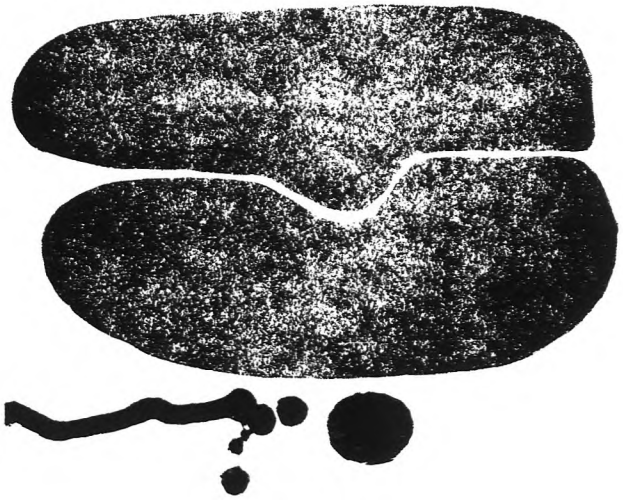
Journal
of the
Balint Society

1997



Vol. 25

JOURNAL OF THE BALINT SOCIETY

Vol. 25, 1997

Contents *Page*

Editor: Philip Hopkins
Assisted by Susan M. Hopkins

With grateful acknowledgement to Dr. Ted Genever and the Editor of DOCTOR.

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 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 Congress.

There is an annual Prize Essay of £250.00p (page 14), and the Journal is circulated each year to all members.

Editorial

The Doctor, his Patient and Time

Dr. Ted Genever's remarkably timely cartoon (*Frontispiece*, p.2) appeared just as I was preparing the contributions for this twenty-fifth issue of our journal,[1] and I am delighted to acknowledge my very grateful thanks for his consent to publish it. Among other things, it beautifully demonstrates the accuracy of the well known adage that 'One picture is worth more than ten thousand words,' as recorded seventy years ago.[2]

However, we are not all so gifted, and have to make do with words. Even then, some are more fortunate than others, like our well known, regular contributor, Dr Sotorios Zalidis, who has been awarded the Balint Society's annual prize for the best essay for the second year running, with his anonymously submitted winning essays, (this issue p.7, and last year's Journal[3]).

Dr Zalidis not only skillfully describes the very complicated medical history of a fascinatingly difficult patient, whose somatisation was associated with his underlying depressive illness and emotional unawareness; he also describes in great detail the nature, and the value of his psychotherapeutic approach which required rather more than the usual 'six minutes for the patient' for each of a number of consultations. Our congratulations and also our thanks must go to Dr Zalidis for sharing his experience (but not his prize money) with us!

Congratulations are also due to the six winners who were awarded this year's International 'Balint' Awards from the Foundation for Psychosomatic and Social Medicine, Ascona. Two of them were home grown. First, Liza-Jayne Clark, who was a final year medical student at Charing Cross Hospital and Westminster Hospital, when she submitted her essay (p.15), which brought her half of the second prize of 2000 Swiss francs, shared with Guatam Sharma, a medical student in Delhi. She can also be congratulated on recently qualifying.

Congratulations also to Gail Kay, a 4th fourth year medical student at University College and Middlesex School of Medicine, for her winning essay (p.20) which brought her half of the third prize of 1000 Swiss francs, shared with William Benko, a medical student in Budapest.

Both described experiences with their early encounters with patients, and clearly demonstrated their awareness of the relevance of underlying emotional problems in the development of illness, as well as their appreciation of the importance of having adequate time for good communication with their patients. They are already way ahead of where I was at, when I started in general practice in 1948, having worked for the previous five years, first in the Emergency Hospital Service, and then in the Royal Army Medical Corps as a graded orthopaedic surgeon (equivalent to a registrar in civilian life). I have described elsewhere how difficult it was for us to cope with the increasing demands made by the huge numbers of patients who were taking advantage of the medical attention which was available and 'free' at the time of their needing it, following the inauguration of the National Health Service nearly four years earlier.[4] At the same time, I became aware of the deficiencies in my hospital training with regard the needs of my patients in general practice. All too often, I could find 'nothing wrong' with them and not knowing how to respond to their awkward questions, I said nothing, or as little as I could get away with.

