioners and Psychiatrists jointly launched their 'Defeat Depression Campaign', in January 1992.

Its aims included improvement in the training for general practitioners, especially in the recognition of mental illness like depression and anxiety in their patients, and how to treat them.

There has been no news about the success of this campaign, but perhaps we might have heard about some useful outcome of it, had it not been based on a battle-like sounding approach. There was little, if anything in it, to suggest that our depressed and anxious patients need, more than anything else - *understanding.* Both doctor and patient need to have facilitation of their understanding of the basis of the patient's illness, especially where somatisation has been the response to the depression/anxiety.

Instead, there are regular reports in various medical newspapers and magazines about the ever-increasing numbers of doctors wanting to retire early, and that many of them are also suffering from increased stress. It was reported at the British Medical Association's annual general meeting at Harrogate early in July 1995, that as a result of this stress, one in twelve doctors are abusing drugs or alcohol, while others are driven towards mental breakdown and suicide attempts.

It is usually said, that this is related to the increasing bureaucracy in the National Health Service, now top-heavy with management who impose more and more useless work-load on them, with the sad effects many are experiencing. Added to this, in recent years, there has been much discussion of the concept of 'heartsink patients' - those chronic attenders who return again and again with persistent, or ever-changing symptoms, if the earlier ones have been controlled by medication. Many of them are almost certainly suffering from undiagnosed depressive/anxiety illness, who are desperately searching for understanding and help to deal with their basic, primitive and unsatisfied emotional needs, and which result in that awful sinking feeling in their doctors who are made to feel frustrated and impotent, due to their inability to help them. These reactions are the effect of their counter-transference, which has been so well described by Michael Balint (page 310 in *The Doctor, his Patient and the Illness, 1957.)*

The issues involved are again succinctly described in the paper on The General Practitioner and the Depressive Patient, by Professor Alex Tarnopolsky, who worked with Balint many years ago, which I am delighted to publish in this *Journal,* (page 20).

It is well recognised that formal 'teaching', with lectures, cannot have the effect produced by the experience of sitting with a group of colleagues and a group-leader who creates an atmosphere in which anyone can speak unhurriedly, while the others listen with free-floating minds, and which allows periods of silence, and time allowed for everyone to discuss and find out what he really means and what he really wants to say.

It still amazes me how, even in groups who meet for only three or four sessions at our Oxford Balint Weekends, readily settle down so quickly to work together in discussing the case presentations. Whatever the group's reaction, the emotions emerging both in the reporter and in his audience, must be accepted and evaluated as expressions of unconscious processes activated by the report. In this way, and over a period of time, each group member can undergo that 'considerable, though limited change in their personality' which Balint described as being necessary if we are to develop the skills required to help our patients in this way.

P.H.

Celebrating the Life of Enid Balint*

Address by Mike Courtenay

In the words of the ancient Greek playwright Aeschylus: 'We must not consider a man truly happy, unless prosperity endures with him to the end of his life,' And although Enid Balint was unlucky enough to die of complications after elective surgery, her ninety years of life remain a splendid achievement.

To me she was a person like no other, very difficult to describe. In the course of her interview with Juliet Mitchell, recorded in her last book, *Before I was I*,[1] she says 'Winnicott always warned me that I had a reassuring personality and I had better watch out.' What he meant was, that in spite of her thinking that she was not being nice to her patients, she was. She defends herself against this charge by recounting how different patients had recalled what she was like with them; some saying she was nice and some saying she was horrible; concluding that their feelings were just part of the transference.

In my personal experience of being supervised by her during the Balint research project on using focal therapy with patients complaining of sexual problems in marriage, she was able to challenge my work without making me feel miserable. Her challenges were so quiet (I can find no other word), that fresh insight was gained without too much pain at the realisation of how one had entered a cul-de-sac with a patient. You will observe from my remarks that my transference was positive, though at the time I had difficulty in identifying the person in my own life for whom she stood in our relationship.

She believed that our life is more than the classical idea of a breathing individual, and that 'imaginative perception' was the hallmark of someone truly alive. For her patients she sought to facilitate the emergence of their own partly imagined, partly perceived, world. This gave reality to the outside world, to the people to whom they related, and to themselves. She saw it as the essence of creativity, necessary to life in its fullest sense.

In ordinary social contact there were so many things one could share with her; music, art appreciation, good food and wine, talking politics and religion. My first journey to the U.S.A. was with her. It was a week at the Albany Medical Centre, where we offered group-experience to medical students, as well as giving some lectures on sexual medicine and family practice. We were staying with Michael Balint's son John and his wife, so there was an opportunity to experience her in a domestic setting. What I am struggling to say is that in whatever setting I met her she was herself, and the spectrum lying between her private and professional personae appeared seamless.

Her working career was astonishing. Her professional interest in people began while working for the Citizens' Advice Bureaux during, and just after, World War II. In trying to look after people who had been bombed out of their homes, she had found that they were not apparently worried about the destruction of their home, but about apparently irrelevant details about whether their neighbour was stealing their salt and pepper. The smallest things were much more important at that moment, even during the war, than the big things.

Later she used this experience to alert family doctors to the fact that it is not the obvious which has to be understood; it is whatever the patient *wants* to be understood, and often do not realise what that is when he comes to the doctor's office. But her work with family doctors did not start until after she began working with marital therapists; which grew out of her work with the families whose homes had been bombed. It was her work with them that brought her into contact with the Tavistock Institute of Human Relations. There she set up the Family Discussion Bureau, which later became the Institute of Marital Studies. During that period she met Michael Balint, who helped her set up training groups for the social workers who were seeing the clients in marital therapy, and it was at her suggestion that they started groups for family doctors. Michael had run such a group in Budapest in the 1920s at a time when any gathering of more than three people outside the home had to be attended by a member of the secret police! His policeman eventually became his patient! Meanwhile Enid undertook psychoanalytic training. In this way she ran a troika of three careers; as analyst in the consulting room, as analyst working with family doctors and as analyst working with marital therapists. Her last book published before her death brings her papers about all these themes together.

Her analytic work lies within the Independent tradition of British psychoanalysis, though belongs to no one but herself. Although her analytic thinking was closely associated with the work of Michael Balint and Sandor Ferenzci, as demonstrated by the references in her book, there is something very English about her intellectual and personal style. She had a commitment to a shared tradition, allied to an unmistakable individuality. She played a leading part in the life of the British Psycho-Analytical Society, particularly in her role of training analyst since 1953. One British analyst has commented that the quality of her presence in the analytical community was hard to pin down; supervision sessions had an elusive quality, though they were never vague.

*Address given at a Memorial Meeting on 25 April, 1995.

They were somehow elusive and distinct at the same time. Sometimes she would show you how to talk to the patient, sometimes help to organise your theoretical understanding. This all mirrors my own experience.

This elusive/distinct mixture stemmed from her subtlety and flexibility with which she used herself or allowed herself to be used as an analyst. In her work with family doctors she did *not* teach psychoanalysis in Balint-groups, and she did not supervise them either, even if it sometimes appears that way. She had a supervisory role in the case discussion seminars at the Institute of Marital Studies, but always resisted any temptation to teach a debased form of psychoanalysis, while still using herself as an analyst according to the demands of the particular situation. The social worker therapists were more sophisticated than the doctors; but because marital disharmony intrinsically involves psychological conflict, she had to be even more alive to the differences of the work from psychoanalysis. In individual psychoanalysis the idea of helping a patient to enjoy neurotic satisfaction would be alien, but might be the very way that analytical understanding can allow a marital therapist to help a marriage.

Enid's elusiveness seems to stem from her exploration of a technique in what the analyst *does not do* may matter more than what he does, and it is more important for him to remember what he does not say than what he does. This is not passivity, but a strict discipline, for the most part invisible. She believed that the first imaginative perception could only arise out of a state of eager aliveness in two people, the infant with the potential for life and the mother alive inside herself and tuning in to the emerging infant. Of course, I now perceive that she was the mother of my professional self, and I bless her for it. For me, and for you too if you wish it, although she is dead, she will continue to live.

Reference:

1. Balint, E. *Before I was I: Psychoanalysis and the Imagination.* Edited by Julie Mitchell, Michael Parsons. Guildford Press, 1993. London; New York.

The Enid Balint Institute of Psychoanalytic Psychotherapy (E.B.I.P.)

Background

In 1980 a Three-Year Training Course in Psychoanalytic Psychotherapy was established at Queen Mary's University Hospital, since then, it has met the training needs of 70 students. That Course was created as an essential aspect of the activities of the Association of Psychoanalytic Psychotherapy in the National Health Service, which was formed also in 1980 by a group of Psychoanalysts holding Consultant Psychotherapist posts in the National Health Service.

Over the years, the Course has developed in many ways and these developments are now incorporated in the E.B.I.P.

Administration of the Training

The Course is organised and provided by a Training Committee consisting of psychoanalysts and psychoanalytic psychotherapists. It is based at the Enid Balint Centre, which is a separate building within the grounds of Barnes Hospital, South Worple Way, London, SW14 8SU. The academic part of the training extends over three years. Following qualification students are admitted to membership of the Enid Balint Society of Psychoanalytic Psychotherapy (E.B.S.P.).

Applicants must possess a University Degree (or equivalent) in a relevant discipline and should be between 25-55 years of age. (This rule may be varied in exceptional cases).

Intake is limited to a maximum of ten students per year.

Full details and Application Forms are available from:

Barnes Hospital, South Worple Way, London, SW14 8SU.
Tel: 0181 878 4981; Fax: 0181 876 5471.

The Enid Balint Psychotherapy Trust

The Trust was established in September 1994 in Enid Balint's memory and the funds are used for the promotion of psychoanalytic psychotherapy, including grants to assist in the training of students.

The Doctor, the Family and the System

John Launer
General Practitioner, Edmonton.

Introduction

When I was invited to address the Balint Society, I wanted to choose an arresting title for my talk, so I called it: 'The Doctor, the Family and the System'. I now realise this title is somewhat ambiguous, if not mystifying. This was unintentional, so let me explain its meaning.

I am both a general practitioner and a family therapist. I am excited about the possibilities which these two disciplines – family medicine and family therapy – offer each other. I belong to a small, but growing band of general practitioners in this country who believe that ideas from family therapy have the power to change general practice. I believe this to be the case for everyday general practice, and for training, research and theory. That is what I want to discuss in this paper.

Like most family therapists, I am interested in all human interactions; not just in the family, but also in other human systems like practices and professional groups; in what goes wrong with them, and how they can be helped. Some family therapists prefer to be called systemic therapists for this reason. Hence the 'system' in my title. It is not meant to carry heavy political overtones, although in general practice in 1995 some of us might think that was appropriate!

I must first describe something about my own professional background, so you can put what I say into context. As a general practitioner, I work in a five-partner training practice which operates from a health centre in Edmonton. Although we are technically in the outer London suburbs our patient population is more typical of the inner city. We work entirely in the National Health Service, non-fundholding and politically left-of-centre. The practice has a tradition of taking on partners and team members with an interest in the social and psychological aspects of people's lives.

Before becoming a principal in Edmonton, I was a trainee with Hilary Graham at the Highgate Group Practice. Some of you may know that Hilary has been one of the pioneers of using family therapy in general practice in Britain.[1,2]

At the time I was with him, his interest in the subject was just beginning. Occasionally during my trainee year he referred a family to Sebastian Kraemer at the Tavistock Clinic, and we would both go along with the family. I was impressed by what I saw. When I joined my own practice, I continued to take a few families there too. Later, Sebastian encouraged me to take the introductory course at the Institute of Family Therapy, where I learned some basic family therapy ideas and techniques.

It is always tempting to present one's CV as a smooth sweep of progress, but things were not like that. By the late 1980s, I was feeling depressed by my work, and badly in danger of professional burn-out. This was partly because of the National Health Service changes and partly for other reasons. I had also been seriously ill with pericarditis. In 1991 I decided to take a year off. At that stage, I was not intending to take my family therapy training any further.

However, through a series of conversations and opportunities, I was offered a place on the clinical training course in systemic therapy at the Tavistock Clinic. I built my sabbatical year around this, with other attachments at our local child guidance clinic, and with one of the local clinical psychologists. After my sabbatical year ended I was encouraged to complete the course part-time and to do an MA dissertation based on using family therapy ideas in general practice. It is fair to say that these experiences have transformed my view of my work and my career.

Since completing my training at the Tavistock, I have been working reduced sessions as a general practitioner, and spending the rest of my time trying to explore and develop this interface between general practice and family therapy. I have been practising family therapy. I have also been teaching general practitioners and general practice staff. I have been trying to help mental health professionals work more closely, and more relevantly, with general practitioners. I shall say something later about these things, but for the moment I want to tell you more about family therapy.

Family therapy

Family therapists see families, of course; we see them together, in twos, threes, or larger numbers. We see families of all kinds. There are no rules about patients having to be married, a nuclear family, or anything else. There is no prior commitment to persuading families to stay together, or to break up, or to behave in any normative way; that is not the point of seeing them. Sometimes we see families together with other people who are involved in their lives, like their social worker, or a schoolteacher, or even the general practitioner. Sometimes we see parts of families because the other members cannot, or do not want to come. We even see individuals, although when we do so, the subject of conversation is often their family and their relationships. Quite often we will have a series of meetings with different combinations of family members.

Family therapy can take place in a single assessment session, or at intervals of a week, a fortnight, a month or even longer periods – perhaps a year or two. Different practitioners and institutions offer different contracts with families, and obviously will also offer a length of treatment in response to the seriousness of the presenting problem.

If you ask us why we see families, we usually give two answers. One answer is to do with problems, and the other is to do with solutions.

We see families because we believe that they are usually implicated in anyone's problems. We have moved far beyond the simplistic notion of blaming parents, or spouses, or families as a whole for any individual's set of problems. At the same time, most of us believe that every problem has a relational aspect to it. In the development of any one person's problem, other people's behaviour has often played a part. Once that problem has arisen, the response of other family members may intensify it, rather than help it. In this context, family therapists talk a lot about 'circular' processes. No general practitioner will need to be told what this means; every day we see patients whose problems make much more sense as part of an interacting pattern rather than just a random, inexplicable set of symptoms.

We also see families because we think it may help them to solve the problem they have brought. Given a chance, some families come up with solutions we would never have thought of as professionals. Others use the opportunity to discover how to collaborate with each other, whereas they might have pulled in different directions if they had not been seen together. Handled properly, many families will find it an important exercise to sit down together and have the opportunity to talk to, and with, each other. For some people, it produces the first active realisation that we are all mutually dependent and can be mutually nurturing.

What do we do in our family meetings which produces these effects, or at least attempts to produce them? One thing we do is to pose lots of questions which emphasise the context of problems rather than the content of the symptoms themselves. We try to get people to think about the causes and effects of their problems within the family. We inquire about how these things arose from the past, and what effects they might have in the future. We try to encourage people to talk about each other, and to each other. Sometimes we propose strategies for them to try, in order to do things in a different way. More often, perhaps, we hope that the interview itself will have its own effects, possibly by opening up new ideas, or by allowing the family to think about old conundrums in new ways.

The picture I have painted of family therapy so far, is simple and idealised. It is a bit like saying that individual therapy consists of lying someone on a couch and listening to them. Much family therapy in practice is fraught with tremendously intense feelings, and much of it succeeds only partially or not at all. In the fifty years of family therapy, there has developed a tremendous body of knowledge about human interaction and therapeutic technique. Family therapy theory and practice has also gone down some blind alleys. Family therapists have done much in the past which would now be regarded as manipulative and even abusive. What we do today is necessarily provisional, and subject to constant mutual critique. Like individual therapists, we are engaged in a mutually educational discussion with our clients.

There are aspects of family therapy which always excite comment. One is the use of videotape and another, that of observers who sit behind a one-way screen. (To confuse matters, this is nearly always termed, quite erroneously, a two-way mirror). The justification for this is simple, therapists can be overwhelmed by the amount of information and the emotions which are present in a family consultation. A video recording, or an observing team provides a degree of detachment. These can help the therapist to reflect, and to think more freely. I should say that I have seen these techniques used with insensitivity and intrusiveness. I have also seen them handled with great respect, so that the families knew exactly what was being done, and why, and came to appreciate their benefits as much as the therapists did. Incidentally, some experienced therapists prefer to work on their own, or with a colleague in the consulting room rather than behind a screen.

In order to train in family therapy, you need to be qualified in another care-profession first. Most trainees are clinical psychologists, social workers or child psychiatrists. An increasing number of individual therapists and counsellors are also asking for training. In Britain, most family therapy takes place in child guidance clinics, although some hospital psychology departments offer it too. At present, family therapy is mainly used for the emotional problems of childhood and adolescence, particularly in eating disorders, and in addressing problems of physical or sexual child abuse. However, much of the original development of family therapy was with families of schizophrenics and, in Italy in particular, it is often used to help such families. In most countries there is an increasing interest in seeing families where an adult member is depressed, and also with older families, and families coming to terms with someone who has a learning disability. In the United States the growing point is with families where someone is chronically ill, physically disabled or dying.

I have already mentioned one similarity between individual therapy and family therapy. There is sometimes a tendency to see these two branches of therapy as ideological rivals, but I think this is ill-informed. Most of the innovators in the family therapy field were trained first as analysts, group-analysts or child psychotherapists. I know of few family therapists who have not had personal therapy or analysis. Many current practitioners work in both fields. Most would agree that the best outcome of family work is sometimes that the most distressed member of the family decides to seek a personal counsellor or therapist. Equally, it is common to see individuals who are in personal therapy but have benefited, or would benefit, from family meetings.

There is something else which links both types of therapy. Until quite recently, both individual and family therapists were prone to treat people as if they were objects for scientific study. I think we are now much more interested in the way therapists and patients jointly try to make sense of their experiences, and which explanations they find useful in reducing the sense of suffering. Therapists of all kinds are becoming less wedded to their certainties, and more concerned to explore new meanings with their clients, often using their own ideologies as starting points rather than revealed truths. I think everyone is also more aware of the enormous power which therapists can use, or misuse, and the need to reflect on this constantly and do what we can to challenge ourselves.

Case discussion

I now want to try to relate all this to our professional setting. What does family therapy have to offer us as general practitioners?

When I started to take an interest in family therapy a few years ago, I felt a compulsion to practise it in my general practice work. Every time I saw patients, I wanted them to come back with their family for an hour's interview at the end of the day. Some of them never turned up. Some turned up and hated it, and others turned up and exhausted me. You may recognise my mistake as the same one that Michael Balint's early followers made – trying to be therapists instead of general practitioners.[1]

I think there is a place for doing formal family therapy within a general practice setting if you have the training the time and the facilities, although there is a need to think carefully about the issues of confidentiality, the boundaries between one's general practitioner and therapist roles, and about criteria for taking on cases for extended work. A few of us around the country are trying to do this, but I suspect we will always be a small minority.

What is much more exciting, and much more relevant as a whole, is to think about how to use family therapy approaches in the six-minute, or the ten-minute appointment.[3] My research dissertation, and some of my work since then, has been centred on this question. I now want to devote some time to this.