I found that many patients then took the opportunity to talk more, telling me all manner of details about their unhappy lives and disturbed relationships. Surprisingly, many of them improved and I came to see what, forty-six years on and some 650,000 consultations later, everyone now seems to know as the result of a television advertisement, that 'It's good to talk!' I also began to learn that it can often be equally good for the doctor to *listen.*

At that time, I was carrying out two surveys, or what would now be called audits of the outcome of what I was doing in my practice. One was an analysis of the presenting symptoms and the diagnoses of a group of 716 consecutive patients seen during the latter part of 1951, which showed that 40% of them were suffering from what were then called stress disorders, or psychosomatic illnesses. It seemed to me even then, that what they needed most, was a doctor who could *listen* attentively to them, with ample time at his disposal, and an understanding of what he was listening to, and how to respond. I decided this was the real treatment which these patients should be offered, discussions, not drugs. This requires time, however, – a lot of time.[5]

The second audit was an analysis of the reasons for 1,200 referrals to hospitals, including pathology specimens, bacterial swabs for culture, as well as X-rays and other special investigations, over a period of three years, and of the outcome of all these referrals. The essential finding was that only 6% of the patients involved, required hospital treatment, mostly in the form of surgical operations. All the others could be treated in the general practitioner's consulting rooms, many of them requiring psychological help, in addition to medication for the control of various symptoms related to dysfunctional autonomic nervous over-stimulation.[6]

The shortage of time was undoubtedly an important factor resulting in the feelings of inadequacy that I, and many of my contemporaries experienced with regard the way in which we were treating our patients, and was among the chief reasons why so many of us responded to Balint's announcement in the

Lancet of 11 April 1952, that '*A Discussion Group Seminar in Psychological Problems in General Practice*' was to be held at the Tavistock Clinic.[4]

Our work in the early Balint-groups helped us to *think* about what we heard, and to examine our own feelings. Most of us felt this was an exciting subjective discovery, and that we had found an invaluable process to assist us in the care of our patients. Eponyms are said to be unfashionable, but medical abbreviations are still popular. 'Balint-work', just like the picture and 10,000 words, is a description equivalent to several paragraphs of prose. It is often said that the Balint-group idea has been integrated into general usage, from practice vocational training groups, but it may be that this integration does not go deep enough. Balint analytical theory was that basic essential processes in the human psyche-soma were inextricably linked with interactional processes between people. If this vital point had not been neglected for so long, the practice of medicine would be in a better shape than it is at present.

Balint concluded in his book, *The Doctor, his Patient and the Illness*,[7] 'My diagnosis is that general practice is seriously ill, but the illness is benign, and provided that the right therapy is applied, the prognosis is good. 'Forty years later, our 'patient' has survived, mostly due to a tremendous will to live, and the altruism of health service professionals. But the illness has been debilitating and it has left scars, and the therapy has not always been focused. I think that Balint would be unlikely to be surprised, but I think he would be horrified with its present condition. All his major concerns have been, or are being destroyed; the continuity of care of the patient by the same doctor has virtually disappeared except in single handed practices, of course; the accessibility and availability of the doctor has suffered with the growth of deputising services, and in the larger group practices where there has been an increase in the use of the 'team', that patients may not even see the doctor, let alone his/her doctor, or it may be a nurse who will be the first to see the patient; the collusion of anonymity is back with us. As for the doctor exploring the emotional dysfunction underlying his patient's illness, which is what Balint-groups should be helping him to learn to do, the patient is more likely to be referred to the practice counsellor, or to a counsellor outside the practice. The doctor only being consulted in the case of some more serious illness ... The error of our day is still that there is a doctor for the body, and some other person for whatever else is affected.

Even the compassion which has always been so important for all doctors – and nurses, too, and always carefully nurtured, has been lost. The results are all too clearly apparent: the increasing dis-satisfaction of our patients, the steeply rising number of complaints against doctors – of all types, especially the family doctor, as I still like to be regarded, even though there are fewer true families to be cared for, the vandalism directed at doctors' premises – and the physical violence against doctors themselves, all point to an alarming increase in the resentment and anger pent up in the population.

A recent Discussion Paper in the *British Journal of General Practice*, notes that compassion too, is being eroded: 'Patients are increasingly unhappy ... patients are less satisfied with those practices that are arguably at the forefront of change – those that are thought *by the profession* to be the most advanced in terms of training and management structure ... despite this dilution, erosion and neglect of personal doctoring, there is evidence that personal care does matter.'[11] The author goes on to quote research evidence that stress results in morbidity, and that compassion relieves stress. 'Evidence-based work from psychoneuroimmunology is gradually illuminating the role of human interaction in health, disease and therapeutic processes[8, 9, 10, 11] (see page 30).

There is an increasing flood of new information about the scientific basis for mind/body interactions, and the psychoneuroimmunological relationships concerning stress, which suggests that there is an increasing need for psychological treatments for an increasing number of conditions,[8, 9, 10, 11] confirming my view that 'The use of psychotherapy in general practice may be limited where time is short; but with its help the doctor can unquestionably get nearer to the ideal of treating patients and not merely the symptoms'.[12]

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PHILIP HOPKINS

What Balint-work can do for Patients

Michelle Lachowksy*

The Eleventh Michael Balint Memorial Lecture, given on 17th April, 1997.