As an illustration, I would like to discuss a family. I have taken a case from the Balint literature and I want to discuss it through a family therapist's eyes. The case was described in a recent issue of the Journal of the Balint Society, and it is exactly the sort of thorny case which intruiges any general practitioner with a psychological bent. It comes from a talk given by John Salinsky to the Balint Congress in Zagreb entitled *Still angry after all these years.*[2] I am grateful to Dr. Salinsky for giving me permission to use it.

First, I must say I do not in any sense claim that a family therapy approach would have been better, or that I would necessarily have handled the case more skilfully than the doctor concerned, who presents his experience with disarming frankness. I am using it as a starting point for showing how a family therapy approach might inform general practice. Incidentally, as you read this, you may well ask yourself, 'What family therapy approach? It sounds pretty Balintian to me'. So much the better. We may be reaching the same ideas by different routes, which would not be surprising.

In his article, John Salinsky describes how he is still prey to that familiar rage which can possess us all as general practitioners in the consulting room, as we feel abused, manipulated and overwhelmed by certain patients. He tells us how he decided to carry out an *'Anger audit'* and presents us with several of the patients whom he saw while conducting the audit.

On the day in question he was already overbooked and many patients had been allotted five minutes instead of ten. Nevertheless, things went well until Maureen and Wayne turned up – a single parent given to somatising complaints, with a very active and destructive four-year old child. Maureen, the mother, presents a plethora of symptoms, but the doctor feels disqualified from taking a de-somatising approach because at the previous consultation she has said, 'Why is it that every time I come here I get told I'm depressed?' He therefore examines her, while Wayne occupies himself with the systematic vandalism of his consulting room. The doctor eventually sends Wayne into the waiting room, examines Maureen's bad back, reassures her and provides her with a prescription and some advice. Maureen then demands further attention for a burning pain in the back passage. There is a tussle over what to do about this, with Maureen claiming she made a double appointment. However, she accepts a further appointment a few days later instead. The 'coup de grace' is when she points out that she has also made an appointment for Wayne. Wayne re-enters and John Salinsky comments as follows:

> 'So we finally gave Wayne the attention he had been seeking. All this time, I had been barely containing my anger and wondering what it was all about. It seemed to have been lit by a number of different sparks: the prohibition about mentioning depression, Wayne's restlessness, Maureen's heavy agenda of physical symptoms and finally the 'double appointment'. Strangely enough, her victory over Wayne's appointment amused me and defused my irritation. I couldn't find a satisfactory explanation for Wayne's 'noisy tummy' and she left, still disgruntled, but I felt quite contented.'[2]

As a family therapist, I have learned that when the Maureens and Waynes of my list come into the room, the consultation is not really with Maureen, or with Wayne, but with Maureen and Wayne together. In fact, as far as I know at this stage in the consultation, the full cast list of patients may have to include a number of people who are absent, like Wayne's father, and brothers and sisters, if he has any, or Maureen's grandmother. I wish I could see a brief family tree. Sometimes if there is time in a consultation I will

take the opportunity to sketch one out so it is available for a future moment like this.

I know that patients book appointments as individuals, but they do this partly because we more or less force them to do so, and partly because our culture, unlike some others, nearly always conceptualises problems as individual ones. It was Winnicott who was credited with the axiom: 'There's no such thing was a baby', and therapists who work with mothers and their children have found this a useful idea. In the same way, one might put forward a family therapy axiom: 'There's no such thing as an individual'. Of course, this can be taken to extremes, but often the problem is not taking it far enough, and here I would prefer not to address Maureen's and Wayne's symptoms separately but to look at them as a whole.

I would like to know about the connections between Maureen's symptoms and Wayne's. For example, when Maureen's back gets worse, does Wayne's tummy get more noisy or less? What would Wayne have to do to make Maureen's back so bad that she had to go to bed and somebody else would have to look after him?

Reading the case account, I am curious to know about Wayne's father. Is he still on the scene in some way, or totally absent? Does he make any financial contribution? Does Maureen's mother offer support or not? Was Maureen's mother also a single mother? Did Maureen ever have a brother, and was he boisterous like Wayne? I think if I was present I would be very tempted to ask these questions unless I already knew the answers.

You will notice two things. Firstly, like most family therapists I have an inclination to inquire about facts rather than feelings. Facts can be metaphors for feelings but, just as feelings can be metaphors for facts, on the whole, people answer factual questions more readily, and often more revealingly. The other thing you may notice is that I am working from a strong hypothesis. It is that symptoms always have an interactional component, and can often be addressed through that interaction. Maybe later on in this particular consultation, I would be interested in the question of diagnosis and labels; an interview about interactions at this point does not rule that out. But sometimes people become so interested in this way of looking at problems that they forget about what they came in with. I always feel pleased when they happens. It is harder to repeat stuck patterns of behaviour when you are having to answer questions about interactions rather than just symptoms.

I am sympathetic with John Salinsky's dilemma in not being able to use the word depression. I recognise it very well. As so often, doctor and patient are caught in a paradoxical position. The patient wants to look for a physical explanation and the doctor prefers not to, even though we are so often accused of the opposite tendency. I think it is not just the doctor's dilemma, but one which is Maureen's responsibility too. I would love to know what would happen if the doctor pushed her a bit on this: does she know anyone suffering from depression? Why does it seem such an offensive word to use? What other ideas does she have about her body and why it is producing so many symptoms? What I am focusing on here is the interaction between the patient's beliefs and the doctor's. There is a negotiation going on in this consultation about what constitutes an acceptable meaning for a symptom, and which meanings are therapeutic.

It is no mean feat that John Salinsky manages at one point to carry out a thorough examination of Maureen's back and explain about discs, facet joints, pain relief and physiotherapy. Seen through a family therapist's eyes, one of the most powerful interventions doctors can make is that we can offer authoritative hypotheses for people's experiences. We can also make reasonable predictions about their likely progress, and suggest physical interventions about their likely progress, and suggest physical interventions which may make a difference. I believe our medical explanations work not because they are true (although they may be) but because they are acceptable to both parties at that moment within the doctor/patient interaction. Maureen seems to find the medical explanation helpful in this instance, since she does not challenge it.

What about anger? If I ever saw Maureen and Wayne, I am sure they would drive me up the wall. Being a family therapist is no protection against that. I would love to have another doctor in the room with all three of us, observing what goes on between us all. What does Maureen do to provoke me? What do I do that provokes Maureen? What does Wayne do to get us to go at each other hammer-and-tongs, or to distract us from hitting each other? What do Maureen and I do that winds Wayne up, and what do we do that calms him down? Ideally, I would like to have a team watching us from behind a screen, and a video camera so I can reflect on what has happened. You may think this is unrealistic, but recently Hilary Graham and I and a group of general practitioners around Britain, have been experimenting with these techniques as a training and research tool, and we hope to write this up for the British Journal of General Practice.

If I had been an observer during Maureen and Wayne's consultation, I think I would have formed the view that Maureen had come because she found that looking after Wayne was back-breaking work, and sometimes she felt he was a pain in the back-passage. I think her symptoms point towards that. I assume she has little help with parenting. I suspect she wants someone to give her a break from non-stop mothering. Interestingly, this is exactly what her general practitioner gives her, by expelling Wayne from the room so she can get a little attention for herself, which is probably a rare and pretty priceless commodity. I admire John Salinsky's courage in letting Wayne rampage in the waiting room, but children often rampage much more dramatically

in front of their parents than away from them, where they can be surprisingly subdued, and this may be a good lesson for Maureen to see. I expect that the waiting room is a fairly safe area for four-year olds, and that the staff will understand exactly what is going on and will keep a watchful eye on Wayne. We often forget how much we do to create a caring environment for our patients in our practices, and this extends beyond the consulting room.

As an observer, I think I would be impressed that Maureen has made an appointment for Wayne too. As we know only too well, this could easily have been a case of, 'While I'm here doctor', but it is not. For Maureen this probably represents an unusual degree of forethought. She has noticed that Wayne needs attention too and that sometimes she cannot give him enough by herself. The noisy tummy may be a fairly tenuous symptom on which to hang this, but her doctor quite rightly does not challenge this. Both he and Maureen know that noisy tummies are not noisy for nothing. So Maureen succeeds in bring Wayne and the doctor together into a helpful alliance. The doctor offers Wayne some welcome containment, and this calms the child down. Not surprisingly, it makes the doctor feel contented too. For a moment, this family feels like a good family.

I think Maureen and Wayne got quite a lot from their doctor. I wonder if Maureen really did leave disgruntled. If she did, maybe it is because she feels that the doctor took some authority away from her by calming Wayne down. No doubt it was a relief to have a doctor, and a man, rescuing her from Wayne's unceasing needs for a few moments. However, it potentially undermines her too. This is a very common dilemma for single parents. They want to hand over authority and yet keep it at the same time, which is understandable.

One way of addressing this, would be to give her praise for noticing that Wayne needed attention, even though she must be preoccupied with her own needs. If I was observing in the room, I might intervene to say this. This might lead into a discussion of how she could organise further help without losing her self-esteem as a struggling lone parent.

Like most family therapists, I am looking mainly at the achievements of this consultation rather than what, if anything goes wrong. This attitude is sometimes called 'positive connotation'. Generally, it is helpful to notice what works well with families, or with consultations. The attitude can of course lend itself to naivete, and one has to be careful not to give positive connotation to what is dangerous or absurd, but on the whole it is an effective attitude to take.

I have also regarded the doctor as an equal participant in the consultation with Maureen and Wayne, not an independent agent. But I know that John Salinsky is aware of this. Elsewhere he has written:

> '(The general practitioner) can ... be regarded as a useful person to have as a fellow traveller: able when necessary to help with the navigation or repair the engine, but mostly there to share the experience and help to reflect on it.'[3]

There is much more to be drawn out of this consultation. If we had a team watching through a screen, I would expect many of my ideas as an observer, would be developed or challenged. Possibly we would have a debate about the role of fathers, or substitute fathers, for in some ways this is what Maureen is inviting her doctor to be for Wayne. There might be team members who thought it was a good idea to praise Maureen, and others who thought it was patronising. Some might wonder about the effect of two male doctors offering help to a woman who might have more experience of parenting under stress than either of them. It there was time, we might report some of this debate back to Maureen and she would see that professionals rarely have a single answer for any problem and that her view is as valuable as ours – in fact more so.

In an ordinary general practice consultation, it is never likely that we will have the full panoply of observers and reflecting teams. How much can anyone actually do in a single appointment – or even, as Maureen believes, a double appointment? When other general practitioners ask me how I can incorporate any of these ideas into brief encounters, I give the same answer which all Balint doctors must be used to giving: unusual, intuitive interventions can be effective very quickly, and it is often a false economy to go into automatic mode and behave like a stereotypical doctor. In fact, the time constraint sometimes forces me to ask in every consultation: what is the single most effective intervention I can make? Brevity can be an ally as well as an enemy. My ideas about Maureen and Wayne's consultation have evolved over quite some time, but I hope I might still have been able to use one or two of them '*in vivo*'.

Much of the time, however, we work under appalling pressure as general practitioners and there is no hope of using such ideas. I note that John Salinsky's practice is particularly flexible in absorbing extra demand, so that many patients on the day of Anger audit were offered five minutes instead of the usual ten. This has advantages, but it must have disadvantages too. I am curious to know how such decisions are made in his work setting, and who makes them? What other ways are there in his practice of responding to unusual demand, and who bears the brunt of these? How much are patients aware of the length of time allotted to them, and of their responsibility to request and use this time responsibly? One of things about looking at systems is that you start to ask as many questions about your own context as you do about your clients. All general practices are pressurised, but some are more pressurised than others, and we do know enough about what makes the difference.

Nevertheless, I recognise that we are all caught up as general practitioners within a wider context. For all kinds of historical and cultural

reasons, we are expected to function in conditions which most other professions would regard as completely unreasonable. I believe that one of our collective problems is that too often we feel guilty about this rather than angry. More and more, I try to share this dilemma with patients too. One of my favourite systemic questions nowadays is the following. 'We have about ten minutes together. What can we most usefully do in that time?' It is possible to pose this in a neutral way, without blame? I think we should not be ashamed of putting the question. I wonder what answer Maureen might give.

Ways forward

I have called the last part of this paper, 'Ways Forward' as I want to describe a little of what is going on at the interface between family therapy and family practice, abroad and at home, and to suggest some future possibilities.

I have already mentioned that there is now a small group of general practitioners and general practitioner-attached staff around Britain with family therapy training or an interest in it. Between us we already have quite a lot of experience in running family therapy clinics at our surgeries, in teaching other general practitioners and trainees, and in applying our ideas to our everyday work. So far we have been getting together informally, but we are exploring the possibility with the Association for Family Therapy, the possibility of obtaining some funding as a Special Interest Group. This will be a relief, because we have a growing mailing list from people – both doctors and others – wanting to come on board, and it will be useful to have a newsletter and set up some training events.

I hope that one of our activities will be research in general practice. The Dutch general practitioner, Huygen, has been doing outstanding work in the town of Nijmegen. He has analysed the life events and medical history of about twenty families in his practice over three decades. His book, *Family medicine: the medical life history of families* is a masterpiece of family research in general practice.[2] If we all kept his meticulous records, and thought about them as penetratingly as he has done, I wonder where general practice might one day be.

Another field we would like to develop is collaboration between general practitioners and mental health professionals. As I am sure you know, there is a lot of literature by psychologists, psychiatrists and others who have worked within general practice. However, most of it describes the 'shifted out-patient' model. There is very little about ordinary general practice, or collaborative work, and little that is family oriented. At the moment, there is a gulf between us and them which means that much of the time they are preoccupied by so-called 'inappropriate referrals', and we are frustrated by their inability to connect with our everyday work. Perhaps family therapy could provide us with the language and the tools to bridge the gulf.

That is something which is certainly happening in America, where the Family Systems Medicine Movement has flourished. The founders of the movement were greatly influenced both by Balint and by Huygen: they looked to Europe and Britain in particular as beacons of humane primary care. Now the situation is in many ways reversed. There is a wide interest among American psychologists and social workers in family work, physical illness and primary care. The journal, *Family Systems Medicine* contains some of the best medical and primary care research appearing anywhere. The annual conference of the Family Systems Medicine movement, in Florida, regularly attracts several hundred participants. Next month, Hilary Graham and Robert Mayer are going to Florida to present their work with eating disorders in general practice.[3] We hope this transatlantic exchange will continue to develop.

We need to talk with therapists, here and abroad, but we need to talk most of all to our own profession. In many ways, we could not choose a worse time to do so. As general practice rolls on relentlessly towards health promotion, income generation and Health of the Nation Targets, who is likely to listen to us? Funnily enough, we believe people will. What we need to do, as Michael Balint did in the 1950s, is to make our thinking accessible to general practitioners. We must show them it makes sense to work in a different way, and produces results. We would like to influence training: in medical schools, in general practitioner vocational training, and in postgraduate courses.

I believe it would be useful for the Balint movement and the general practice family therapy movement to learn from each other. I hope that you could benefit from the new ways of looking at human experience, and human problems, which family therapists offer. I am sure that we could learn a great deal from the decades of reflective experience in the Balint movement.

There is one promising development in this respect. Last month the Tavistock Clinic decided, at long last, to take general practitioners onto its staff, each for one day a week. At present they only have money for the first year, but there is a commitment to try to make the two posts permanent. Among other things the purpose of the posts is to develop training for general practitioners based on individual and family therapy, and models of collaboration within general practice. Andrew Elder has been appointed to one of these posts and will be attached to the Adult Department, where he hopes to revive their Balint work, among other projects. I have been appointed as the other, and I will be working with the Child and Family Department. We are already offering an introductory course to systems-based approaches for general practitioners and their team members. One of the exciting aspects of the Tavistock initiative for both Andrew and myself is that we will have the chance to combine our own different therapeutic orientations and skills

in developing the kind of projects which we think general practitioners need.

I hope there may be other places where collaboration takes place between Balint doctors and the systemic general practitioner movement. The common interests are many. Both movements have a commitment to self reflection, training and qualitative research. Both are determined to integrate traditional medical learning within the wider framework of the whole human situation we find ourselves in as doctors and patients. Both approaches see the medical interview as a therapeutic intervention in its own right. Finally, both our movements emphasise human interaction as the irreducible core of our job as general practitioners and the chief source of our healing.

References:

1. Graham, H., Senior, R., Lazarus, M., Mayer, R. and Asen, K. Family therapy in general practice: views of referrers and clients. *British Journal of General Practice,* 1992: **42**; 25-28.
2. Graham, H., Senior, R., Dukes, S., Lazarus, M. and Mayer, R. The introduction of family therapy to British general practice. *Family Systems Medicine,* 1994. **11, 4;** 363-373.
3. Balint, E. and Norell, J. (Eds.) *Six Minutes for the patient: interactions in general practice consultations.* Tavistock Publications, London. 1973.
4. Salinsky, J. Still angry after all these years. *Journal of the Balint Society,* 1994, **21**; 23-25.
5. Salinsky, J. Fact or fiction? In Elder. A. & Samuel, O. (Eds), *While I'm here, doctor* (pp. 89-94). Tavistock Publications. London: 1987.
6. Huygen, F. J. A. *Family medicine: the medical life history of families.* Brunner/Mazel, New York. 1982.

International Balint Centenary Congress 1896-1996

The Hungarian Michael Balint Psychosomatic Society and the International Balint Federation will jointly organise this Commemoration Congress as the Tenth International Balint Federation Congress and the

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The Eye and I: psychological aspects of disorders of the eye*

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Summary

In this paper, I report the findings of a project designed to study the significance of emotional conflicts in the causation of eye disorders. The work was based on interviews with 50 patients, 34 in the Eye Department of a general hospital and 16 in a general practice surgery. They were asked to see me either because no physical basis had been found to explain their eye disorder, or because it was suspected that emotional factors might have contributed to its development or to its failure to respond to treatment. A background of emotional difficulties of varying degrees of severity was revealed in 40 (80%) of these patients. After describing the themes elicited and giving vignettes of typical cases, I discuss the possible links, in some of the patients, between their emotional difficulties and their eye disorders. I show that a limited psychotherapeutic approach can, in some patients, make a significant contribution to their treatment.

Introduction

Although psychological factors are often considered in connection with many disorders of the gut, the respiratory system, the cardio-vascular system and the skin, they are hardly ever referred to in connection with disorders of the eyes. This is surprising as the eye is not just an organ of vision but is one of the most significant organs through which an individual makes contact with the world. Everyday language indicates that it is inherently recognised that the eye and the mind are very much equated. *I see* means 'I understand'. We visualise a problem. *To have one's eyes open* is to be emotionally and intellectually aware of what is going on. But if there is something we do not want to acknowledge, because it may be unacceptable, we *turn a blind eye*. The eye can reflect aspects of one's personality. We can *look with love* but we can *look with hate*. We can go in to *a blinding rage* and *looks can kill*. To make *eye contact* means making a relationship, and seeing *eye to eye* means experiencing mutual understanding. *Giving insight* means giving internal sight with the eyes to the mind.

Heaton[1] is one of the few authors who stresses, with particular reference to the eye, the unity of body and mind, and argues that physiology, pathology and psychology should not be split apart. There is only one comprehensive survey of psychosomatic ophthalmology – that made by Schlagel in 1947[2]. A pioneer in this field was W. S. Inman (1876-1968), who published over 50 papers on psychological aspects of various eye disorders, of which perhaps the best known is on stye[3]. This, and many of his other essays were published posthumously in his fascinating book, *Styes and Wedding Rings*.[4] I am a psychoanalytic psychotherapist with a particular interest in psychosomatic disorders. For the past two years I have worked, for two days a month, in the Eye Department of Queen Alexandra Hospital, Portsmouth (Inman's old hospital), and, over the past year, for two half days a month, in the Well Street Practice, Hackney, London, to study psychological aspects of disorders of the eye. A description of how the project was set up, and of the work of the first year, has been given by Brook and Fenton.[5]

The patients were referred to me by ten doctors in the two settings. This paper is based on the first 50 patients, ranging in age from 9 to 81. Except for two, all were out-patients. Two-thirds were women.

The investigation took the form of semi-structured interviews of an hour each. The purpose was not to establish a psychiatric diagnosis but to try to understand whether any intra- or inter-personal conflicts may have contributed to the eye disorder. The interviews can be described as a process of prolonged psychological assessment. One patient has had twelve interviews and one seven. The remainder have had from one to four.

Themes

1. Difficulties associated with grieving was a frequent finding. Many patients had suffered bereavements and had not been able to come fully to terms with the loss. A man who sought help because his eyes irritated during the day and watered at night, had lost a sister to whom he had been particularly close; his symptoms started when he went to visit her family many months later. A middle-aged woman suffering from recurrent attacks of uveitis had desperately longed for children but had suffered stillbirths; she described how the memory of seeing her dead babies had tormented her ever since. A young woman who said that her eyes had been sensitive all her life had lost her mother when she was an infant; in the year that she reached the age at which her mother had died her eyes became painful and she could no longer see clearly. A young adult who had lost his mother when he was a child complained of sore eyes which were always worse during the month in which she had died.

2. Some had not been able to mourn other types of loss. A woman who sought help for dry eyes, said 'I cannot cry, tears won't come'; she had

*Based on 11th Michael Balint Memorial Lecture given on 15 March, 1994.

experienced many disappointments and frustrations to which she had not been able to adjust. Seven women had strong feelings about a significant birthday and developed eye trouble (recurrent conjunctivitis, blepharitis, sore or painful eyes, deterioration of vision) at this time: four at 40, one at 50, one at 60, one at 70. All these patients revealed strong feelings about not having properly fulfilled themselves. In fact, the birthday confronted them with feelings of disappointment, frustration and sadness about the loss of the life they wished they had had.

3. Sexual difficulties were frequently elicited. A young woman developed blurred vision as she began to lose interest in sex. Another woman developed painful eyes on discovering that she had been sexually betrayed. In some there were aspects of voyeurism.

4. Several were turning a blind eye to their problems. A woman who complained of intolerable pain behind her eyes described a particularly painful episode in her life and said: 'I blotted it out, otherwise I would have gone mad.' Another woman who complained of painful eyes, described a recurrent dream related to her fears of the future: she is planning to go somewhere and the dream suddenly stops 'like switching off the TV'.

5. Some had lost their capacities to think clearly: a woman complaining of not being able to see properly described how her way of coping with anxieties was to throw everything out of her mind. She was thus not able to think or to see.

Case Vignettes

The patients I saw can be divided into two distinct groups:

Group 1: Those suffering from **inflammatory disorders of the eye** of varying degrees of severity: **uveitis, blepharitis, conjunctivitis, sore eye.**

Group 2: Those with no physical changes in the eye. There were three sub-groups: **a) severe eye pain b) functional disorders: diplopia, blepharaspasm, increased lacrimation c) visual defects: blurred vision, 'tunnel vision', progressive loss of vision.**

There were roughly equal number of patients in both groups. In about half the patients in both groups, the eye problem was their only complaint, and in the other half it was one of several symptoms, some vague, most unexplained. A number of typical patients have been selected but for reasons of confidentiality will only be reported as vignettes.

Group 1: Inflammatory disorders

A man in his late 30s who suffered recurrent uveitis had, as an early adolescent, found his father being carried out dead, having hanged himself. 'What I saw,' he said, 'was terrible.' He had never been able to grieve fully for his father. He was much more successful in life than his father had been and he developed the attacks of uveitis when he reached the age at which his father had committed suicide. The eye trouble cleared after one interview.

A middle-aged clerk gave a two year history of **recurrent blepharitis**. He was a man of limited resources who had always lived alone. His only interest was his work and he maintained that life was satisfactory until three years previously when he was made redundant. Since then life had become increasingly meaningless and he was afraid of just passing time until death. He said that he felt trapped in a frozen state and if he thawed the dam would burst. He made it clear that if he were to experience his feeling about his situation he would be overwhelmed with tears and become inconsolable.

A woman who developed **recurrent conjunctivitis** just before her 40th birthday gave a vivid description of her fears that she was now losing her youth and her looks. She was constantly looking in the mirror for reassurance. '40,' she said, 'is the weeping sore.'

A woman with a nine-month history of a **sore left eye** had lost her mother early in life. She had difficulty in making satisfactory relationships and had been married twice and rapidly divorced. She had now become involved with another man and the eye trouble started as they began to consider marriage.

Group 2: No physical changes

a) severe eye pain:

An elderly lady complained of severe pain in her left eye for almost a year. It had been fully investigated, including a brain-scan, and no pathology found. She had had a good life with a lot of happiness but also many painful episodes. Her characteristic way of coping with any unpleasant feelings was by denial. 'I never,' she said, 'let anything hurt me. I have never shed a tear in my life.' Over the past year she had experienced particularly painful losses and in this setting developed incapacitating eye pain. The pain cleared after three interviews.

A middle-aged woman who complained of aching, **painful eyes** said: 'Tears won't come. I can get no relief from sadnes and frustration.'

b) functional disorders:

A man in his late 30s was sent to hospital as an emergency because of a sudden attack of **diplopia**. He gave a history of severe writers' cramp which suddenly cleared, but the next day he was seeing double. This slowly resolved but, as it did so, the writers' cramp returned. The interviews revealed that he had intense, precariously controlled, anxieties about himself and that he had now reached an emotional crisis in his life. He was in a state of confusion not being able to see where he was going.

A woman in late middle age complained that her **eyes were painful and kept filling with water**: 'They are not tears,' she said, 'I don't cry.' She stopped being able to cry when her only daughter, who was to have been her comfort in her old age, died a few years previously. She had

not been able to experience the pains of grief but in a later interview expressed some anger: 'A daughter,' she said, 'shouldn't die before her mother.'

c) visual defects:

A young man complaining of **blurred vision** was in a late adolescent crisis wanting to become independent but frightened of separating from his parents. His mother was slowly deteriorating from a neurological disorder which had started with eye symptoms. He said that he could not 'see his way out of his difficulties'.

A married woman of 47 complained of **'tunnel vision'** which, she said, was having a very restricting effect on her life, as she could only see clearly if she looked straight in front. She was frustrated in an unhappy life and longing for sexual excitement, but it became clear that her conscience was ensuring that she restricted her life and kept on the 'straight and narrow'.

A very worried-looking 50-year old single man, with a six months history of **progressive visual loss**, leading to an inability to read, had had many investigations, including a brain scan, all of which were normal. It emerged that his mother, on whom he had been deeply dependent, had died six months previously at the age of 85. 'I am trying,' he said, 'to blot it out.' His eye symptom cleared after one interview.

Outcome

The most significant finding was that 40 of the 50 patients had varying degrees of difficulty in coping with painful or unbearable mental conflicts. It seemed, as will be discussed later, that their eye disorders were pathological outcomes of these conflicts.

In eleven of these 40 patients a few interviews brought about a significant change. In seven, there was a complete recovery from the eye disorder. (Two women had suffered from severe eye pain, one for nine months and the other for seven months. In both, the pain cleared after a few interviews. In another two who had suffered from less severe pain, there was a similar improvement. Another patient suffered from blepharospasm which also cleared. The eye trouble of a patient with a history of ten attacks of acute episodes of iritis over the previous year cleared after three interviews. A man with a six months' history of irritating eyes said, at the second interview, that this had cleared, as also had a longstanding irritation of his testicles.)

In the other four patients the disorder also cleared but a new problem developed elsewhere. (One patient had, over the previous two years, suffered from several severe attacks of uveitis. After the first session the eye trouble cleared completely but almost immediately a severe potency problem developed. In another patient, recovery from progressive loss of vision after one interview was followed by a return to heavy drinking. In another the clearance of longstanding recurrent uveitis was followed by an increase in the severity of chronic vague abdominal pains, and in the fourth, the complete relief from severe eye pain precipitated a marital crisis.)

In all these eleven patients a follow-up, six to twelve months later, has shown that the recovery from the eye disorder has been maintained.

In another ten patients a few interviews made an impact, although to a lesser degree. They said that, after a few interviews, there was slight or no improvement in the eye disorder but, instead of being a major problem, the eyes were now felt to be much less bothersome.

In the other 19 there was no change in the condition of the eye but in some of these patients, sharing my understanding of the assessment with the ophthalmic surgeon or the GP proved helpful to them in their further management of the patient.

Discussion

The fact that this was a selected group probably explains the high percentage of patients with emotional problems. However, the crucial issue is whether the link with their eye disorder was causal or coincidental. The following finding strongly support the hypothesis that the emotional difficulties actually contributed to the eye disorder.

First, in 11 of the 40 patients who had difficulty in coping with emotional conflicts the eye disorder cleared or was markedly improved after only a few interviews (in three patients after one interview and in most of the other in two or three). There was no other influence to explain the improvement as there had not been any change in the treatments they had been having. The improvement was unrelated to the severity or duration of the eye disorder but was clearly related to the patient's response to the opportunity of talking about their emotional difficulties. Almost all the patients had come to their doctors only seeking help for the eye disorder; their emotional difficulties would not normally, therefore, have been considered. Some were keen, as one patient put it, 'to look at myself'. A man, whose eye trouble cleared after one interview, said 'I feel a darned sight better. I feel a different person.' Another said 'I can see better.'

It was the patients who valued the experience of being understood who were more likely to respond to even a few interviews. One said 'I think it's because I'm beginning to look at my problems; you have opened my eyes.' After a further two interviews his eye trouble cleared. Some were cautious; one patient put it succinctly: this is as much as I want to invest at present.' Others did not want more than one interview. I was, therefore, striking that there should have been such a marked and rapid improvement in 11 of the 40 patients where it seemed that emotional difficulties had contributed to their eye trouble.

Second, in these 40 patients, there was, as indicated in the vignettes, a clear link between the eye disorder and their particular experiences in

life, and how they reacted to them. Many had suffered painful losses and were afraid of being overwhelmed by varying degrees of sadness, rage, sorrow and despair, with which they feared they could not cope.

In several of these patients the difficulties in grieving were associated with difficulties in weeping. The literature on psychological aspects of weeping is limited. Greenacre makes the suggestion that weeping following a loss is part of the feeling of helplessness and resignation in a situation about which one can no longer aspect to do much.[6]

In other patients, there were sexual conflicts related to phantasies of forbidden desires to look, such as voyeurism, in which seeing had become sexualised. In others, the content of the mental pain seemed to be denied and split off from their awareness of it, leaving them experiencing only the sensation of pain. In fact, these patients were turning a blind eye to their problems. Remarks like 'I cannot see clearly,' 'I have nothing to look forward to,' 'I cannot focus properly', 'I cannot see properly what is behind me or what is in front of me,' made by many of the patients in whom testing had shown that their sight was normal, usually proved to be psychologically correct.

Most of the disorders in group 1 – the inflammatory disorders – seemed to be, partly or entirely, somatic expressions, and consequences, of acute or chronic mental conflicts. The disorders in group 2 – where no physical basis was found – seemed to be symbolic expressions, in physical terms, of various emotional conflicts. In both groups, there was a considerable variation in the depth of psychopathology and range of symptomatology.

Some readers may find it difficult to accept these finding as there were no controls. However, controlled clinical trials are not the only way of ensuring reliable knowledge.[7] Interviews of the type described can elicit some of the personal tragedies behind the illness. They can identify some of the emotional conflicts, point to their origins and suggest their relationship to the eye disorder. **In fact, this study strongly suggests that an eye disorder, often inflammatory, may be one of the pathological outcomes in people who have not been able fully to grieve painful losses**.

I tried, in the interviews, to create a setting that enabled the patient to discuss any psychological difficulties he wished to, without making him feel under any pressure to do so against his inclinations. As well as exploring possible links between the eye disorder and emotional difficulties, my aim was to give the patient the experience that his feelings could be understood and to try to help him to be more in touch with accessible feelings of which he seemed less aware. This was the essence of the psychotherapeutic approach and was the process that led to the improvement in those to whom it was meaningful. Working at each place only twice a month meant that I could not see any patient more frequently than once a fortnight, usually once a month. Although these intervals seemed right for some, a fortnight was certainly too long a gap for others to contain the anxieties that were uncovered. It probably was one of the reasons for the change of symptom in four patients. It has not been possible for any of the patients to have any systematic or intensive psychotherapy. Not only might more patients benefit from these treatments but the insights obtained during these treatments might further increase our understanding of some eye disorders.

Conclusion

This study, which can be described as work-in-progress, strongly suggests that some eye disorders may be the pathological outcome of unresolved emotional difficulties. In this series, difficulty in grieving was the most frequent problem behind the eye disorder. The study also shows that a psychotherapeutic approach based on an understanding of these difficulties can, in some patients, make a significant contribution to their treatment.

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References:

1. Heaton, J. M. *The Eye*. Tavistock Publications. 1968.
2. Schlagel, T. F. *Psychosomatic Ophthalmology*. Baltimore: Williams & Wilkins. 1957.
3. Inman, W. S. Styes, barley and wedding rings. *Br. J. Med. Psychology* 1946: 20: 331-338.
4. Inman, W.S. *Styes and Wedding Rings*. Book completed in 1964, but published posthumously. Churchill Livingstone, Edinburgh and London, 1973.
5. Brook, A. & Fenton, P. Psychological aspects of disorders of the eye. *Psychiatric Bulletin*, 1994; **18**: 135-137.
6. Greenacre, P. The development and function of tears. *Psychoanalytic Study of the Child*, 1965: **20**: 209-219.
7. Dudley, H. A. F. The controlled clinical trial and the advance of reliable knowledge: an outsider looks in. *Br. Med. J*. 1983; **287**: 957-960.

Joy in the Doctor/Patient Relationship*

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She had been waiting for over an hour. There was a queue of patients wishing to be seen at the Young People's Clinic before their school bus passes became invalid at 4.30 pm – buses taking them to the far flung extremities of the Island. She – I call her 'She' for I never knew her name – had an extra pressure. She did not want to be late home. Her parents would ask questions and she carried a guilty secret. The receptionist interrupted me – 'I'm sure this young girl needs urgent help, she is very agitated and she's gone out of the door – can't wait any longer.' I rescued her from the street outside where she was surrounded by a group of young, distressed, excitable, encouraging confidantes. She could only spare a minute. She told me her story walking down the corridor towards my consulting room – so much for confidentiality – one night of unprotected sex and subsequent amenorrhoea. Roller-coastered along, I handed her a urine specimen bottle. She dived into the Ladies and I returned to my room attempting to make some sense of this encounter.

The door burst open. 'It's started.' The tears were rolling down her face. She grabbed hold of this stranger doctor and hugged me so closely I felt part of her. 'You are wonderful, thank you, thank you for everything.' Were it so easy to elicit such joy in all our patients. Her joy was palpable and infectious to the clinic staff as well as to the doctor.

Sometimes the joy is a long time coming and even then might only be felt as such by one partner of the doctor/patient relationship.

Mrs A had attended my Psychosexual Medicine Referral Clinic a year before. Her problem was loss of libido since the birth of her daughter. Our sessions together were very stimulating – intellectually. She was articulate and had a clear, razor sharp mind. She was able to use many of my interpretations and recognise and pay tribute to her many psychological defences. However we always ended with her question, 'But, why?' and my thinking, 'Where are the feelings?'. After four consultations she thought she thought she had made some progress and it was her decision to go it alone.

Nine months had passed when she rereferred herself. The first appointment followed her predictable pattern. The doctor sat back and struggled with some thinking and feeling. Her relationship with her child appeared to be very significant but it was the image of a child being hugged emanating from herself, from this neat, clean, controlled, intellectual mother that seemed more so. I shared this with her on her second visit. Initially she denied any relevance. Then as her eyes darted around the room and became congested she remembered weeping at the cot-side when her child was a baby but had not known why. She told me in a controlled manner with an incongruous smile and a joke in her voice of her overwhelming despair when unable to control her boisterous toddler, 'On occasions I sit down and cry.'

Unexpectedly the tears poured down her face. She held her head in her hands and dropped it into her lap and sobbed and rocked. Images of loss flooded back. Her father's attempt at leaving the home when she was very young – 'He walked away down the garden path and I cried.' His final exit when she was a teenager, and the death of her mother. 'If I love people too much, they leave.' The patient was overwhelmed by grief – yet the doctor felt a sense of joyful relief. At last we were touching feelings, something Mrs A had lost, as in her original presentation – loss of libido.

It appears necessary for grief and sadness to be first embraced before joy can emerge. On reviewing my doctor/patient relationship over the past three years this seems to be a common pattern.

Four patients spring to mind, all female, all strong, outwardly confident professional or business women. Each patient is unique and each doctor/patient relationship is unique but among these four were features common to all.

They shared rich, eventful past histories – termination of pregnancy, physical and sexual abuse, prison and prostitution. Each complained of loss of libido and two of additional dyspareunia. It would have been so easy to concentrate on these colourful histories leading the doctor – nowhere. The breakthrough in each case followed the release of feelings in response to the same statement by the doctor – 'That must have been awful for you.' Each looked at me in disbelief. These were the burden bearers of the world, they made life easy for others – what was this doctor saying, that they too could have feelings, that they too could be vulnerable? In each case, through their own unique struggle and in their own time, successful, loving, joyful sexual intercourse returned. As one said to me, 'I used to carry an anxious knot which descended and enveloped me, but the flood gates opened, the water poured out and now I have a shoulder against it and it's just a trickle.'

Joy and sadness can ebb and flow in the same consultation and if recognised can often allow insight into the origin of the patient's problem. Mrs B, an Indian lady living in the UK had hardly sat down before she thrust in my face her 'TB wrecked body'. She was angry. 'I no longer want sex.' She was wistful. I encouraged her to

*The Balint Society Prize Essay, 1995.

talk of her past sex life with her husband. 'We were in India then.' She was animated, her eyes twinkled, 'It was warm and we used to dive under the bedclothes and cuddle,' she chuckled.

Although previous cases exhibited sadness, this last demonstrated the feeling of anger – again one of the grief responses. Anger featured in several of my doctor/patient relationships – anger often directed at myself. The acceptance of this feeling within the consulting room allowed two particular patients to use the feeling with confidence within their relationships to produce a positive effect. Both in their late twenties, one male, one female, both harboured a false belief that release of anger would be disabling and would drive away important relationships. In fact, each found to their surprise that release of anger actually empowered them to express their own needs. Each came back to share with me the joy of this experience which had now spilled over into all areas of their lives. Each was now able to understand and accept both aspects of themselves. He – man and mouse, she – woman and fragile bird.