I do not know which is harder, to be a doctor or to be a patient – of course you might say a doctor chose to be one, the patient as a rule did not choose to be one. But they both need each other in order to assert their specificity, and to assume their roles. The one makes the other, they both depend on each other, and they may even confuse their roles sometimes, playing games, from hide and seek to musical chairs, to the harsh drums of sick organs or to the fine tuning of soul-music. Did not Balint himself encourage us to dance with our patients?

We all experienced those times where personal troubles make life difficult to cope with, and where we feel we cannot go through the motions, nor do our everyday's doctor job. And suddenly, with the first patient of the day, we easily slip into the 'doctor-person', as we were before becoming the healer. The healer?

But why on earth did we decide to protect humanity from sickness and death? Why did we not only accept, but choose such a tremendous responsibility? Did we really believe we could find ways and means to fight pain and suffering, did we think we could bear not to win those fights? Did we feel we were capable of witnessing the death of a child, the decaying of mind and body? And if we wanted to be part of life's dramas and maybe even deflect some of life's arrows, how did we imagine we could survive boredom when things seem to be petrified from one consultation to another?

Well, it may not be easy, but it can be extraordinary. And not only when we have been 'good doctors', when we feel we made the right decisions and gave the right treatment but even more so, when *we did not do anything*, but simply were there at the right time and at the exact place where the patient needed us. The problem, as Balint wrote, is to known when and how to prescribe ourselves. No book gives the formula, the exact dose at which the 'drug', doctor, is to be given. As with all drugs, too much for one person is too little for another, and sensitivity or addiction may occur. But pleasure is a potent 'drug' also and a happy doctor certainly is a bonus to most of his patients. The hermeneutic circulation is quite apparent here, as we all know that part of that pleasure is also a gift from the patient to the doctor.

Some patients may need us, on the contrary, to vent their aggression and not tolerate too much equanimity on our side. Our response to those solicitations is quite clear in a Balint-group, and by accepting what we cannot change in ourselves, nor change what we cannot accept in them, we do often arrive at a solution, at majorem patient's gloriam.

It is of course much easier, and somewhat tempting for us to hide behind screens and other sophisticated tools, rather than add to our own doubts and anxieties of our patients. But we cannot, and we should not exclude the patient from what is happening in his or her body, or from what we are trying to do *with, within* that body. True, his or her representations of that body are quite different from ours, but what is the difference; and does it really matter? What he thinks and what he feels, his way of life and ideas about it, that is what really matters, that is food for thought, of the same value as the body temperature or the blood pressure. It is only a question of time and timing, and it is also part of what Balint-work does to help us to help our patients.

Sickness and suffering are the objects of our concern, the sick and suffering person is our partner, the subject of our concern. Although we are well aware that we sometimes inflict discomfort, hurt and wounds – all for our patient's own good as we all know! We must not fall into that modern trap: the opposition, the duality, between high-tech medicine and relational medicine, the one being totally alien to the other, thus creating the rift into which our patient cannot but fall, a void which might suck him in, if we did not pull him out and hold him, at least metaphorically, in our Balintian arms.

Our encounter is not a contest, it is the weaving of a complex tissue of emotions where both protagonists try to join forces against that third partner, the illness itself. Do you not think, or rather have the feeling that Balint-groups are, or could be the laboratory where we can work on that astonishing chemistry, the patient/doctor relationship, which is, or rather gives us, our daily bread.

It is through that double-bind that Balint-training brings more to the patient, and not only to the doctor – it is that feed back which is the RNA messenger that patient's and doctor's cells alike recognise.

So how can we build that bridge, when we don't even know what length it should have, if it has to be of thick rope or of thin air? Maybe it is more of a line that we throw, whenever we open our door and our ears – and what about our heart? – to that person, long known or yet unknown, who paid a pound of flesh for the dubious privilege of becoming our patient. Because let us face it, to become a patient one has to fall ill...

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The patient/doctor relationship like any interhuman relationship is made of what is said, what can be said and what cannot, of words and attitudes, but also of symptoms offered, accepted or refused, of exchange and barter. It is anything but static and monolithic, but one thing is never modified: we, and we only have the right to unveil the other's body, to invade the other's mind, in a word, to have access to the other's innermost privacy. Exhorbitant though it may be, that is what that famous medical 'power' is about.