A vivid moment of the doctor/patient relationship in my work, in the area of psychosexual medicine, is at the genital examination. Although often a time of release of sadness, tears of grief and anger, it can also release a cathartic sense of joy.

Mrs C, in her early sixties, had attended my Well Woman Clinic for a routine cervical smear. Commenting on her vaginal introital spasm I asked her about her sex life. She and her husband had not made love since his prostate cancer was diagnosed and treated five years before. 'I nursed him with an indwelling catheter.' I could feel the loss but was it tinged with fear. 'What a shame,' I said, 'I wonder whether you thought the cancer was catching?' She sat up and grabbed hold of my hand tightly. 'That is what I wanted to ask the doctors but I had felt so stupid.' I added that I was wondering how her husband had been feeling. 'It was he who suggested I came today,' she said. 'He'll be thrilled – he's outside now' – not for much longer I hoped.

Mrs D was 24 years. She had been referred to my clinic with dyspareunia. She had a history of multiple investigations, gynaecological and urinary. She wanted a baby. 'My husband is very good but he protects me from the pain and that makes me feel more of a failure.' I bore this statement in mind as she readily accepted examination. Indeed she did have introital spasm but there was a total lack of vaginismus in the upper vagina. I shared this with her and demonstrated her use of her vaginal muscles. She was elated and kept repeating the word – confidence. She now felt confident and because I was a confident woman it had been transferred to her. She explained, 'It wasn't the pain that worried me – it was the fear of my inability to deal with it.'

Fear, this time of the unknown, had led to the cessation of a sexual relationship in a 32 year old female patient following hysterectomy for CIN III. She had changed, she knew that, but the fantasy had overtaken reality. Confrontation of these feelings at the point of self examination revealed an overwhelming sense of pleasure, 'It does not feel any different up there.' With this new inner knowledge she could now share this part of herself once again with her partner.

Sometimes joy is so well defended and suppressed in the recesses of the subconscious that a force greater than words and examination is required to liberate it. Two patients have revealed such feelings in hospital.

A male patient with whom I had struggled to work, joyfully told me of his last and best erection. It had been released following morphine therapy for severe angina. Mrs E, 35 years, had a history of past sexual abuse. She had been admitted to hospital for a hysterectomy for menorrhagia. 'That night, following the anaesthetic, I had a nightmare in which I vividly relived the abuse. When I awoke I was on the floor, I felt at peace, released and happy. The wound which had knotted and festered had been taken away at last.'

In my form of therapy I usually work with the individual patient who considers they own the problem. It can be a wonderful feeling when joy is felt between doctor and patient in the consulting room, but can it always be transferred outside and particularly in the field of psychosexual medicine, can it be transferred to the partner? If it can, what might be the consequences?

Mr F was an anxious businessman. He hid behind his newspaper and visibly shrank from this female doctor. He complained of erectile dysfunction with his wife. Over the sessions he paid tribute to his past sexual life. He released tears, initially with embarrassment, 'Forgive the wetness of my face,' but subsequently with real joy, 'I have never cried in front of somebody before and certainly not my wife.' 'I'm getting older, I'll not be able to leap over a five bar gate any longer but that does not mean I can't do anything athletic. He really enjoyed the work and welcomed the tears and expression of feelings. Slowly he transferred the process to home and his relationship with his wife. The latter was ready and responsive as they resumed a new and maybe improved sexual life together.

Mr G had initially presented with his wife. They wanted a baby but he was unable to ejaculate inside the vagina and in fact was frightened of penetrating at all. She let him continue therapy alone. His confidence grew just like Mr F's. He wanted to use the work at home but to no avail. Eventually Mrs G accompanied him to the last session. At close quarters I was able to visualise his new found strength sap away in the presence of his partner.

Mr and Mrs H came together. Mr H had made the appointment for his wife as if for a child. They too wanted a baby, but although married for eight years the marriage had not been consummated. It was his wife's problem. Mrs H excluded him from the room during her pelvic examination. I felt his being shut out. Through the

vaginal examination and a didactic doctor/patient relationship Mrs H achieved surprisingly rapid success. However it was her joyful expectation of her husband to penetrate her newly prepared vagina that exposed a shift in the balance of their relationship and produced feelings of frustration in Mrs H. Mr H found he was unable to achieve an erection with this new more experienced partner and he came alone for therapy for himself. The outcome? In his words, 'We are now both complete, confident people, able to make choices. How many others are there feeling as we did but without help. We thought we had a good relationship but it has certainly changed for the better since becoming a sexual one.'

As doctors we are often burdened by our patients' sadness, grief, anger, frustration and pain. So easily we can become subsumed by 'woe is me'. Let us therefore remember the flip side of the coin – 'begone dull care' and let ourselves be transported by our patients into their personal paradise of delight.

Sometimes the joy might be fleeting – the glint in the eye, the upturn of the mouth, the chuckle of the voice. Sometimes more tangible – the firm handshake, the body hug. For some the need to share the good news of success by telephone or letter and for others the demonstration of joy through photographs of weddings or babies.

It is an image of this last one that sums up for me the joy in the doctor/patient relationship. I came across one of my ex-patients in a local shop. 'I was going to write to you,' she said, stroking a very pregnant abdomen. 'I was going to send you a photograph of the baby when it is born. This is a mark of the success of your work.' Yes, I felt glad and happy, but it was she who owned the success, she who had suffered the pain and it was she who deserved the JOY.

The Balint Society Prize Essay, 1996

The Council of the Balint Society will award a prize of £250.00 for the best essay on *The Human Face of General Practice.*

Essays should be based on the writer's personal experience, and should not have been published previously.

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

Length of essay is not critical.

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

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

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

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

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

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

The prizewinners will be announced at the 27th Annual General Meeting in 1996.

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The General Practitioner and the Depressive Patient

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Some modern medical schools plunge the student into contact with a family, a new-born, or a patient in a surgery. However, most of us started with the biochemistry of the cell, the anatomy of the corpse and the physiology of the rat to discover late that 'There was a man, after all!' – and there was also a child – and a woman.[1] First, 'we' were medical students, 'they' were patients. Later, we realised that we were all people, and that we all had feelings. These were quickly disposed of. Medical training prepared us badly to deal with the emotional experiences of every-day practice. In this paper I will examine the impact produced by depressed people and will also consider how we can use that knowledge about ourselves to deal with out patients. Physician, know thyself.

Countertransference

People of all walks of life go through an ordinary morning surgery; general practitioners are probably overexposed to human problems. They are not alone, however, in their difficulties in handling feelings aroused by ordinary practice. Psychoanalysts, those specialists in emotions and relationships, have repeatedly described two pitfalls of their work: extreme detachment and over-involvement. Freud himself described the psychoanalyst ideally as a surgeon who puts aside all his feelings to concentrate on the operation,[2] but more realistically as an ordinary man sensitive to the patient's praise, flattery or reproach, and even as someone prone to react neurotically with his patients, hence the need for the analyst himself to be analysed. These problems are broadly referred to as 'countertransference'. In this wide sense, countertransference refers to the emotions, occurrences and behaviour that doctors are prone to, *in response to* their patients. In a narrower sense 'countertransference' refers only to the doctors' *neurotic reactions to* their patients, something to be disposed of for the sake of good practice. Although the term 'countertransference' originates in psychoanalytic practice, it can be extended to other doctor/patient situations. It is often difficult to distinguish clinically between the two types of countertransference mentioned above, ie. (1) which has been induced, communicated or 'provoked' by the patient and (2) those other feelings primarily arising in the doctor and not really specific to the patient.

The first patient ever reported by the Viennese general practitioner, Joseph Breuer, and his younger colleague, Sigmund Freud, was a very disturbed but intelligent, attractive and enterprising young woman, Anna O. We owe a lot to this patient who helped develop the cathartic therapy.[3] Breuer offered her much time and daily dedication. The treatment had its ups and downs but it all came to a crisis when Anna developed a phantom pregnancy and hysterically screamed that she was carrying Dr. Breuer's baby. Dr. Breuer, a respected physician, was so stunned that he literally ran away. It has been suggested that Breuer's special interest in Anna O was not only clinical, but was also emotional: Breuer had lost his mother as a young child, and found in Anna O a vicarious, intelligent, idealised young mother who answered solicitously to his ministrations.[4] Others may sarcastically say that he was engrossed with the patient in the way that many men fall for young women, without recourse to her psychopathology or to his past – and perhaps this was Frau Breuer's view. Humour aside, the story helps us delineate the two types of countertransference, with potential implications for every close clinical relation: was Breuer's over-involvement with Anna O a consequence of a subtle web laid out by the patient, culminating in her psychotic conviction of having his baby? Or was it that Breuer felt that the patient filled a vacuum in his life? Let us consider a more ordinary case.

Empathy

An adolescent boy comes to the general practitioner with a number of preoccupations: fatigue, some headaches, back-ache, worries whether his sight is alright? The doctor rules out major pathologies, orders the necessary tests, the lad seems to be alright but he is obviously not 'all right'. The doctor draws a blank when asking about any crises with girl-friends or parents, but on a second occasion finds that the boy engages very easily on the question of exams. Suddenly it all makes sense. If the doctor had been questioning himself whether the patient was anxious or depressed, it now 'clicks' that the diagnosis is 'adolescent burdened by his O levels'. This is also something the doctor immediately understands, and the consultation flows freely. The doctor remembers his own exams, and reflects that every new case may turn into a challenge, like a Medicine final. The rapport established we call 'empathy', the 'I know how you feel' type of response. When this happens doctor and patient are likely to have a warm feeling of togetherness; the patient may be relieved and helped, and the doctor may be justifiably pleased.

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Complementarity

Now suppose that the adolescent does not let up but instead, encouraged by the friendly ear, goes on and on and on. The doctor arranges to see him at the end of an evening surgery and discovers that there is much more than he expected – that the young man is obsessionally perfectionistic and pathetically insecure. A couple of talks force the doctor to accept that none of his reasonably encouraging comments help much. They are constantly met by an objection, or by another anxiety, or by another demand, or they are twisted in subtle ways. The doctor is likely to lose patience, and realises he feels progressively overwhelmed, exhausted, impoverished and defeated. Had he not thought the diagnosis was 'burdened' adolescent? The doctor, in fact, is having a taste of it. He knows now, through being exposed to the patient, what it is like to be in the patient's shoes, and this experience is very different from the fond and somewhat idealised memories of the student-times he had on the first encounter. Then there was a warm feeling of understanding, now the 'understanding' results from being immersed in the patient's inner world. These different feelings are powerful messages of how overwhelmed the patient feels by his own inner demands. The doctor is certainly not indifferent to ordinary sufferings; does it mean he has to be a martyr? Is he to suffer all these? This situation is very different from empathy; in psychoanalytic theory it has been called 'complementary' reaction to, or complementary identification with the patient.[5]

Enactment

There is more; there is a risk of this; response. The doctor may finally become irritable and for a time, hates this and other neurotics that come his way. He is neither a surgeon nor a martyr and does not consider himself a saint. One possible outcome of this situation is that he angrily demands that the patient pull himself together and stop that nonsense. After all, the boy should be perfectly capable of keeping his common sense and read for his exams. For a while he gets the patient off his back, but an observer may realise that this appeal to regain self-control is another demand on the already burdened patient. Such an appeal may be therapeutic in some cases and iatrogenic in others, but this will not be discussed here. My point is that the doctor might have added his own weight to the demanding perfectionist voice the patient carries within himself. The doctor, inadvertently, would be impersonating the patient's pathology, enacting precisely what the patient suffers from.[6]

This is the third turn of the screw of emotional responses. The doctor has represented or enacted a part of the patient, a part that the patient has somewhat delivered to him. This also has a name in psychoanalysis, counteridentification, and is understood as the result of the mechanism of projective identification.[7] We can divide the doctor's reaction, calling the first, a 'stage of empathy' and the second a 'stage of bearing'.

The Stage of Empathy and the Stage of Bearing

This case was developed with a bias on the doctor's emotional response; 'what to do' was simply ignored. At the stage of empathy, letting the boy speak was the first thing 'to do'. The other stages of complementary identification (bearing) and enactments may be difficult to manage without some interest and skills in psychological problems. The patient may need more than an isolated consultation: psychotherapy, including that done by the general practitioner, may be contemplated. Note that my implicit condemnation of the 'pull yourself together' is given as an example of how the doctor may be drawn unconsciously to act in particular ways by particular patients. I believe that support and an appeal to the patient's strengths and resources may be beneficial in the right circumstances.

The adolescent of the example shows the patient's participation to the emotions of the encounter: his projection of an unpleasant burden in three progressive steps of increasing intensity. However, what the patient projects need not be aggressive or unpleasant. Patients may induce a seductive or over-protective attitude in their doctors, as a result of having communicated their need to be loved, their low self-esteem, or their need for parental care. Ordinarily, these feelings give foundation to a good rapport and are enjoyed by both patient and doctor, because the latter also needs to be appreciated and loved. Their absence is painfully noted: remember those patients who move from reticence and mistrust to provocative dissent.

On the other hand, the doctor is not a blank screen reflecting the patient's moods. The adolescent may reactivate unpleasant memories about one's own failures or about one's own children's exams. Then the doctor may become either more empathic or less able to listen, feeling burdened or angry. All these feelings the doctor has to bear. It is only when they are very intense and interfere with the doctor's functioning that they constitute a case of countertransference as a neurotic reaction of the physician. I will give an example later in this paper.

Bearing Sadness and Self-reproach

I imagine the mind as an inner stage where different characters act or interact, love, hate, repel and attract each other. At the stage of empathy, the doctor remained an emotionally involved observer, but still an observer of the patient's predicament. At the stage of bearing, the doctor came to impersonate some of the characters of the patient's inner world: the consciously burdened student (complementarity) and the unconscious oppressor (enactment).

The example was chosen because the situation in which a demanding part of the personality torments another victimized part is similar to what happens in depression.

Two dynamic features of depression will be introduced here: feelings of loss and self-

reproaches. A balance is established between the patient's feelings and the doctor's threshold or tolerance for them. As a result, the doctor sympathises with the patient or the patient becomes unbearable. This is not static, it changes as different matters are discussed. We intuitively accept that loss produces depression and we empathise with someone who feels impoverished after the loss of a relative or an opportunity. We also understand some self-reproaches: 'Had I written that letter!' 'Had I treated him more generously!' Intuitive acceptance and empathy go hand in hand.

What happens at the other stage, which I have called the stage of bearing? The situation changes when (1) the patient's reaction seems disproportionate to the loss; (2) when the link cannot be easily established between depression and its trigger; or (3) when the reaction is distorted or displaced. For example, if a depressed patient insists she suffers from the same cancer that killed her mother and rejects help for her unsolved mourning, intuition may fail, or it may not be enough to support the doctor's tolerance of the patient. There is a strangeness and a distance between them. The doctor's role shifts progressively from being 'understanding' to simply 'standing' the patient.[8] The problem is that what the depressives tell is difficult to bear; it is not just sad and painful, it is also alarming (suicide threats) and it provokes dismay and despair. If for any reason the doctor is caught in a vulnerable mood, he may be overcome by emptiness and desolation. The doctor's temporary despair, his experience of being submerged and without escape mirrors the patient's depressive state of hopelessness (complementary).

Frequently, the doctor may feel de-skilled as he is drawn into an area that is not only difficult, but also in which he is ill-prepared to navigate. His self-esteem may go down and affect his judgement. Something of the defeatist attitude of the depressed patient seems to have contaminated him. Moreover, the patient's defeatism will be displayed against the physician; the patient will reject tablets, advice, reassurance and referral to a psychiatrist (I am not a madman, I have always coped on my own). Unresponsive patients provoke frustration and anger.

The doctor is in the difficult situation of bearing all of this while simultaneously keeping in mind the professional responsibilities and the vocational call of doing things to bring relief. However 'bearing' need not mean 'martyrdom'. 'Martyr' in Greek means 'witness'. At this stage, the doctor may recover some of his autonomy if he considers that his feelings give an indication of what the patient feels, and of what the relatives feel. A possible way of dealing with these situations is self-examination: the doctor may try to name what he is feeling. Thus he will stop being a passive receptacle of the patient's inner world and actively think about all these. (This may require a transient disconnection from the patient's speech, or some reflection after surgery.)

Further, the doctor who is also an amateur psychotherapist may try to find ways of reporting these names back to the patient, thus placing the feelings in a middle ground between the two of them. Not every patient will be able to take this, but it will offer some the possibility of observing their emotions from some distance. Also both patient and doctor may de-toxify themselves from the burden. The process, of course, may not be smooth and the result may not be immediate.

Broadly speaking, therefore, the doctor may feel (1) all that resonates in himself in empathy with the patient's predicament, and (2) all that the patient cannot tolerate in himself and projects because it is too intense, such as excessive guilt or excessive anxiety (complementary).

Although what is emotionally bearable or unbearable has some universal characteristics, each general practitioner will be more sensitive to particular themes. Each doctor has specific types of patients lingering in his mind: the old and infirm; survivors of the war; depressed mothers and their children; the misfits; the socially deprived. Practice balances itself and a selection of sorts is established, especially in group-practices. The temptations of becoming a pedagogue, a psychotherapist or a social reformer are lurking there, if only one had the time to listen to them. For many doctors all these effects make general practice a fascinating experience.

Suicide Threats

Faced with suicidal mood or ideation, the doctor is likely to feel at least alarm or anxiety, based on different roots.

(1) Empathy for another human being.

(2) Professional responsibility; the patient's suicide implies the doctor's failure to protect. Thus, the suicide threat may be consciously experienced as an attack on the doctor himself, with images of the coroner's inquiry, worries about reputation, etc. However unpleasant, it may not be unwelcome as it may induce a meticulous handling of the case. Moreover, as a consequence of the threat, the doctor may feel annoyed or angry with the patient, then react with guilt and be prompted to act even more conscientiously.

(3) The doctor will be relieved when a specialist takes care of the patient and when a depressed mother reassures him that she 'will not do it' for the children's sake. He may worry less while the children are busy keeping mother alive. Responsibility is relieved, and conscious and unconscious guilt are lessened.

(4) The doctor may also feel indifferent or paralysed, or led to the point of stating, 'It is his responsibility, not mine, he is a perfectly able human being who has the choice of doing or not doing it.'

This situation is much more complex. The first issue is the diagnosis – is a dramatic threat 'manipulative' or 'serious'? How severe is a suicidal threat expressed with bland, misleading indifference?

Second, to go further, we will assume that suicide is a reaction of one part of the patient's personality attacking another. The doctor may be unconsciously drawn into that scenario, playing one or the other role. For instance, he may find himself in the hopeless position of defending 'life' against a patient who incarnates 'death' by being completely negativistic and impervious to any offers. A possible way out is to reinstate the conflict *within* the patient, with an appeal to the part of him that wants to live and has brought him to the surgery.

Alternatively, the doctor may become indifferent, which does not necessarily mean callous. Indifference may consist of failure to pick up clues, of being unduly confident of the patient's own resources, of not seeing the patient promptly or frequently, and other ways of not responding. I postulate that this indifference may be fed by the patient's indifference: there is a cold side to the patient that is planning the murder of himself, and the doctor may be identified (unconsciously) with it. The patient has come to the doctor implicitly expressing his need for help, but the part that speaks up is the indifferent killer. The doctor may be caught by it and fail to protect.

Guilt and self-reproach are conspicuous in depression, but they are also universal feelings. The doctor's own guilt is likely to be stirred up by the depressive patient, by empathy or by complementarity, and as a consequence either zeal or indifference may follow. The expression 'it is not my responsibility' may imply that there is too much guilt to bear and the doctor has said 'enough'; he has to draw the line somewhere, sometime. If the doctor is under pressure, say, undergoing bereavement himself, his threshold may become very low. There is a serious conflict between responsible care and martyrdom that many doctors solve by being clear about when to refer the patient to someone else. The alternative of remaining indifferent is perhaps the most damaging reaction the suicidal patient may encounter, because it matches the indifference he has for his own life, and leaves him unprotected to face his own destructiveness.

The Wounded Healers

How the limits of tolerance are established depends on a constellation of influences that range from childhood upbringing to specialised training. The doctor's anxieties may be exacerbated because of some similarity between the patient and himself, but this kinship may be very obscure. The patient lingers in the doctor's mind as a preoccupation that cannot be dismissed. Unravelling why this happens may require some time, some thinking, and also some help.

The following story of a colleague who was himself in analysis shows how two not infrequent experiences in life, an abortion and an infantile separation, persist and influence professional attitudes. This doctor felt very anxious treating young pregnant girls who came for consultation or advice: he saw them as much more depressed and distraught than they were, and had some pressurising need to lead them towards a termination of the pregnancy, 'for their sake and the child's sake'. He felt relieved if that was what the girls wanted, and he was aware of some compulsive pressure towards that solution. He could respect, but not empathise with women who wanted to have children on their own and felt despairing about their lot. The doctor's analysis revealed how his compulsion was stimulated by two incidents of his life. As a young man, he had been involved in the abortion of a child fathered by him, in very distressing circumstances for him and his girl-friend. These memories were conscious but were also producing unconscious guilt. In this compulsion to seek terminations he was telling himself that the termination in the past had been 'the right thing to do'.

However, he was also very solicitous with every pregnant married patient, ensuring that it was a wanted child, that the time was right, that care was taken of the other children, etc. The analysis of his excessive anxiety exposed a traumatic separation in childhood. He had been a Second World War-evacuee and during his absence his mother, already pregnant, had given birth to a younger sister. A complicated chain of events had been established in the doctor's mind, which included anxiety of war, losing home, separation from mother and birth of a sibling, all leading to the feeling that he had been definitely replaced and forgotten. For this man, every pregnant woman was in a measure his mother or his girl-friend, and every baby an unexpected sibling. He was a good doctor and in no way a disabled neurotic, but some traumatic events of his life were leaving their mark in his professional attitudes. However, not every doctor needs psychoanalysis; and Balint-groups provide a forum for discussing emotional involvement in practice.

Coping with the Depressed Patient

Patients communicate with feelings as well as words. Doctors know their patients emotionally in two broadly defined manners, which I have called 'empathy' and 'bearing'. In empathy, the doctor resonates with the patient; for the doctor this is a situation of tolerable intensity, although usually the patient feels much more pain. The sharing of the emotions brings relief. These patients usually have relatively well-organised personalities and are able to think about themselves as relatively coherent, defined characters.

At the stage of bearing the situation is more difficult; there is much more to tolerate and less to appraise with ordinary intuition. Patients operating in this manner project or discharge in doctors and in everybody else what they cannot contain within themselves, all that is 'too much' for their inadequate intra-psychic systems. It all pours out in the surgery and, on occasions, the doctor feels like a rubbish bin, where portions of unhappy, unmerciful existence are disposed of. These patients might be going through very traumatic experiences and need to sweep clear their

system at that particular time. However patients who do it constantly are less mature personalities, including those who survive with support, those who struggle in psychotherapy and those who are unhelpable. One feels impotence, anger and in the end much sadness. For the doctor interested in psychotherapy these patients may be rewarding because, sometimes, a few shared understandings may definitely help them, and may also ease their way to the psychotherapist or the marriage counsellor.

However, if the doctor is to foster a continuing relation with the patient, even without any psychotherapeutic intention, he will have the problem of allowing the tension to grow in himself. This is the very tension that the patient cannot tolerate and therefore projects, acts out, brings under the cover of a psychosomatic symptom or displays an excessive anxiety accompanying ordinary symptoms. The doctor's 'bearing', 'being there' enters into conflict with the ordinary 'doing' of medical practice, the act of examining, prescribing, or referring that legitimises the consultation and brings about the feeling of accomplishment. For the general practitioner with an interest in psychotherapy, the bearing is part of the going along with the patient ('respecting the defences') until the moment when a different intervention is possible.

I have described how the doctor's tolerance is the result of a personal equation that contributes to the forging of different relationships with different patients. The doctor's intellectual armamentarium, his medical information and his particular skills, contribute to his stance but are not completely independent of his emotional disposition. Together they result in the basic attitudes that tend to either 'medicalise', 'psychologise' or dismiss depressions. One cannot force oneself to become a psychotherapist and many doctors do quite well managing their depressive patients in other ways. The ability to know one's limits, the capacity to respect the patient's needs, and the willingness to direct the patient to someone else who can meet those needs, are as important here as in any other clinical decision. But, at bottom, the management of depression is a psychological matter, even if the depression at hand is endogenous. Therefore, to lack some elementary psychological skills, at least in the handling of the patient/doctor relationship, is inexcusable.

Some doctors think that general practice would be boring without these patients, and feel the privilege of being admitted into the privacy of someone else's mind. But depressives also stir up some of our deepest fears and, by resonance, doctors may be prompted to think about failing, about the wasting effect of practice, about their own physical and psychic health, and about their future. A general practitioner involved in psychotherapy told me:

'Once I saw a woman of 40, her husband was suffering from cancer. He was withdrawn. The wife tried to put on a brave face and became over-optimistic. The husband became more and more unhappy and reclusive. There was something grotesque and cruel in the scene. I tried to convince her that there was something to mourn (the future), and that there was something serious to be sorry about (the illness); finally, she cried, and I cried as well for my own losses, my father, my ailing mother clinging ferociously to her old manners, the loss of the National Health Service as I knew it and had fought for. Because at that level we were essentially the same human beings.'

How is one supported to bear all these? As in every other situation in life, by your spouse, by your friends, by your values, by the figures you identify with – a senior colleague, a respected professor, your mentor, Osler, Balint, Schweitzer, your father. Also by your training, by your wisdom and your knowledge, by the drive that makes you go on reading and go on struggling, by your experiences of life. And by some specific training to understand emotionally disturbed patients that should include knowledge of psychological development, knowledge of mental functioning (the relationship between body and mind being particularly relevant for general practice) and some psychodynamic insights to help you understand what happens between you and the patient who comes in, sits down and starts talking.

I wish to thank the general practitioners Drs. Cyril Gill, John Horder and Richard Stone for their help at the stage of researching this paper; to Dr. Paul Williams for encouraging me to write it, and to Miss Gala Barrett for typing it.

References:

1. Escardo, F. (1960) *Curso de Pediatris.* Universidad de Buenos Aires, Buenos Aires.
2. Freud, S. (1912) Recommendations to physicians practising psychoanalysis. In *Standard Edition, Vol. 12* (Ed. and trans. J. Stratchey). pp 109-120. London, Hogarth Press. 1955.
3. Breuer, J. and Freud, S. (1893) Studies on Hysteria. In *Standard Edition, Vol. 2.* (Ed. and trans. J. Stratchey). London, Hogarth Press. 1955.
4. Hollender, H. H. (1980) The case of Anna O: a reformulation. *American Journal of Psychiatry.* **137, 7**, 797-800.
5. Racker, H. (1957) The meanings and uses of countertransference. *Psychoanalytic Quarterly* 1957. **26**, 303-357.
6. Sandler, J. (1976) Countertransference and role responsiveness. *International Review of Psycho-Analysis.* **13**, 43-48.
7. Grinberg, L. (1962) On a specific aspect of countertransference due to the patient's projective identification. *International Journal of Psycho-Analysis.* **13**, 436-440.
8. Joseph, B. (1983) On understanding and not understanding: some technical issues. *International Journal of Psychoanalysis.* **64**, 291-298.

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Obituary

R.C. Veldhuijzen van Zanten

Rob Veldhuijzen van Zanten, a general practitioner in Enter (The Nederlands), died on 16 April 1994, aged 67 years. He was the youngest son of a general practitioner in Enter, and took over his father's single handed practice in 1956. He retired in 1992.

Rob was an extraordinary man who suffered for a great part of his life from a manic-depressive disease, which was fatal in the end.

I first met him in 1959, when I was a member of the 2nd Amsterdam Balint-group, led by the psychiatrist/psychoanalyst, J. Wyel. Rob visited us while he was studying the functioning of the Balint-groups in the Netherlands. He had already met Michael Balint by that time, and had visited the Tavistock Clinic. He had also made a study-trip to the United States of America, where he visited Balint-groups and their leaders. He was one of the first doctors from abroad to recognise the importance of Balint's work for general practice.

He participated in Balint-groups in his region, and stimulated his colleagues to join an existing group or to form, and become members of a new group.

On the basis of his studies, he wrote a report about the Balint-work in Holland,[1] described earlier by the French military psychiatrist, Dr. R. Gelly, *le phénomène hollandais*.[2]

During one of the International Balint congresses, the Chairman introduced Rob as 'the man who brought Michael Balint to the Continent.' This serves as an excellent illustration of the significance of Rob Veldhuijzen van Zanten's efforts in the promotion of Balint-work not only in the Netherlands, but also in other European countries. For many years he was a representative of the Dutch Committee on Medical Psychology; he was also a member of the board of the Dutch Psychosomatic Society.

He organised the now historic postgraduate Boerhaave course in Leiden in 1960, on Training Methods in Medical Psychology, which was largely concerned with the significance of the doctor/patient relationship. Michael Balint was one of the distinguished speakers, who also brought with him one of his groups, which demonstrated the way in which they worked together. This course was a tremendous success, and was a great stimulus for the spreading popularity of Balint's work.

Rob had many contacts and friends not only in Holland, but as in other countries, who shared his interest.

While preparing this obituary more than a year after his death, I found a photograph in the *Journal of the (British) Balint Society,*[3] of another 'fishbowl' demonstration of a Balint-group at work at the First International Balint Congress, in London, in 1972. Rob is there, with another Dutch colleague, Dr. G. J. Schiethart, a general practitioner in Amsterdam, participating in a Balint-group led by Enid Balint and Philip Hopkins. That also, is very typical of Rob! He was always present when something important was taking place, and he never refused to be a volunteer in a Balint-group.

Interestingly, he presented a short, but comprehensive paper on the Organisation of Dutch General Practitioner Study-groups on Medical Psychology at this First International Balint congress, in which he compared the British style Balint-groups with the Dutch groups in his own special way. '. . . . . the British Balint-groups may be likened to a heavy, rich, red wine, while the Dutch groups resemble more a light Rosé; the one is produced under an *appelation controlée*; the other grows according to a process of *fermentation naturelle*.[4]

The last months of his life were tragic. His family were unable to make any contact with him, and in the end, we lost him. With Rob, we have lost a good friend and an enthusiastic colleague. Our sincere and heartfelt condolences go to his wife, Bertie, and to his four children. He has left us with feelings of great sadness, but we will not forget him.

HEERT J. DOKTER

References:

1. van Zanten, R C V, 1967. Un phénomène Hollendais? *Repot of International Congress of General Practice*, Salzberg, 1967.
2. Gelly, R. 1966. La psychologie médicale en Holland, *Revue de Medicine Psychosomatique et de Psychologie Medicale*, 4, 353.
3. *Journal of (British) Balint Society*. 1972. Frontispiece.
4. van Zanten, R C V, 1972. Organisation of Dutch general practitioner study groups on medical psychology: a short report. Page 111, in *Patient-centred Medicine*. (Ed) P Hopkins. London, Regional Doctor Publications. 1972.

Book Reviews

THE PARADOX OF PROGRESS. James Willis. Radcliffe Medical Press, Abingdon, Oxon. 1995. 152 pages. £15.50. ISBN 1 85775 063 2.

This pithy little book of thoughts by James Willis, who has once in the past, spoken to the Balint Society at the Royal College of General Practitioners, does not mention Balint once. It may be symptomatic of the way Balintism has been absorbed into British general practice. For it is a book fighting for, and trying to define the traditional, slightly paternalistic general practitioner, aimed both at qualified doctors, and the general public.

Dr. Willis uses cases frequently to illustrate his points which adds colour to complex ideas. What do general practitioners do? Try to synthesize a patient's complaint from an ocean of material presented, and then care for them personally. The lucky specialist can omit areas not relevant to his speciality perhaps looking down on the general practitioner who does not have a clear grasp of ***his*** specialism – but then for the general practitoner, clarity is not always possible. He even puts forward the idea 'generalists must lie/ controlled lying, or slippaage is the only means we have of coping with the complexity and the uncertainty of life'. Why does Dr. Willis write at the moment? Because we are being assailed all around by 'progress'. Management consultants using new information technology have shown that we are only performing well if everything can be measured and quantified. Thus in hospital 'we can have nurses who deal personally on a daily bases with life and death situations, spending hours of each week tapping codes into computers'.

Of course, many health workers, even general practitioners, react positively to this call. Any *training* will improve one's abilities. Lists, checks and targets make one feel in charge, gain appreciation from some patients, can be measured and, clearly, paid for.

On top of this, there are the rules managers make for us to make sure responsibility is accounted for. If we perform every check and test as they ask, *they* will not be where the buck stops. The workers on the ground may have no possibility of carrying out any useful work as they are so busy following rules and, God forbid, a national newspaper article focusing on some individual case, and we can be given a sheaf more of rules too time-consuming to follow. A marvellous example of this, and witness to Willis' sense of irony and humour, is the 1965 Morris Minor manual which required daily checks of the tyres for stones and their removal. Was this ever really possible for anyone? His summary of this is that 'rules are not solutions at all – they have become the problems'.

The prose is clearly written although I would prefer rather more descriptive, less cryptic, chapter headings to help pull the ideas of the book into a more coherent whole. That said, it is a very thoughtful, provoking read, and will help both general practitioners and the public to understand our work and thinking.

DAVID WATT

A DOCTOR'S DILEMMA: STRESS AND THE ROLE OF THE CARER. John W. Holland. Free Association Books, London. 1995. 250pp. ISBN 1 85343 313 6. hardback; ISBN 1 85343 306 3 paperback. £15.95.

This is an exceptionally clear and succinct account of an extremely complex problem area; and as such could be valuable for anyone working in primary health care settings. It is well enough written to make it hard to put down, which cleverly ensures that the 'stressed' professional will feel compelled to finish it!

The author has over 30 years' experience in medicine, mostly as a general practitioner, and additional experience and training as a counsellor. He has also been a Vocational Training Scheme Trainer and Course Organiser.

John Holland has tried to look beyond the usual accounts of 'busy-ness' and external factors in the genesis of stress, and the interaction of these between doctor and patient. The doctor's responsibility is unusually extensive in terms of both hours and scope – omnipotence is encouraged both by the Department of Health, and the doctor's own beliefs, conscious and unconcious. It constitutes an extreme example of care-need: similar to parenting.

Doctors are frequently driven by their inner need to control psychological pain, distress, and anxiety, at the same time believing that they must be above any feelings that might be seen as weakness. Many doctors are workaholics – 'working to give themselves value, rather than added-value.' These states of mind potentiate stress in its most destructive forms, giving rise to blinkered attitudes, and killing relationships and creativity.

Stressed patients superimpose their stress on the doctor's own stress, and may treat the doctor as a 'thing' – only there to fill their needs. Given the doctor's need to be needed, a powerful and devouring interaction can be set up. We know that considerable awareness is necessary to assist in disentangling the aspects of the problem that

require the patient to gain understanding and work *with* the doctor. Holland acknowledges Enid Balint's idea that the patient is 'held' intermittently – but is 'let go' at the right moment also. He explicitly states that 'Tavistock-style groups' help doctors to 'discover ways of being relaxed in disquieting situations.' He also makes an important point about knowing when referral for psychotherapy may be part of the duty to the patient.

The book covers emotionally-charged topics such as out-of-hours work, and visits, being 'used by the patient', and anger in the consultation. All these are perceptively discussed, as are partnership issues, group dynamics, 'splitting' of the 'practice team', and patients' fantasies about team members. A good understanding of psychosomatic disorders is shown in the chapter on 'The Doctor's Role'.

Although Holland does not quote Balint-work much in the text (the best-known texts appear in his reference list), he clearly grasps the issues at the heart of Balint-group work: 'Doctors spend a disproportionate amount of time with people with disturbed feelings – these people will turn to the doctor to share their unpleasant feelings and often unconsciously leave him to carry them on their behalf . . .' The troublesome concept of projection is very clearly addressed, without any undue simplification.

Projection of distressing unmanageable feelings is commonplace in childhood, but adult patients may unwittingly continue to use a parental or authority figure as the recipient of their uncontainable feelings, especially at times of crisis. 'Projectors' are people who have not had their angry, anxious selves responded to with empathy in childhood. Projection can even operate over a telephone line – it can sometimes be stronger in the absence of face-to-face contact. This point is of special significance to the general practitioner, given the key role of the telephone in out-of-hours work. Some doctors are particularly susceptible to being 'hooked' in this way, and experiencing 'projective identification'. Doctor/patient situations are especially open to projections of dependency, sexuality, or powerlessness. Doctors who take a pride in 'not letting people down' easily get sucked into doing what dependent people want, may be vulnerable to conscious and unconcious seductive behaviour, or feel controlled by patients who project their own fear of powerlessness into the doctor. This is all very useful reading for members, or prospective members, of case-discussion groups.

In summary, this is a really good read, and more stress-busting than new computer software (and cheaper!) – although of course, a cognitive scientist would classify it as useful 'software' for the psyche.

SUSAN M. HOPKINS

STRESS: Conceptual and Biological Aspects. Frederick Toates. 352pp. £49.95p. ISBN 0 471 06021 7. Chichester. John Wiley 1995.

Not only have I been privileged to have the opportunity of a preview of this remarkable book, I am also delighted to be among the first to recommend it highly to all who are concerned and interested in the role played by stress in the aetiology of illness and its treatment.

In his preface, Dr Toates modestly states he makes no claim to comprehensiveness, but as one who has tried for over fifty years to understand and use the relationship of stress as a precursor to illness, I have found no other author get so near to integrating the relationship between the biological foundations of stress and behavioural phenomena.