Such a potency, such a power, earned through teaching absorbed at the university can, if topped by Balint-training become a fairy's wand instead of incurring the risk of being a witch's needle. It can be turned into an asset, as well as a guarantee of quality. Naturally, we are the doctors, we know we are the ones who always keep our clothes on, even put something else over them, a uniform or a protection. We are in an upright position, whereas the other is often lying down and half-naked.

Those images, those emotions, if we can recognise them, if we can feel their impact on both patient and doctor, then we can use them instead of ignoring them in our patient, and hiding them from ourselves. We have been taught during our studies and trained in our contacts with our patients to wear a mask, our doctor-face, where real feelings should be blotted out and erased. Why should we not be allowed, or should we not allow ourselves, to share something as precious as joy or sorrow with our patients? What is the benefit of not showing that we care, not as a mother or a sister, not as a grandfather or a best friend, but as a doctor, in our place, in our role, at the right distance. The distance where we, patient and doctor, bear each other well enough to learn from one another. That therapeutic distance is not always easy to find, and can vary for the same patient from one consultation to another. Keeping a certain neutrality is sometimes hard, but it is necessary. The best evidence for that, is the difficulty we all experience when we have to treat those we love, who are too near, or to whom *we* are too near.

'It is never the same person who thinks and who weeps' said Mallarmé the French poet, when writing about his child's death ... but keeping a cool head does not imply icy bed-manners, and trying to warm your hands before putting them on an abdomen cannot but give better results, a better assessment of the situation, and of the relationship. Such attention to small details, is simply pure courtesy, which is so necessary to oil all human contacts. Certainly it makes the patient whole again, not reduced to the slice of himself which he brought us, not reduced to that sick part of herself, not only a uterus or a breast, but a woman as a person, with a heart and a head up there, at the other end of the bed or the table.

As we speak in French of the *travail*, the work, of giving birth, one could speak in the same terms of the work of the relationship. Patient and doctor together are engaged in creating something which is theirs, while moving toward a better mutual understanding. It is not a simple process which can only evolve, either in a right or in a wrong direction. Both partners must prepare themselves for a certain dose of frustration. Quoting Balint, it is on that basis of satisfaction and frustration on both sides, that a unique contact will establish itself between the physician and those of his or her patients who keep coming to him. We are hard put to describe that bond in psychological terms. It is not only love, trust, mutual respect, identification and/or friendship, although all these parameters exist at one moment or another, but a company for mutual investment. Balint means that the doctor is at the head of a precious capital invested in his patient, and that the recipocity is true, the patient having made a precious deposit at his doctor's too. But he goes on stressing the point that this double asset should not be squandered away, but used, or made fruitful, so that both doctor and patient can receive their rightful dividends.

Balint-work gives our patient more than a guarantee of quality, it is an assurance: we assure him or our full attention, of our deepest concern for his interest during all the time we share with him, or her, a time which is his or hers during the whole consultation.

Preparing this paper, I found those lines of Toni Morrison, that wonderful writer, addressed to adults by a child: 'They do not talk to us – they give us directions. They issue orders without providing information. When we trip and fall down, they glance at us.'

Well, the respect and the insight, the courage and the flexibility we all hope for, may well be what Balint-work helps us to acquire or to enhance. I like to think that along with the right word, the gesture expected or not, the handful of science, the headful of imagination, even the taste of a tear as quickly dried as the ink of our prescription, that is what we hope to offer our patients, not forgetting of course the cherry on the cake ... a zest of our own personal magic!

'So if There is Nothing Wrong with Me, Why Does it Still Hurt?' *

Sotirios Zalidis
General Practitioner, London

Introduction

When a patient feels physical pain, common sense tells him that the pain signifies damage of the part of the body where the pain is felt. When the skin is jabbed with a pin, the pain is usually accurately localised and the patient can put his finger exactly on the point of injury. Medical research however, has revealed that the ability to localise the pain in the region of the injury is limited to the skin and does not apply when the source of pain is in deeper tissues. Ronald Melzack and Patrick Wall in their book, *The Challenge of Pain* remind us that visceral pain is often felt in bizarre locations.[1]

Doctors are trained to recognise these patterns of referred pain and this is the type of problem that demands intellectual understanding. For instance, inflammation of the diaphragm produces pain which the patient insists is located in the shoulder. The explanation for this strange referral is that the diaphragm which separates the chest from the abdomen, originates in the embryo from muscle tissue which forms in the fifth cervical segment. This muscle migrates from the neck to the chest, to form the diaphragm, where it develops into our main respiratory muscle. During the migration from the neck to the thorax, the muscle carries with it its nerve supply which also originates from the fifth cervical segment. This is the phrenic nerve which runs down the lower neck and through the entire length of the thorax to innervate the diaphragm. Apart from this special migration, the rest of the fifth cervical segment like all other segments forms local skin and muscle. The area of the skin supplied by this segment, the dermatome, runs as a band from the midline of the back across the top of the shoulder blade and down the upper arm. As a result, pain triggered by nerve impulses arriving from the phrenic nerve, is mistakenly interpreted as coming from the area of skin supplied by the rest of the spinal cord segment. In other words, pain is referred to the segment of origin of the nerves. Also they quote the remarkable study of Jones who showed that inflating a balloon at various levels of the digestive system sometimes produced pain felt in the back or even at the site of a scar of an earlier operation.[2]

When the patient experiences physical pain, common sense tells him that only physical examination and physical investigations will find its cause. Psychosomatic research however, has demonstrated that emotions have physical components which can be perceived in isolation from the psychological experience of the emotion, and felt as physical sensations in various parts of the body.[3] Unfortunately, our ability to think about emotions is handicapped by the dualistic tradition that permeates our training according to which, body and mind are separate entities that may meet and interact. Emotions however, bridge the body/mind divide because they are at the same time both physical and mental and they can be pleasant or painful.[4] A very brief way of stating this new way of thinking, is to say that emotions are considered to be carriers of information about the relationship of the person to others and to himself. This information is carried by certain affective components. There is a cognitive component which leads therapists to pay attention to the meaning of an emotion as well as to the story behind it; there is also a somatic component which refers to the muscular activity and the body changes caused by autonomic arousal and neuroendocrine activation, as well as a hedonic component which refers to their quality of pleasure or suffering, and which gives them their motivating role.

Having an emotion or an affect does not necessarily mean that we are aware of having it. Because sometimes we confuse the physiological arousal of an emotion with an illness or a 'virus', affect theory reserves the word 'feeling' for the subjective experience of an emotion that we recognise as part of ourselves. It is only when all three components occur simultaneously and are free from blocks causing isolation or dissociation, that we are capable of adequate reflective self awareness, and have the capacity for sensitive self observation, that we can recognise that we are experiencing a feeling.

At the beginning of life, emotions serve mainly as communication to the mother. They are undifferentiated, their somatic component is very strong and they are experienced mainly as physical sensations, images and impulses to action. Gradually with the development of verbal skills the precision and effectiveness of words demonstrate verbal language to be the preferred way of handling emotions. Cognitive processing and symbolic elaboration of emotional arousal contributes to emotional differentiation and attenuation of their somatic components, so that emotions can become more idea-like and useful as information to the self. This is a delicate process and needs a lot of environmental support if it is to be succesful.[5]

Getting to grips with these considerations involves emotional understanding which according to Michael and Enid Balint, is more complicated than purely intellectual

* The Balint Society Prize Essay, 1997.

understanding. Whereas for the solution of a physiological or mathematical problem, it is sufficient to understand the external problem, and there is hardly ever any need to understand ourselves as well, emotional understanding presupposes a fairly keen appreciation of what the emotions under observation mean, both to the observed and the observer.[6]

A clinical example

Mr Baker, a sixty-year old retired postman came to see me in the middle of a busy surgery on a December 15th, for his first consultation complaining of a new illness consisting of pain in the ball of his right foot. He is a known sufferer of ischaemic heart disease, for which he had a coronary angioplasty five years previously. He is short, obese and speaks softly with a fixed jolly grin that never varies, as if he is wearing a mask .

This was not our first meeting. We had met for the first time two years previously when he had developed shingles after the funeral of his beloved brother-in-law and I remembered vaguely that he had suffered recently some other significant bereavements. I examined his foot and, finding nothing wrong with it, had a general discussion with him about foot-care. Just as I thought that we had come to the end of his appointment and had exhausted his problem, he told me, rather timidly, that he also had a pain '.. like a strain' in the right lower abdominal area for a month. What started as a straightforward consultation was unexpectedly turning into something more complicated. As my surgery was running late, I suddenly became very time-conscious, and quickly looked through his notes. I saw that ten years previously, he had suffered an episode of severe right epididymo-orchitis, for which he was admitted to hospital for vigorous antibiotic treatment. Since then, he had had the pain on and off, and he was afraid that the infection had returned. I examined his abdomen and testicles, but could find no evidence of any abnormality. I told him I could not find anything wrong. He looked at me in his usual smiling, friendly way and asked, '*... but if there is nothing wrong with me, why does it still hurt?*' My irritability for running late was compounded by a sense of embarrassment for my failure to find a satisfactory explanation for his pain. I did feel however, that his smile seemed rather incongruous with his complaint, and that if I did not want to lose my credibility and the friendliness implied by the smile, I would have to look harder for an explanation for his pain. I needed time to read his notes carefully and remind myself of the discussions we had had, and at the same time I wanted to make sure that I was not missing a serious organic disease. I therefore ordered urine-analysis, a battery of blood tests and x rays of his foot, and asked him to return in two weeks, when I would have the results of the tests.