Understandably, as a biologist, his extensive researches and most detailed analysis of the conceptual issues in stress research, are mostly based on animal studies, but there is repeated cross reference to man also. While concentrating on the nature of stress, and commenting on the lack of an adequate definition for it, there is equal concern with the organism's responses to its failure to cope with the challenges of environmental stressors.

The book is divided into ten sections dealing with a wide variety of topics such as the effects of the immune system on neuronal and hormonal controls; and the effects, of hypothalamic-pituitary adreno-cortical and sympathetic-adrenal-medullary hormones on behaviour, to the implications for health and pathology.

Finally, there is a fascinating section on conclusions, which emphasise the need for the practising doctor to keep himself well informed about the effects of abnormal functioning of the underlying biochemical, hormonal and enzymal factors in the body's reactions to stress, which underlines the importance of dealing with these underlying processes, and not merely treating the symptoms arising from them.

Hopefully, this goldmine of information should be available in time for it to be a useful addition to the practice library for Christmas.

PHILIP HOPKINS

From the 26th Annual General Meeting held on 19th June, 1995

President's Report given by Dr Peter Graham

Once again it give me great pleasure to welcome so many friends at this, our 26th Annual General Meeting, keeping alive the flame of the Balint Society.

We have received apologies from a number of people who are unable to be with us this evening due to other commitments, most related to the ever-increasing demands made by the National Health Service for more and more form-filling and reports which, no doubt play a large part in making it so difficult for doctors to find time to attend regular, weekly Balint-group sessions. Erica Jones will be talking about the relevance of this soon, and will be making a very interesting proposal for us to think about.

Even though this has been a vintage year for us, it has marked the 25th anniversary of Michael Balint's death, which in turn, has been over-shadowed by Enid's death in September of last year. There are still many of us who have memories of working with them in their groups, and all of us know the results of their remarkable work, and its influence on general practitioners all over the world, which can only spur us on, to continue developing, and adapting their ideas to the changing demands made on us.

Our year started very well with the annual Oxford Balint Weekend at Lincoln College, followed soon after by the excitement of the Ninth International Balint Congress at Charleston, South Carolina. For me, the highlight came in the preliminary keynote speeches which introduced us to a brave new world of research. One particular memory, that of the cartoon of the Red Indian pow-wow around the old camp-fire, deep in the forest, smoking their pipe-of-peace, which seemed to me to be a good metaphor for Balint-groups, and will live with me for a long time.

Our regular meetings at the Royal College of General Practitioners have all been well attended, meaty and thought provoking, starting in October last year, with Alec Franks' remarkable story of violence in a quiet Sussex garden, all part of his *'very peculiar practice.'*

In November, Caroline Garland shocked us with her detailed description of surviving a disaster, and the longer term outlook about post-traumatic stress and the children of Holocaust survivors, which was followed by a very good discussion.

John Launer's fascinating paper read to us in February this year, on the *Doctor, the Family and the System,* appears on page 6 of this Journal, to allow us the opportunity to study it in more detail, and to appreciate his emphasis on the value of looking after the *family*, not just an individual, reminds us of the importance of the potential of being a *family doctor.*

David Scharff's account of the effects of marital dysfunction in a couple after child abuse, recorded on video and shown to us in March, held our rapt attention, and led to an animated discussion.

In April, we held an extra meeting, to celebrate the life and work of Enid Balint, with a starting with a stirring paper by Mike Courtenay, with contributions from many other speakers who shared their personal thoughts of her as Earth Mother and her enigmatic personality.

For the first time, our annual Balint study-Day at the Hospital of St. John and St. Elizabeth, on the *Human Face of General Practice,* included a Balint-group for Nurse-practitioners, as well as a group for doctors, and was very successful. We are very grateful to David Watt for organising all these meetings so capably.

The Group-leaders' Workshop has mete twice this year, when we had a video and a transcript to discuss. The Research Group has changed focus to the *Doctors' Defences* for its next project.

In July there was the Balint-group preliminary meeting for the Course Organisers at Ripon (see page 41).

Soon there will be a *Festschrift fur Enid,* at The Institute of Psycho-analysis, when several of her close colleagues will present papers in her honour, at 8 p.m. on 20th September 1995. Will members please let me know if they wish to attend this meeting.

Next May, we are looking forward to visiting Budapest for the Tenth International Balint Congress, which will be the *Centenary Congress of Michael Balint's Birth* (see page 12), and in 1998, we have agreed to host the 11th International Balint Congress in Oxford.

There have been a few papers on Balint themes published in various medical journals, but there have been no Balint books since *The Doctor, the Patient and the Group*[1] and *Before I was I,*[2] were published in 1993. I am aware that we have a very low profile as a medical society at the present time, and I think that the only way to improve our image is to increase the number of Balint-groups.

There is now a new fund available in Thames Region called LIZ Educational Incentive Money. Anyone who can propose a scheme and audit it, may be rewarded with their fee. I hope somebody will.

Altogether, it has been a very good year – let us hope that next year will be even better.

References

1. Balint, E. Courtenay, M, et al. The Doctor, the Patient and the Group: Balint Re-visited. London. Routledge. 1993.
2. Balint, E. *Before I was I: Psychoanalysis and the Imagination.* (Eds. Julie Mitchell, Michael Parsons) London, New York. Guildford Press. 1993.

Secretary's Report, 1995

Our year began in September 1994, with our Annual Oxford Balint Weekend, which was the best attended conference since I have been secretary. There were 52 participants. We were pleased to welcome two visitors from overseas, Dr. Alan Johnson, a psychotherapist from Charleston, South Carolina, who leads Balint-groups on their Family Practice Residency; and Dr. Katrin Fjeldsted, a general practitioner and politician from Iceland. Notable, was the presence of six medical students, on Cyril Gill Bursary subsidised places. We were also glad to have with us, four practising psychotherapists, attending as group members. We were again grateful for the presence of two English psychoanalysts, Dr. John Sklar and Dr. Harold Maxwell, who gave their expertise to the Society, as leaders of two of the groups. The groups were successful, as reported to the plenary session. Sadly however, there was the usual problem of there not being enough time during the plenary session, for everyone to say all they wished, especially about the possible reasons why there seems to be so little interest in Balint-work in Britain, while the Balint movements in other countries are developing so well.

The lecture series consisted of five meetings on Tuesday evenings at the Royal College of General Practitioners. The numbers attending each lecture have improved over the past year, with 15-25 people attending each presentation.

The last meeting of the session was on 25th April, to remember Enid Balint, and to celebrate her life. The evening started with a heart-warming and stimulating contribution by Mike Courtenay (see page 4), followed by contributions from most of the audience.

In November 1994, a good number of Society members attended the 9th International Congress in Charleston, South Carolina. It was a meticulously planned meeting, using a large range of audio-visual aids (see page 36).

The Balint Society's Research Group which was started two years ago at Oxford, and led by Mike Courtenay, was prompted into analysing itself by the Charleston meeting. We have now changed our topic from accidents, to work on doctors' defences. Enthusiasm is much higher and in time, we hope to gain useful insights.

The 10th International Balint Congress will take place in Budapest from May 2nd - 5th, 1996, celebrating the 100th anniversary of Michael Balint's birth (see page 12), and we hope that many members will make their way to Central Europe for what promises to be a great occasion. We have agreed to host the 11th International Balint Congress in September 1998 in Oxford. Any members interested in helping to organise this, will be most welcome.

Last month saw the Society's first trial in the U.K. of a Balint-group for practice-nurses, at a Study-day meeting at the Hospital of St. John and St. Elizabeth in St. John's Wood. There was also a Balint-group for doctors, making it a very successful day (see page 43). We hope to have a meeting solely for practice-nurses next May. They will also be welcome at Oxford this year.

In addition, the Tavistock Clinic is trying to establish an on-going group for practice-nurses, and anyone interested can obtain information from Andrew Elder or Oliver Samuel at the Tavistock, where they now hold part-time posts developing general practitioner liaison with the clinic.

The Group Leaders' Workshop, organised by the President, continues to meet at the Royal College of General Practitioners, but has had only two meetings this year, there being a dearth of transcripts, and no time to meet together.

Lastly, I look forward to seeing you all at Oxford for our annual Balint Weekend which will be from the 15th - 17th September this year.

(Concluded from page 39)

As can be seen from the Table, 48% of the Balint-group leaders described their group as task-oriented,and 53% as process-oriented. Looking at the technical level, the insight-oriented approach prevailed in 79%, and the supportive-structured-focal approach in 22%. Both the patient and the general practitioner are the main focus in 53%, general practitioners only, in 37%, and patients only, in 11% of the Balint-groups.

The conclusion from these findings is that Dutch Balint-groups work is more insight-oriented than behaviourally-oriented, and that a range of insight-oriented techniques are used. This last finding is important, because many general practitioners in the Netherlands still think that Balint-groups are purely psychoanalytically oriented. This may have been so in the past, but the present Dutch Balint-group is characterised more by its insight- and doctor/patient-oriented approach, than by the psychoanalytical approach as such.

On the other hand, a vital difference exists between a supervisory and a Balint-framework, due to the emphasis in the latter on insight into one's own functioning *vis-a-vis* the patient, instead of learning to deal with the patient's problems which, in our view, is the main issue in supervisory work.

We hope that the results of this study will enable us to instruct those who report about Balint-groups in the Netherlands, on a more realistic basis.

Minutes of the 26th Annual General Meeting

Attendance was poor at the 26th Annual General Meeting, in contrast to recent years, but there was a quorum present. Several topics of interest to members were discussed, and were thought to be worth publishing in this year's journal.

The most important item was a motion proposing to change the Constitution, so that the Annual General Meeting can be held '... before 30th September each year', instead of '... before 30th June each year'. This will enable us to hold the AGM at the Oxford Balint Weekend for 1996 and, if this proves to be successful, in other years in the future. It is hoped that this will encourage more members who live outside London to attend not only the Annual General Meeting, but also to come to the Oxford Balint Weekend. Perhaps a members' meeting will be arranged for this year's Oxford Weekend, probably at the end of the Sunday morning.

Erica Jones suggested a very interesting topic for discussion at this proposed meeting, that we should consider allowing full membership of the Society for candidates who have attended six weekends of Balint-group meetings, instead of attending three terms of weekly group-meetings for one year, as has been successfully practised in Germany for some years. This might help to increase the number of Balint-trained doctors in the U.K. at a time when it seems that so few general practitioners are able to find the time to attend weekly groups. It could also prove to be a more practical procedure for accreditation of doctors wishing to include Balint-type psychological work with their patients in general practice, as it does in Germany. Perhaps our work may then be more acceptable as a qualifying procedure for psychological work in general practice. Interestingly, this method has also been used very successfully in the Psychosexual Institute's training scheme for its members.

Currently, John Salinsky and Erica Jones are members of a working party of the International Federation of Balint Societies, which is engaged in formulating criteria which would be recognised internationally for Balint-group Leaders.

Despite the concern about the waning interest in our Society, fourteen candidates were admitted members to membership of the Society:

Full Members: Dr. Rachel Levene, Dr. Arthur Niesser, Dr. Alex Connan

Foreign Associate Members: Dr. Ebbe Kyst, Dr. Lars Thorgaard

Student Member: Christopher Beith

Associated Members: Polly Blackner, Donald Bryant, Ann Cornwall, Dr. Ian Todd, Dr. Eva Jacobs, Dr. Patrick McIlvoy, Dr. Max Gibbs, Dr. J. D. S. Campbell

Council announced that the winner of the Prize Essay Award for 1995 was Dr. Jane Botell, Senior Clinical Medical Officer in Psychosexual Medicine on the Isle of Wight, for her essay on *Joy in the doctor/patient relationship* (see page 17).

Finally, it was proposed by Council, and agreed by the Meeting, that the following shall serve on the Council for the next session:

The Balint Society

(Founded 1969)

Council 1995/96

President: Dr. Peter Graham

Vice President: Dr. Paul Sackin

Hon. Treasurer: Dr. Heather Suckling

Hon. Editor: Dr. Philip Hopkins
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Members of Council: Dr. Doris Blass, Dr. David Davidson, Dr. Andrew Dicker, Dr. Erica Jones, Dr. John Salinsky, Dr. Pat Tate

DAVID WATT

The Erasmic Effect

Address by Dr. Oliver Samuel

My memory must have a pessimistic streak. When I think about my time in general practice, I find it a great deal easier to recall the failures than to think instantly about the times that things went well. I believe that most of my patients have been pretty well looked after and many remain as patients and friends years later; but the ones I really remember are those whose care was less than perfect. As for the catastrophes, every one is just like yesterday. So I have spent a little time reflecting on one of the shadier sides of my professional work; not the downright disreputable, but the less well conducted care that I and, I suspect, many otherwise quite good doctors have given to their patients.

I know well that the social and political structure of a country has a profound impact on the way patients are being looked after and this also influences how the services operate when they are being treated unsatisfactorily. In the United States, patients are, by our standards, subjected to excessive investigation, meaningless screening and over treatment; while here, because of the capitation system and the list of registered patients, degrees of neglect are more likely than any kind of excessive medical care.

There have been many discussions of exactly what constitutes good quality care. Robert Maxwell listed six adjectives to describe his view of the qualities that are essential. They are: effective, acceptable efficient, accessible, equitable and relevant.[1] The misdemeanours of bad care can quite readily be plotted against the relevant quality in this spectrum of virtues.

Most doctors look after their patients pretty well and Balint-trained doctors are able to offer their clientele a particularly personal kind of quality care. Of course, all doctors lapse from absolute excellence from time to time, and the way doctors lapse is profoundly influenced by culture, politics, training and patient expectation. So now consider in what particular ways Balint-trained doctors are likely to behave when they are providing less than the best kind of care. The major abuses of Balint-doctoring include insensitivity, prurient curiosity, and offering unwelcome invasive interpretations. But I would prefer to look at some of the more insidious misuses of the special relationship that sensitive doctors try to build up with their patients. To do this I offer some cases from my own practice; cases of which I am none too proud.

These four patients received inadequate care such that I remember them all with absolute and ineradicable clarity. Each of them was not treated well in a different way, so they do not form a simple pattern of repeated error, but illustrate different kinds of difficulty in which I seemed to flounder.

Not enough care:

He was a teacher, married and proud of his grown up family. He had come from poverty in a small village in Ireland, the oldest of many children. With his mother's help, he struggled and made it to university and a professional career, but he never forgot his own early struggles, so that when working in his rough tough secondary school, he was always on the side of the children from the worst backgrounds. He worked as deputy head for many years but would never contemplate daring to go for the headmastership. His view of himself was heavily marked by his humble origins and perhaps by some of the more punitive aspects of his deeply religious upbringing.

As he moved towards retirement, his personal doubts seemed to increase and the fears that had always prevented him speaking in public, even to the school parents grew greater. He found it more difficult to leave the house and after he finally retired, he became housebound. I saw him often to talk about his problems and his family, and I felt very close to them all. I thought that he might be helped with the phobias by our clinical psychologist, and he welcomed the offer of further help. And it was she who gently pointed out to me that my patient was in gross congestive cardiac failure – something that I had utterly failed to notice. Sadly he died a few weeks later, still almost obsequiously grateful to me for all my care and attention!

What had gone wrong seems obvious. He had a complex and engaging personality, one that evoked both deep respect for his achievements, and sympathy, concern and real affection. But befriending had taken over from medical care and I made pastoral visits rather than professional ones. I liked him too much as a friend to be able to keep my medical perspective awake.

Too much care

The first I knew about her illness was when she asked advice about a small lump in the breast that he had been there for a couple of weeks. The mass was already tethered to the skin and deeper layers and the axillary nodes were involved. She had a highly malignant cancer that recurred only a few months after intensive treatment and the outlook was grim. I tried to offer all the help I could and gave time to talk with her and her husband to help them cope with the awfulness of the situation. Her response to all my sensitive concern was to seek medical help from one of my partners. She told him that she really found my attitude to her insufferable – all talk and no action. She wanted him to take over and look after her properly like a real doctor. She then went on a crusade through the available alternative treatments, from the British diet to Lourdes (and this lady was Jewish!) My partner kept me informed about her as her condi-

tion deteriorated and one day I was asked to visit her at home. She said that she would like me to take over her care and look after her again, but on one condition. There was to be no discussion, just good doctoring. And so it was for the short time that remained.

She just did not want to put feelings into words: she wanted to be cured rather than helped, and she wanted to curb my concern and wish to be involved. She did not like the kind of doctor that I offered to be. My partner held the brief until she realised that cure was no longer possible. She then wanted my technical skills but strictly on her own terms, a contract that I willingly agreed to follow.

Over identification

This patient had a disastrous history of recurrent miscarriage, so she adopted a son and later a daughter. Tragedy still tracked her and the girl died as a cot-death. Throughout these troubles, I saw her and her husband often and was very close to them. She then decided against the odds to risk another pregnancy and had a son, who she named after me.

Sadly after several years, the marriage failed and at this time I noticed that she preferred to consult one of my partners. She was now about to re-marry and came one day to talk about her, now adolescent, adopted son's behaviour. I tried to explore whether he was being treated differently from her natural son. The thought was utterly unacceptable, and she became very angry and left. I have not seen her since. I know that shortly later she moved out of the district.

I found that having her son given my name was a difficult double-bind. It seemed to fix our relationship as special yet, like her marriage this did not endure. When she left her husband and was contemplating a new relationship, I too became *persona non grata*. I had the impression that she seemed to think that I disapproved of what she was doing. So I had become wrapped up in some way with her past and, like her first husband, was no longer welcome in her new life.

Under identification

For the last patient, I remain a completely organic physician. She has a son with learning difficulties, and she has always sought help with his problems from specialists. When one failed to help adequately she would find another and at last someone has offered her the diagnosis of 'Fragile X Syndrome.' The boy is now a tall teenager who was brought to see me recently with colicky abdominal pain. It was Monday morning and there were no abnormal signs, so I suggested that he was well enough to go to school. This suggestion evoked a spasm of pain and immediate specialist referral was demanded. The surgeon found no organic problem and my patient came later to discuss his report. She seemed incredulous that I should think of psychological causes for such obvious disease, and then later asked me for some pills for her nerves. I asked her if she could tell me about the problem, but she simply said 'I couldn't possibly tell you about it.' She did agree to see our psychologist but later cancelled this appointment.

I have known that this patient was carrying a heavy burden, from the first time I noticed her son's retarded development. But despite many opportunities, she always politely declined to share the problems with me, or with any of my colleagues. We have gone on with our rather sterile relationship for more than twenty years and I can see no chance of changing it. I just cannot get close to her.

Doing it right but getting it wrong.

Balint-doctors are not exempt from the general sin of offering their patients poor care. We each have our own ways of avoiding what we ought to be doing. At times, all doctors need to avoid getting involved with their patients, and commonly they do this by prescribing medication that is not absolutely necessary, or by referring the patient on to a specialist instead of examining the patient's problem properly. Balint-training does not stop any of us from sticking to a strictly organic mode at times or, worst of all, becoming a psychic detective inspector in relentless pursuit of the inner truth.[2]

From the cases that I have described, you can see how easy it is to get stuck in the wrong model and become either too close or excessively distanced. Patients then get the emotional aspects either neglected or uncomfortably over-treated.