All the results were normal but, looking at his records again, I discovered that his brother had died on December 15th, five years previously, and his mother on December 16th one year earlier. To my astonishment, I realised that he had come to the surgery to consult me on the double anniversary of his mother's and brother's deaths!

When Mr. Baker returned to the surgery for his second consultation, I gave him the good news that all the tests were normal. He looked at me with his jolly smile and told me that he still had the pain. I contained my irritation which I could not quite explain at the time, and I asked him whether he was afraid that the pain might be due to something serious. He admitted that he was afraid that the pain might be due to cancer. I asked whether anybody in the family had died of cancer and he told me that his brother had died a slow and agonising death with cancer. I then shared my astonishment with him that he had chosen the double anniversary of his mother's and brother's deaths to come to tell me about his pains, and I suggested that December must be the gloomiest month for him. He agreed, but immediately became suspicious that I might be considering the anniversary of the deaths to be 'the cause' of his pain and therefore imaginary, and he protested. He told me that these things did not bother him, and that his pain was real. As he was talking in his usual jolly grin, I noticed that tears welled up in his eyes, and he wiped away a tear as it rolled down his cheek. I realised then that I was on the right track and that this man had great difficulty in dealing with feelings of sadness. I told him that I did not dispute for a moment that he was in pain and that his pain was real, and to reassure him that I was taking his complaint seriously, I asked him to lie on the couch for a fuller physical examination. There was some tenderness in his right iliac fossa and I was able to tell him that I could find no evidence of cancer, but that his pain could be due to spasm of the bowel or possibly appendicitis. If the pain got any worse I could ask a surgeon to have a look at him. I asked him to come back to see me a week later with a double appointment.

When he returned for his third consultation, he reported that his pain had stopped after he drank a glass of sparkling water over the week-end! I felt impatient with his lack of insight but kept my feelings to myself. Looking through his notes again, I remembered, that I had also seen him in the surgery with similar symptoms, just a few days before his mother's death a year previously. I summarised the content of our previous two consultations and I told him that in my experience, people do develop physical sensations around the time of the anniversary of the death of important people in their life, and wondered whether his pain had something to do with the feelings he might have about the deaths of his mother and brother. He found this idea an unusual one, and assured me that he was an intelligent man and that what he experienced was not beyond the realm of ordinary human emotion.

He also told me that he was a practical sort of person who had discussed the possibility

or his own death with his son and in fact, had made his will. The idea of death did not frighten him, and he was philosophical about life. He considered humanity as a speck of dust in the universe and that he felt richer for having lived. He might be apprehensive about possible suffering before death but the actual dying did not frighten him. And yet, I suggested, nobody loses a mother without sadness, and asked him how he felt when his mother died? He said that in fact, he had felt a sense of relief because she had Alzheimer's disease and could no longer look after herself. She had never wanted to be a burden to her children. 'Perhaps you felt that for you, your mother had already died – before her actual death?' I commented. He agreed that it was sad that she had lost her mind and that she had become a shadow of her former self, but her death was the end of her suffering. He said all this in his usual jolly, smiling, friendly manner, but his eyes had become moist again.He wiped them and apologised for his watering eyes. I commented on his gesture and asked whether he was wiping away tears? He admitted this was so. I asked whether they might be tears of sadness? He realised that talking about his mother was a sad topic but he did not feel any sadness. I reminded him that I had seen him wiping his eyes before, and wondered whether his abdominal pain was real, in the same way his tears were real, a physical manifestation of an emotion that he could not feel? His fixed grin was somewhat reduced by an expression of puzzlement and thoughtfulness. We had come to the end of the consultation and I wondered what symptoms he would present with in a year's time ...

Postscript

The following year he requested a visit because he had an episode of chest tightness, sensations of numbness, loss of balance and incoherent speech – one week after the double anniversary. By the time I visited, he was back to normal. We discussed the differential diagnosis, and he told me that his father had died suddenly of a heart attack seventeen years previously at the age of seventy-seven years, and as he was afraid that the effect of his coronary angioplasty was wearing out, he requested a referral to the cardiologist. I thought that this was a very reasonable request and complied with his wishes.