It is hard to get the balance right and, of course, patients' needs often change over time. The temptation is to work in the mode that suits the doctor best, rather than that which corresponds to what the patient really wants. The balance involves many dimensions beyond just the medical, social and psychological, for high quality care must also be effective, acceptable, efficient, accessible, equitable and relevant.

In and out of synch

Enid Balint pointed out how a doctor can get very close to the patient, but then has to withdraw somewhat to see what is going on.[3] It seems to me that patients do exactly the same; coming very close when that is what they need, but then readjusting the proximity and accepting or rejecting their doctor's 'loving care' according to whether it feels helpful.

Should the objective be to reach some kind of synchronicity with the patient? Should a doctor try to be exactly as close to his patient, as the patient needs to be close to the doctor? At first this may sound right, but I doubt if it is either possible or even something to be aimed at. I feel that sensitive doctoring really demands that we move closer and further from our patients feeling in response to their needs, but always slightly out of synch, so that we neither get locked in nor distanced without knowing what is happening. A sensitive but effective lack of synchronicity provides the space in which we can reflect on what is

going on and to perceive what is happening; to try to make sense of the feelings involved in personal doctoring.

The Erasmic Effect

In the 1940s and 50s, around the time when the first Balint-groups were forming, Punch magazine contained a series of advertisements for Erasmic shaving soap. They showed drawings of three faces covered with different amounts of lather. Although the faces in the advertisement were always changing, the advertising slogan remained the same: 'Not too little, not too much, but just right.' After years of trying to get it right with patients, I wonder how often we do manage to achieve the Erasmic effect.

References:

1. Maxwell, R. Quality assessment in health. *Brit. Med. Journ.* 1984: **288**; 1470-1472.
2. Balint, E. and Norell, J. S. (Eds) *Six Minutes for the patient.* London. Tavistock Publications. 1973.
3. Elder, A. and Samuel, O. (Eds). 'While I'm here, doctor'. London. Tavistock Publications. 1987.

Balint in Russia

There is now a Russian Balint Society, based in St. Petersburg.

Thanks are due to Dr. Peter Toon, a member of the Department of General Practice and Primary Care of the Medical Colleges of St. Bartholomew's and the Royal London Hospitals, and of the Balint Society, for the details leading to the publication of this very exciting news.

The Russian Health Service is struggling to free itself from both the inefficient practices and the mechanistic views which characterised Soviet medicine. Prominent in this process is Professor Yuri Gubachov, a psychosomatic physician, now Professor of General Practice at the St. Petersburg Academy for Postgraduate Medical Studies.

He participated, with Peter Toon, in an Exchange Fellowship jointly awarded by Glaxo Laboratories and the Royal College of General Practitioners in 1992. This included a visit for Professor Gubachov to the Ripon Balint Weekend, where he presented what was probably the first case in Russian, to a Balint-group outside Russia, interpreted by his accompanying colleague, Dr. Alexander Kossovoi.[1]

A link has now developed between a Balint-group of British general practitioners and a Balint-group of Russian doctors in the St. Petersburg Academy for Postgraduate Medical Studies, together with exchange visits and joint Balint work. During one of these visits earlier this year, Dr. Paul Julian led a goldfish bowl demonstration of a Balint-group. Another important event was the recent publication of an article describing the philosophy of the Balint approach to the doctor/patient relationship, in a Russian medical journal.

Dr. Vladimir Vinokur, who is a senior lecturer in Professor Gubachov's Department, and is President of the new Society, with four of his colleagues will be visiting London shortly, and will be meeting members of the (British) Balint Society this month, and will also visit them in their practices to see how the British National Health Service works.

It is hoped that we can look forward to more exchanges of this sort in the future, so that we can continue to benefit from sharing our experiences with each other.

P.H.

References:

1. Balint Weekend in Ripon, 1993, in *Journal of Balint Society*, 1993, **21**, 37.

The Ninth International Balint Congress, 1994

Charleston, South Carolina, USA

The Ninth International Balint Congress was held in Charleston, South Carolina, USA, from the 9th to the 13th of July 1994. It was planned and organised by the American Balint Society in association with the International Balint Federation. Charleston is the home of the Medical University of South Carolina, whose department of Family Medicine has provided an excellent and justly admired training for American family physicians for over 20 years. Thanks largely to the influence of Professor Clive Brock and his colleagues, Balint training has a greatly valued place in the curriculum and Charleston graduates have carried the Balint philosophy to other training programs all over the United States.

Charleston is also a delightful city in which to hold a conference. It emerged physically unscathed from the Civil War and has street after street of elegant eighteenth and early nineteenth century houses adorned with graceful columns and with wide porches (known as *piazzas*) extending along one side to provide shade. The visitor can stroll along quiet streets, admiring the houses and peeping into the delightful hidden gardens, then emerge at the waterfront for a view of the blue waters of the bay and its distant sheltering islands. In the evenings the bars and restaurants give off a gentle throb of music and delightful cooking smells perfume the air. The weather is pleasantly warm, even in November. No one is in a hurry: even the cars process quite slowly down Meeting Street. The people are friendly and full of Southern courtesy.

So much for the City – what about the Congress? Meetings were held in the Omni Hotel which manages to be huge, modern and luxurious inside, without drawing too much attention to itself from the outside. About 65 people attended the conference of whom about 35 were from the USA. There were also 9 from the UK, 7 from Sweden, 2 from Germany and Hungary and one delegate each from Belgium, France, Iceland, Norway, Slovenia, South Africa and Switzerland. In addition, the organisers had invited three experts in qualitative research to come to observe our activities and share their conclusions with us. The theme of the Conference was 'Balint Training in a New World' and much of the emphasis was on finding what was important in our work and thinking about how best to pass it on to the next generation.

Each morning we had a communal buffet breakfast in the conference lobby before the day's sessions began at 8 am. (Americans believe in getting down to work early). On the first day, we were welcomed to the Congress and to Charleston by Frank Dornfest and Clive Brock. Roger van Laethem (Belgium), the treasurer and founder of the International Federation, gave us a brief history of the first eight International Balint Congresses. On each of the first three mornings there were papers from three plenary speakers, followed by discussion, and then a 'fishbowl' group which met in another room but could be seen (and heard) via large screen closed circuit television.

In the afternoons, there were ongoing small groups followed by short-paper sessions. The three 'researchers' each contributed a paper, and were present throughout the Congress, listening attentively and scribbling furiously on their note pads. In addition, they also participated as silent, but friendly, observers in three of the small groups. On the last morning they gave us their conclusions (see later).

Plenary Papers

On the first day, the theme was 'Future Directions' and the speakers were Frank Dornfest (USA), Jaques Dufey (Switzerland) and Penny Williamson (USA, researcher). Frank Dornfest introduced the theme and spoke about the challenges to Balint work from new concepts and ideas about the doctor/patient relationship. Jaques Dufey, who is a past president of the Federation and a genuine country general practitioner with a practice on the shores of Lake Geneva, gave us an account of the evolution of his thoughts and feelings about Balint training over a professional lifetime. Penny Williamson then gave us an enthusiastic introduction to Qualitative Research, which she described as the study of 'Lived Experience'. The discipline has two modes, she told us, which are phenomenology, the science of observation, and hermeneutics, which deals with meaning and interpretation. (This last word has always puzzled me but now that I know that it is named after the Greek god Hermes, the messenger, I shall remember what it means).

The second day's theme was 'Balint Leadership', and was chaired in characteristic style by Conny Svenson (Sweden) who is also a hard working country doctor. No one who saw them will forget the green striped abstract drawings he produced in order to clarify a point. The speakers were Michael Courtenay (UK), a Balint leader of great distinction who was in one of Michael Balint's early groups in London; Stanley Levenstein (South Africa), and from the research team, Ritch Addison (USA). Michael Courtenay gave an eloquent account of 'three great leaders' who had been major influences in his own development. They were Michael Balint, a father figure, Enid Balint, the mother of the movement, and Tom Main who had been more like an elder brother. Stanley Levenstein began by paying another tribute to Enid Balint who sadly died earlier this year. He went on to talk about the most important attributes which a Balint-leader should have, which he said were Insight, Courage and

Respect. He discussed the difficulties of acquiring these qualities and made an impassioned plea for the Federation to take the lead in establishing standards and procedures for accreditation of leaders. Ritch Addison gave us a very helpful outline of important research activities including the unearthing of contradictions, the exploration of the background in order to understand the foreground, and the alternation between empathic observation and objective interpretation. He went on to outline a research design which would help potential Balint research groups to avoid the pitfalls and the dangers of getting stuck.

On the third day, the theme was 'Assessing Outcome'. The speakers were Alec Chessman (USA), Michele Lachowsky (France) and Will Miller (USA, researcher). Alec Chessman, who is a graduate of the Charleston family medicine program, has a keen intelligence and a wry sense of humour. In his talk he asked how we could discover the essence of Balint training and try to preserve it. His tentative conclusion was that the experience in the group helps the doctor to provide an equally safe environment for the patient and encourages him to be more interested in understanding the patient's story. Michele Lachowsky gave us her perspective on Balint, as a woman and a gynecologist. Her delightful paper in perfect idiomatic English compared the doctor's relationship with her patient's body to that of the group-leader with the members of his group. Both needed respect as well as attention. Will Miller, the third member of the research team, described the book *Treatment or Diagnosis*, about the repeat prescription relationship which he saw as a model of qualitative research carried out by a Balint-group.[1] He urged us to cherish the most important features of our work, including relationships, stories, the cultivation of self-awareness and humour. As researchers, we should steer clear of attempts to demonstrate patient and doctor satisfaction at least in the short run. 'You promote uncomfortable knowledge' he warned us. We were 'a dissenting counterculture' but we needed to impress the dominant culture so that we could get some of their money to carry on our work.

Fishbowl Groups

Our Congress was sharing the hotel venue with an international film festival and in this part of the morning sessions, it seemed that we were having a film festival of our own. It was a new experience for most of us, to find ourselves watching a Balint-group on a very large screen (just like a movie) while being a little uneasily aware that the action was all going on in real time in the studio next door. Those who were in the fishbowls were understandably nervous beforehand and some observers found some of the Hollywood style closeups a but too close for comfort. However, there is no doubt that the method allows the group more privacy while giving the audience an excellent view and an audible sound.

On the first day, the fishbowl group was made up of residents and graduates of the Charleston family medicine unit, led by Clive Brock and Alan Johnson (whose rich background includes Jungian psychology, Buddhism, and the martial art of Tai Quan Do). On the second day, a group of second year Charleston residents was led by two more members of their talented teaching staff, Alec Chessman (family physician) and Peggy Irwin (psychiatrist and psychotherapist). The final fishbowl was occupied by one of the ongoing afternoon groups which had already met for two sessions with Erica Jones and John Salinsky (from the UK) as leaders. This group also had its adopted researcher (Ritch Addison) on board. He was very supportive but completely silent except for an eloquent sneeze towards the end. After about 45 minutes in the fishbowl, each group came back into the main hall to take part in, and hopefully to survive the discussion of its proceedings. These discussions were lively and fairly contentious, as usually happens on these occasions the spectators had a very different view of the game from the participants. Nevertheless it was a good opportunity to observe the styles of different leaders, to marvel at the 'Parallel Process' appearing yet again, and to reflect that Balint-groups in the New World are not very different from those in the Old.

Small Group Sessions

In the afternoon, the conference split up into small groups for the first session of ninety minutes. Three of the groups had a research observer who provided some useful feedback at the end. All the groups seemed to work well together despite some stylistic differences apparent between co-leaders who had not previously worked together. The fact that everyone participated in one or other of the groups seemed to have a unifying effect on the conference as a whole.

Short Papers

The final session of each of the first three days was devoted to short papers. These covered a variety of subjects including the problems associated with forming and running groups, the art and science of group leading and some new ways of improving doctor/patient communication. The standard of papers was high and all these sessions were well attended.

Final Plenary Session

On the last morning, Ritch Addison summarised the tentative conclusions reached by the three qualitative researchers. They wanted in particular to draw our attention to what they described as the Core Values and the Creative Tensions of Balint-work as they had observed it.

Core Values

- Continuity
- Relationships
- Respect for the feelings and interpretations of others
- Unconscious processes

- Attention exclusively to the doctors professional ego
- Toleration of ambiguity
- Finding and giving meaning in life and work
- Providing a holding environment
- Allowing for the exploration of other possibilities

Creative Tensions

- One right answer ... Multiple levels of meaning
- Hierarchy ... Partnership
- Tradition ... Change
- 'Specialness' ... Expansiveness
- Comfort ... Anxiety

These ideas of feeling states were to be seen as balancing each other rather than being in opposition.

They suggested the following possible lines along which further Balint research might be developed:

- Continuing the Conference process
- Leadership
- The Balint process
- The story
- The training process
- Specific clinical topics
- 'Compare and contrast'

There followed a general discussion led by a panel consisting of all the Congress' plenary speakers. The main themes were the importance of 'The Unconscious' in the psychoanalytic sense of the concept of Hierarchy. Finally members of the Congress rose and said how much they had enjoyed and been refreshed by the whole experience.

We broke up into small groups, exchanging addresses and parting hugs, promising to meet again, reluctant to say goodbye. Our thanks go to the organizers, Clive Brock and his team at Charleston, notably Alan Johnson, Alec Chessman, Gebhardt Steuer, Peggy Irwin and Hollie Watson, for their thoughtful planning, hard work and wonderful, warm hospitality.

Reference:

1. Balint, M., Hunt, J., Joyce, D., Marinker, M. and Woodcock, J. *Treatment of Diagnosis: A Study of Repeat Prescriptions in General Practice.* London, Tavistock Publications. 1970.

Addendum: The Three Researchers

Penny Williamson is Executive Vice President of the Academy of Physician and Patient, and Associate Professor of Medicine, John Hopkins University School of Medicine, Baltimore, Maryland.
Ritch Addison is Assistant Clinical Professor of Family and Community Medicine, University College of San Francisco, Santa Rosa, California.
Will Miller is residency Training Director, Family Practice, Lehigh Valley Hospital, Hahnemen University, Allentown, Pennsylvania.

JOHN SALINSKY.

International Balint Award 1996 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 Verità' (the mountain of the truth) in Ascona. Owing to their influence on medical training in medical schools these seminars are acknowledged as the 'Ascona Model' (WHO), and their main purpose consists in Balint teamwork, 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. An award of **SFR 10'000.** will be made to the author of the best description.

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. **Reflexion.** A description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. **Action.** The student's perception of the demands he (or she) felt exposed to, and an illustration 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.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st of January, 1996** to the following representative:

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

The presentation of prizes will take place at the International Balint Centenary Congress in Budapest, Hungary.

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

Balint-groups in the Netherlands, 1995

H. J. Dokter, Emeritus Professor of General Practice
and R. W. Trijsburg, Professor of Psychotherapy
Erasmus University, Rotterdam

The Dutch College of General Practitioners has for some years, developed standards for the work of general practitioners, which represent the state of the art and can be used to measure the quality of care given by them.

General practice has been increasingly acknowledged as a scientific discipline in the Netherlands during the past twenty-five years, following the enormous development in research by general practitioners, especially in the field of the 'clinical' or 'medical sciences'. For example, otitis media, allergic rhinitis, upper respiratory tract infections and low back pain, have been investigated in depth, with remarkable results. Seventy PhD theses in the field of general practice, written mostly by general practitioners, have been produced in the past two years, some of them based on research into the doctor/patient relationship.

This has become an important subject in postgraduate training schemes for general practitioner trainees who are supervised and encouraged to improve the quality of their work, and to gain some insight into their personal development as doctors. But, in spite of this, Balint-groups for trainees in Rotterdam have not been successful, possibly because they were compulsory.

Continuing medical education is becoming more important, but courses which are accredited by the Dutch College of General Practitioners, and are compulsory for general practitioners who wish to renew their registration, have an emphasis on somatic medicine. This is seen as a disadvantage by some Departments of General Practice, as well as by the College itself, which is very concerned about the way in which general practitioners are performing in their surgeries and in particular, how they are relating with their patients.

The Dutch College was involved early in 1994, in setting up a Working Party to study Balint-work in general practice, to co-ordinate the work of existing Balint-groups, and to encourage the formation of new groups. Meetings have also been organised for Balint-group leaders, together with successful demonstrations for general practitioners and geriatricians of the work done in Balint-groups.

We are looking forward to their report on the doctor-patient relationship, which is currently in preparation. This may lead to further consideration of using Balint-groups as an experiential method of training doctors by helping them to gain insight into their own personal professional behaviour, and to become more aware of the importance of understanding, and making better use of the doctor/patient relationship.

The Working Party has also created a training programme for Balint-group leaders, psychologists and psychiatrists with a psychodynamic background, as well as experienced general practitioners. There has also been increasing interest in the use of Balint-groups outside general practice, for example, for those concerned with the pallative care of terminally ill patients with malignant disease. It has been found that doctors who are very enthusiastic and empathetic with their patients, are more likely to develop the 'burnt-out' syndrome, and that this can be prevented by attending Balint-groups.

A survey of what patients want/expect of their doctors showed that above all they want, as do patients in other countries, sufficient time with their doctors, so that they can be treated in a human and empathetic way, to be taken seriously; and to be informed adequately and openly about the diagnosis and proposed treatment of their illnesses. One of the most important goals, therefore, is to form as many new Balint-groups as possible.

There were sixteen Balint-groups meeting regularly in Holland in 1993, and although the group-leaders' names were known, little was known about their methods of leading their groups. One of us (RWT) sent questionnaires to 16 group-leaders, of whom 13 replied. One stated that he had stopped his group-work, but failed to give a reason. The remaining 12 group-leaders reported that they were leading 14 groups, involving 102 general practitioners.

Two groups have a long history, going back to the early nineteenseventies, and three to the 'eighties. The other nine groups started working after 1990, giving a mean of 8.2 years (median 12, range of 1 - 23 years). The mean number of sessions during a year is 15.3 (median 12, range of 10 - 40). The mean number of group-participants is 7.8 (median 7, range 7 - 10). Accepting that the number of participants was stable throughout the years, there has been a total of 812 'general practitioners' in these 14 Balint-groups. The number would be much greater, of course, if the figures for the larger number of earlier groups which have long since stopped meeting were known.

All the groups are 'open', that is, if a member leaves, another doctor may join the group. No members have left the four groups which have existed for three years or less. Over 96 members have left the nine groups which have been meeting for 3 - 23 years. This means there has been a turnover of 1.07 general practitioners each year (median 1). If we exclude the groups which have not lost any members, the mean number of years of participants was 5 (median 4, range 3 - 10 years).

Nine of the Balint-group leaders are psychiatrists; three are clinical psychologists; one is a sociologist, who is also a family therapist, and one is an anthropologist, who is also involved in the formal training of general practitioners. General practitioners are co-leaders in five of the groups. Most groups operate on an informal basis, but all have explicit rules about confidentiality, absence, frequency of meetings, location, and cost.