Discussion

When we put ourselves in our patients' shoes and imagine the kind of feelings they must be experiencing, we make an assumption – that everyone will have the same emotion under similar circumstances, and that a named emotion always refers to the exact duplicate of our own. This is a very adaptive assumption which most of the time confirms our common humanity. However, there are exceptions, and when we meet a patient whose emotions appear not to be what we are expecting, then the discrepancy between our expectations and what we observe can be a painful experience.

It is well known that painful feelings of grief are reactivated on the anniversary of the death of important people in our lives and that a positive response to suffering is sympathy. When a patient experiences grief and talks about his sadness he elicits the doctor's sympathetic response. Usually the patient is comforted when the doctor listens to his suffering sympathetically, acknowledges and validates his feelings, and accepts his crying with patience and compassion.[7] Good experiences like this with the doctor, or with friends and family, help the patient along the journey of mourning and acceptance of his grief and coming to terms with his loss .

When I discovered that Mr. Baker consulted me on the day of the double anniversary of the deaths of his mother and brother to tell me about his physical suffering, I realised, by putting myself in his shoes, and imagining how I would be feeling in his place, that I would be grieving for the loss of my beloved relatives, I was expecting therefore to share in his grief. So when he announced at the start of his second visit in his jolly fixed grin that the pain was still there, I found the incongruity between his smiling face and the verbal account of his pain irritating.

Michael Balint has given us useful advice when he pointed out that the solution to the tricky problem of considering any feelings that the doctor might have towards the patient, is to treat them as an important symptom of the patient's illness, but that on no account should he act upon them.[6] I have trained myself to follow his advice, so I was able to manage to hold on to my painful feeling, and treat it as a prompt to reflect upon our emotional communication. By imagining myself in his situation, I could experience some of the sadness and distress of a reactivated grief, but his fixed smile denied any emotional communication at this level. I therefore wondered whether my irritability was my response to our lack of mutuality to his incapacity to experience sadness, or rejection of the emotional experience of grief.

If he had felt distressed or sad, then my resonance with his sadness would have provided a bridge between us. The recognition and validation of his emotional state would have created an atmosphere in which he could have revealed and recognised himself. In our discussion, I could have expressed my understanding of his predicament in useful words, which could have helped him reveal and expose more of himself. This might have led to a better understanding of himself and constituted a successful mourning experience which would take him a step closer to coming to terms with his losses. If all this had happened, we would have experienced a satisfying closeness that comes from sharing emotion, and I would have felt effective in my role as his doctor. However, confronted with his symptoms which were uncoupled from his sadness as an explanation for his suffering, and in the absence of a medical

diagnosis, I had an initial feeling of impotence against which I reacted with irritability. Perhaps my feeling of impotence reflected his own impotence toward his distress. This incongruity became even more acute towards the end of the second consultation when his eyes filled with tears, an event he did not recognise as a sign of distress. I have heard it said that grief that has no vent in tears makes other organs weep. Usually the opportunity to weep in the consultation can be therapeutic, not only because it allows a full expression of the emotion of distress but also because it can provide relief from sadness by communicating the emotional suffering, eliciting the therapist's sympathetic response and sharing the emotional experience with him. However despite his weeping, Mr. Baker's facial expression continued to display the jolly, fixed grin which suggested an absence of grief. In other words, he was displaying only one component of the crying response and he seemed to be unaware of the sadness of which it is usually an expression.

The fate of the crying response

Silvan Tomkins, the founder of affect theory, in his seminal work, *Affect, Imagery and Consciousness,* reminds us that the crying response is the first response the human being makes on being born. It is a response of distress at the excessive level of stimulation to which the neonate is suddenly exposed.[8]

According to Tomkins, Distress/Anguish is one of the negative innate affects with which we are genetically endowed. The idea that affect is expressed in degrees of intensity is so important to the idea of innate affect that Tomkins gave all of them paired names to indicate the range over which each might be experienced. The rest of the negative affects are: Anger/Rage, Fear/Terror, Shame/Humiliation, Disgust/Revulsion, Dissmell/Shunning. The positive affects are: Interest/Excitement, Enjoyment/Joy, and there is a neutral affect, Surprise/Startle.

The face of the crying, six-weeks old baby, displays already the full extent of the crying response. The mouth is open, the corners of the lips are pulled down, there is an arching of the eyebrows which gives a sad expression to the face, and there is the characteristic wailing sound of crying, which leads to an engorgement of the blood vessels of the eyes.The spasmodic pressure on the surface of the eyes and the distention of the vessels within the eyes, according to Darwin reflexly activate the lachrymal glands, and the baby weeps.[9]

The general biological function of crying is to communicate to the person and to others that all is not well and to motivate both the self and others to find the cause of distress and do something to reduce the crying response. The crying response can be activated by so many distressors that it is a response of general significance. It enables general suffering and communication of such suffering. It is as important for the individual to be distressed about many aspects of his life which continue to overstimulate him, and to communicate this suffering, as it is to be able to become interested in anything that is changing around him.