The group-leaders were invited to indicate which of the goals listed below were considered to be important, and their responses follow:

to
- gain insight into one's own countertransference reactions: 100%
- share emotions and problems, and obtain support from the group: 100%
- gain insight into more or less unconscious aspects of the doctor's behaviour: 92%
- gain more insight into what might be going on with the patient: 92%
- bring about changes in the doctor's behaviour: 85%
- find adequate ways of handling the patient: 85%
- improve the doctor's diagnostic skills: 62%
- formulate adequate treatment policies: 62%
- make an 'over-all' diagnosis: 46%
- learn to collaborate in the group: 31%

Insight-oriented goals prevail in Dutch Balint-groups, but they are not the only goals. To a lesser extent, cognitive learning and behavioural changes are also desirable goals. From a technical point of view, the following goals were also agreed by the numbers shown:

To
- clarify the doctor's problems: 99%
- ensure the safety of the group: 92%
- deal expeditiously with any problems arising in the functioning of the group: 92%
- deal with any emotional problem in any group-member: 77%
- use the countertransference at the group-level in order to clarify a particular problem presented by a doctor: 77%
- clarify the patient's problem: 62%
- see supportive techniques, such as clarification, cognitively framing the problem: 62%
- consider group dynamic aspects of the group-discussion: 54%
- concentrate on a task-oriented working style of the group: 45%
- consider strategies for handling one's own emotions: 46%
- desist offering interpretations as much as possible: 46%
- formulate a diagnosis for the problem patient: 38%
- help the doctor to change his/her approach: 31%
- interpret a problem in the doctor/patient relationship in terms of the doctor's earlier experience: 31%
- use psychoanalytic insights and techniques with the exclusion of other insights or techniques: 23%
- consider the doctor's medico-technical work: 23%
- limit discussion to certain categories of patients, for example, psychosomatic disorders: 8%
- psychotherapeutic approach: 0%

It appears from the list, that the most important issues in Dutch Balint-groups are the ways in which each doctor works in the group, and the dynamics of the group as a whole. The issues concerning the patients' problems seem to take second place. Technically speaking, clarification and confrontation are important aspects of the group-work. Supportive techniques are also important, but are used to a lesser extent. It appears that psychoanalytic techniques, such as interpretation, are not the central techniques used in our Balint-groups. Nor does it seem that attempts to alter the behaviour of the group members by instruction, are typical of Balint-groups. The analysis of the group-leaders' working methods is shown in the Table:

Table showing the categorisation of the working methods of Dutch Balint-group leaders

	Type of Balint-group			
	Task-oriented:		Process-oriented:	
Orientation of	Supportive Structured Focal:	Insight-oriented:	Insight-oriented:	Totals
Doctor	11	5	21	37
Patient			11	11
Both	11	21	21	53
Total	22	26	53	101

The totals of the percentage do not equal 100% due to rounding up of figures

(Concluded on page 30)

The Oxford Balint Weekend, 1994

Raoul Boot
Final year medical student, University of Maastricht

I felt really welcome at the 1994 Balint Oxford Weekend. This was not only due to the good atmosphere, but probably also to the way in which I was invited to come to this meeting. For this invitation depicts the atmosphere quite well.

In Ascona, I met John Salinsky. He invited me to attend the Balint Oxford Weekend. I later remembered the meeting would be in the autumn, so I phoned John in September. He told me the weekend would take place in two weeks, and he would be pleased if I could come, and sent the invitation papers. They arrived on Monday. I telephoned him again on Tuesday, to ask if it was still possible for me to come to the meeting? If not, it would save me a lot of trouble organising my journey. The answer was simple, 'We are expecting you. Everything has already been arranged.' I managed to arrange a ticket for the boat, and I crossed the Channel the next evening.

At Lincoln College in Oxford, I was also welcomed very warmly, in this case by David Watt, who immediately knew who I was, though he had not seen me before. This feeling of being really welcome continued the whole weekend in this beautiful place of Lincoln College. I am sure I was not alone in experiencing it.

I know it is not always true, but I think that poverty makes people less friendly, less polite and more cynical. Yet in spite of more people having a difficult life in England than in the Netherlands, I experienced the atmosphere in England as more respectful, more polite and friendlier. I am aware that I have not seen much of England: both my visits, to two hospices a few years ago, and to this Balint meeting, were quite 'protected' – quite 'safe'. So probably, I cannot assess the differences fully, but I think there is a real difference between the two countries. This difference is also reflected in the language. A lot can be expressed directly in only a few words in English, without being impolite. That is more difficult in Dutch.

When I use a different language for a long time, I start thinking in this language. Thinking in another language is thinking in another way. An example of this difference between English and Dutch, is that in Dutch there are two words for 'you'; one is formal, one is not. Using the two 'you'-words improperly can be very impolite. As far as I know, such a difference does not exist in English. The ranking in social classes, though, is much more common in England. I suppose that there is also a much stronger hierarchy in the medical profession than in The Netherlands. Though a 'formal' and 'informal' you do not exist, I am convinced that the hierarchy is experienced in some other way. One reason for thinking this came from this weekend. In due course, it will become clear why I got this impression.

The education system of my 'native' university, the University of Maastricht, is unusual, even in The Netherlands. It is a problem-oriented education. We start with cases on paper and discuss them in a group of ten students, supervised by a university staff member. In these sessions we set our learning goals which we then research in the library. After a few days we meet again to discuss our findings. Everybody uses different books, so that quite a lot of different answers and opinions have to be discussed. This also makes it clear that nobody has the right answer, and that we must work together to learn more about human problems.

In addition, we learn from the very first week, under supervision again, to carry out a physical examination on each other. Further, actors play the parts of patients, and we students have to play the role of doctor in the consultation, which is videotaped, and later seen by our fellow students who provide us with feedback.

I think the Maastricht practical medical training in hospital is not so different from 'normal' practical training. But once I heard a doctor comment that we students from Maastricht are more inclined to work together, and to help each other to cope with the emotions provoked by our work, more than students from other Dutch universities.

Back to the Oxford weekend again. At this Balint meeting we all worked together discussing problems. It was impressive how much depth we gained in so short a time in a group, which was composed of people who did not know each other before. Also the way we worked at problems, was new to me. Someone presented a case; the other members of the group asked some questions to clarify the case, and we then discussed what we would think, feel or do in such a case. It was the group who worked on the case, not only the case-presenter, and who asked some questions. When someone made the 'mistake' of questioning the case-presenter too much, the safety of the procedure was questioned.

From these sessions, I think, everybody could take what was valuable for him or her; we all worked not only at the presented cases but also at 'similar' cases we had experienced ourselves.

Discussing consultations in my course until now, consisted mostly in asking and answering questions. I will remember the safety of this 'new' Balint procedure.

At the end of the meeting, I was further surprised by a remark made by a fellow student, that he felt an equal member of the group, though he was not a doctor yet. One of the doctors also said she had forgotten we were students. It seems, I have been shaped at least partly by the Maastricht education system; I really could not imagine that a student who is 'not a doctor yet' could gain from the experience of this kind of tutorial group.

I was studying social and environmental

medicine during the last few weeks before I came to the Oxford Weekend, I had been solving problems like: 'Can I eat onions grown in my garden, where there is a lot of lead in the soil?' After this weekend, I became aware again why I am studying medicine!

A Second Balint-day for Course Organisers in Ripon, 1995

For the second year the Balint Society ran a study day for Course Organisers immediately prior to the Annual Conference of the Association of Course Organisers. A report on the first study day held in 1994 was reported in the Balint Society Journal of that year.[1]

The aim of the day was once again to expose Course Organisers who may already lead Case Discussion Groups to the Balint method of leadership.

This year there were 7 participants, 5 of whom had attended last year and 2 leaders, John Salinsky and Heather Suckling. In view of the small number it was decided to run a single group throughout the day.

Although both leaders regard themselves as traditional Balint leaders who have had the advantage of absorbing the method by long participation in Balint-groups, they recognise that if Balint is to survive in the modern world, there needs to be acceleration of learning for group-leaders. Therefore it was decided to break with tradition and to make explicit the essence of leading a Balint-group. Lists of guidelines and techniques were written on a flip chart and left on view throughout the day.

Guidelines for leading a Balint-group

1. Focus on a doctor/patient relationship.
2. Protect group-members.
3. Don't talk too much!
4. Discourage interrogation of the presenting doctor.
5. Look at process rather than seek solutions.
6. Create a safe environment.

As the group was made up of Course Organisers, we did not list the need for honesty, confidentiality and owning statements, as these were assumed, but probably should have been included for the sake of completeness.

Note
It is thought that 1, 2, 4 and 5 are specific to Balint-groups, but the other guidelines are applicable to all Case Discussion Groups.

Techniques

1. Arrange the chairs in a close circle.
2. Space the leaders within the group (so they are neither next to each other nor directly opposite each other).
3. Do not talk directly after your co-leader (usually!).
4. Ensure accurate time-keeping.
5. Enable all members to participate.
6. Encourage reflection and deflect questions appropriately.
7. Listen to, and respect your co-leader.
8. Represent the patient.
9. Stick to the presented case, discourage anecdotes.

Note
3, 6, 8 and 9 are probably specific to Balint-groups.

For the first case, the group was led by the two experienced leaders, but after that, the leadership was rotated for each case. John and Heather then acted as ordinary group-members, but did not present cases.

At the end of each case, time was allowed for discussion on the leadership, Pendleton Rules were observed.

Some misconceptions about Balint were clarified for instance, that the focus is not on the doctor's feelings or neuroses, but on the relationship between the doctor and patient. If the doctor gains insight into his or her own psyche that is a bonus, but personal to that individual and is not made explicit in the group.

It was noted that discouraging interrogation of the presenter serves two useful purposes. Firstly, it encourages all the group-members to apply their minds to the patient's problem and secondly, it protects the presenting doctor.

The feedback was positive and it was considered a successful day. Personally, I had had some anxieties about rotating the leadership, but these were not realised. I attribute this to the quality of the participants and to the fact that everyone followed the guidelines. Perhaps it was rather too good to be true!

The consensus view about making the guidelines explicit, was that it was valuable to have these at the beginning, but that it might have been helpful to cover them during the course of the day to avoid the 'Big Brother is watching you' feeling. We will implement this suggestion at the 1996 workshop when we hope to attract more Course Organisers.

HEATHER SUCKLING

The Human Face of General Practice

Oxford Balint Weekend

15th - 17th September 1995

Experience group discussion about the doctor/patient relationship.
Groups, mostly made up of general practitioners, can explore the psychological aspects of their work with patients.
Practice-nurses will be welcome.
Group experience is not necessary.

Venue: Lincoln College, Oxford

Price: £180.00 (£165.00 Members), including board and lodging

Conference commences Friday evening and ends with Sunday lunch.
PGEA approval.

Contact: Dr. David Watt, Tollgate Health Centre, 220 Tollgate Road, London, E6.

The International Balint Federation, 1995

The most significant and exciting international event in the last twelve months was, of course, the 9th International Balint Congress held in Charleston, South Carolina, USA in November 1994 (see page 35). Although only some 65 people attended, this was in some ways an advantage because we felt, by the end of the conference, that we knew everybody really well and had been working closely together (just like a Balint-group). For those of you who missed it, there will be another opportunity to experience the charms of Charleston by attending the American Balint Society's Group Leaders' Intensive which will be held from October 14th to 18th 1995 at the beach resort of Wild Dunes, which is just outside the city.

Group-leaders and aspiring leaders will have the opportunity to observe each other's style of working, learn some new ideas and improve their skills in a friendly relaxed atmosphere. If you cannot make that one, the next full scale International Congress awaits you in Budapest in May 1996. The Hungarian Balint Society will be celebrating Michael Balint's 100th birthday and they have invited us all to join the party. There will be lectures and demonstration groups in English and Hungarian (with simultaneous translation) followed by small group sessions in the language of your choice. Needless to say, Budapest is an exciting city and there will be opportunities to see the sights, taste the food and swoon to the sound of those sensuous violinists.

Meanwhile, the International Federation council continues its work of keeping Balint enthusiasts from many different countries in touch with each other. The council meets twice a year and each affiliated national Society is allowed to send up to four delegates. At our last meeting we were guests of the German Society in a little 19th century Schloss by a lake near the old town of Potsdam in the former Eastern half of the country. Our main preoccupation at the meeting was with the question of accreditation (or 'credentialling' as the Americans say) for group-leaders. Some of the European Societies already have quite strict criteria which have to be satisfied before someone is accepted as a qualified leader. They mostly have to do with the leader's previous experience and training both in psychoanalysis and in Balint-group leading. In some countries only analysts can be leaders whereas, as in Britain and the USA, while there is no formal accreditation, there is now a clear acceptance of general practitioner leaders who have had plenty of experience in Balint-groups and have acquired, by osmosis, some familiarity with the psychoanalytic way of listening to the Unconscious. The International Federation president, Dr. Frank Dornfest (USA) proposed a new approach to accreditation which would be based more on an examination of the work leaders actually do with their groups, on the assumption that what you do is more important than who you are. Discussion of each other's work (by means of transcripts or tapes) would also make accreditation an educational process. These ideas were taken up with enthusiasm and we are now trying to collect examples of good leadership so that we can put together a list of qualities we are looking for in a leader. Everyone is cordially invited to join in the process by writing to me.

After the meeting we had an evening boat cruise (with buffet) on the river Havel and some community singing led by the legendary Professor Boris Luban-Plozza (Switzerland). Sadly, the Brits were too bashful to sing any English songs, so the Continentals came up with a Scots one, 'My Bonny Lies over the Ocean' which they all seemed to know. I am already practising for next time.

The following day we had a tour of the grounds of Fredrick the Great's magnificent palace, *'Sans Souci'*. There were 23 people at the meeting and between us, representing 10 countries. As I think you can tell from this report, it is possible to have a lot of fun at International Balint meetings as well as doing some serious work. It is also very interesting to see how Balint is faring in different parts of the world. Some of the older Societies (Britain, Holland, Switzerland) are feeling rather depressed because of the Balint Society members are getting old and there do not seem to be many youngsters coming up to replace them. On the other hand the newly democratised East European countries are fizzing with activity and seem to have plenty of young doctors and students wanting to join groups. Meanwhile Germany, France and Belgium continue to forge ahead. The German Society is particularly remarkable. Their secretary (Dr. Heide Otten) tells me that they now have nearly 1000 members and 300 leaders. There are fifteen weekend meetings a year in different parts of the country. If you speak German or not, you will be welcome to attend any of these events.

If I can't persuade you to travel abroad, I shall simply have to bring the International Balint Federation to Britain. Yes, the next International Congress after Budapest will be in Oxford in September 1998. It should be a wonderful experience but please – you do not have to wait that long.

For further information about the International Balint Federation, please contact me, Dr. John Salinsky, 32 Wentworth Hill, Wembley, Middlesex HA9 9SG. Telephone: 0181 904 2844.

JOHN SALINSKY
General Secretary
International Balint Federation

London Balint Study-Day

18 May 1995

The Balint Society held its first Balint-day which included a Balint-group for practice-nurses in the Conference Centre of the Hospital of St John & St Elizabeth, London. Seventeen people attended, forming two groups, one of seven practice-nurses and one with six general practitioners and general practitioner-trainees. Andrew Elder and Mary Burd, a psychologist, led the nurses' group, Marie Campkin and David Watt led the doctors' group.

The day began with a beautiful, thoughtful and lucid account of Balint-work, given by Andrew Elder. He described the change of emphasis in the 1960s, from general practitioners as 'mini-psychiatrists' to genuine general practitioner doctor/ patient-work within our short appointment systems. He also gave a feel of what a Balint-group was like for those who had not previously experienced one.

As last year, the Hospital Conference Centre was very congenial, with good catering facilities and group-meeting rooms. Both groups met three times, twice before, and once after lunch. The plenary session that followed, dealt mainly with the dis-satisfaction of the nurses and the doctors being together at a meeting, but apart for the groups. The nurses valued the day highly, as it was so different from the type of the very goal-orientated study they usually participate in.

The idea of having groups for practice-nurses has been around for some years,[1] and most recently suggested in an editorial in this journal by Dr Philip Hopkins.[2] The Tavistock Clinic plans to form an on-going group for practice-nurses this autumn.

There was debate both before and after this Study-day on whether doctors and nurses should be mixed in groups. The group-leaders felt that there had been an advantage in the nurse-only group, but if nurses wish to attend the Oxford Balint Weekend this year, we shall mix them in doctor-groups as we have done with psychotherapists.

Next year, the Society will run a Balint Study-day solely for practice-nurses, as the general consensus of opinion of all present, was that there should be sufficient interest.

DAVID WATT

References

1. Steinberg, P I, Shaw, B F. An evaluation of Balint-training for psychiatric nurses. *Journ. Balint Soc.* 1989:**17**:28.
2. Hopkins, P. What happened to Balint? *Journ. Balint Soc.* 1993:**21**,3.

Balint Prize for the Field of Health and Nursing Care, 1996

To promote relationship-orientated care, based on the Ascona Model (WHO), prizes will again be awarded for papers in 1996.

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 Medicine 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 1995.

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 1996** in Ascona, Monte Verità during the Ascona talks on the theme *'The Ageing Person and his/her Social Environment'.*

Programme of Meetings of the Balint Society for the Twenty-sixth Session 1995-96

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

Dr. A. J. HAZZARD, General Practitioner, Stanstead, Essex. **Hermaneutic Research.**	24 October 1995
Dr. Paul MacDONALD, Psychotherapist, Shropshire Community Health Service Trust. **Balint, Heart-sink and Health Care in the Nineties.**	21 November 1995
Roger NEIGHBOUR, Author, *The Inner Self.* (Title to be announced)	13 February 1996
Dr. Georgia LEPPER, Analytical Psychologist, London. **The Impact of Counselling on General Practice.**	19 March 1996
Dr. Michelle Laschowsky, Gynaecologist, Paris. 12th Michael Balint Memorial Lecture.	24 April 1996

Other Events

The Oxford Balint Weekend, 1995 Will take place at Lincoln College, Oxford from Friday at 6 p.m. to Sunday at 1 p.m.	15-17 September 1995
London Balint-Day Meeting for Practice-nurses at the Hospital of St. John & St. Elizabeth, London. (Details to be announced)	May 1996
Annual Dinner, 1996 (Details to be announced)	20 June 1996
The Oxford Balint Weekend, 1996 Will take place at Lincoln College, Oxford from Friday, at 6 p.m. to Sunday, at 1 p.m. (Full details to be announced)	September, 1996

All meetings are PGEA approved.
Further information is available from Hon. Sec. Dr. David Watt.

Instructions for Contributors

Manuscripts and communications for publication in the Journal should be forwarded to Dr. Philip Hopkins.

Style

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

Abbreviations should be avoided.

Use approved, not proprietary names, when referring to drugs.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article.

All references should give the names and initials of all authors; the title of the article; the title of the journal abbreviated according to the style of *Index Medicus*; year of publication; volume number; and the first and last page numbers.

We welcome the submission of documents on 3.5" computer disk. IBM compatible files only please. If possible, please send files in Microsoft Word for Windows version 6 or 2. Other acceptable files are WordPerfect versions 5.0, 5.1, or 5.2; Wordstar versions 3.3 to 5.5; Word for MS-Dos 3.x to 5.x. Authors should supply the name of the file on disk. Please send one hard copy with your file.

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