Although the communication of distress to the mother is primary during infancy because of the baby's helpless dependency, the significance of communication of distress to the self increases with age. Just as the drive signal of hunger is of value in telling the individual when he is hungry, and when he should stop eating, so the distress cry is critical in telling the individual himself when he is suffering and when he has stopped suffering. The cry not only has information for the self and others about a variety of matters which need relief, but it also motivates the self and others to reduce it. According to Silvan Tomkins, the face is the major display board of emotions and it is from our awareness of the way the skin and muscles of the face have been rearranged or distorted by the set of motor messages generated by the affect, that we figure out what we are feeling.

However, adults very rarely display the full extent of the crying response. The adult has learned to cry as an adult by transforming the innate cry and interfering with its expression. So what we see in place of the baby's cry for help is a defence against the cry. He can transform the duration of the crying response, its intensity and he can also divest it from all the facial grimaces of the cry. Another transformation is the display of only part of the cry which then carries the burden of communication. Or his face can display the cry but without the characteristic wail of the crying response as he learns to control the vocal part of the cry. The adult can also employ a substitute cry, in which there is no sound and no facial responses but in which the massive set of motor messages which would have been sent to the face and vocal cords, are sent to some other set of muscles thus providing some expression of the original cry. There is no part of the body which may not be the recipient of the set of motor impulses which would ordinarily produce the distress cry accompanying pain. Silvan Tomkins found that some individuals report characteristic contractions of the thigh muscles, others of the calf, others of the scrotum, and others of the shoulder, or even the gut. Indeed very often we find a patient complaining of symptoms of irritable bowel syndrome in an emotional setting which would justify the crying response.

One of the most suppressive defences for the control of the overt cry of distress is an interference with the facial grimaces of the cry. Inhibitory messages may be sent to the lips, causing the 'stiff upper lip', or to both upper and lower lips causing tight lips, designed to keep the mouth closed and prevent the cry of distress. A more general defence is the mask-like frozen face in which the active facial musculature is kept under sufficiently tight control so that all affects, including distress are interfered with at the site of

expression. I think that the jolly, fixed grin that Mr.Baker was displaying was a variant of these techniques of interference with the facial expression of painful affect. In this way, he deprived himself of the crucial feedback of sensory information from the muscles and skin of his face, which is essential for becoming aware of what emotion he was experiencing.

Intolerance of sadness

Sadness or distress is but one component of grief, which is a complex emotional state, that usually follows a bereavement. Grief includes anger, fear, shame, guilt, helplessness; any one of these emotions, or all of them can be intolerable. The extreme defences I have mentioned already, indicate that there are people who cannot tolerate distress, not even in the smallest doses. There is evidence that those who cannot tolerate distress, most often have in the past suffered great shame, anger or fear along with, or consequent to distress, which is added to the distress. Or that earlier on in life they were allowed to be overwhelmed and therefore made to feel helpless by very intense emotions which flooded them and so they are left with a lifelong fear that this experience could be repeated and disorganise them, and therefore they have to defend against awareness of distress.[8]

There is evidence of his massive exposure to death in circumstances which aroused overwhelming distress and fear in Mr. Baker's past history. He told me of this experience two years previously when I saw him for three consecutive consultations following the development of shingles. It happened during a raid by the Luftwaffe in 1945 outside a London Underground Station. As the German aeroplanes were approaching, the sirens began to sound the alarm and the British guns opened fire. There were explosions in the sky and the shrapnel started falling down and pinging on the pavement. All the passers-by rushed for shelter. The Underground Station was being built at the time, and a large crowd ran towards it and started going down the steps. It was so crowded that one could not elbow his way through the crowd. Mr Baker was one of the last to run towards the station, but what he did not know was that there was a terrible crush when bodies piled on top of each other further down the steps. One hundred and thirty people died within a few minutes.The authorities kept the disaster secret during the war in order to preserve national morale, but finally a commemorative plaque was erected in the station. He was nineteen years old at the time and he became involved in helping to bring the dead bodies to the surface. He gave this account in his usual jolly, grin but when I asked him how he felt about it, he told me that he could not eat for a week after that tragedy.

The role of shame in denying or repressing traumatically intense feelings has been explored by Leon Wurmser, one of the very few psychoanalysts who has written about this most painful of affects. In his view, the mask-like face of the person who is not aware of his emotions reflects a global denial of emotion which is motivated by shame and is a consequence of early traumatisation of a very severe emotional or physical kind.[10] Mr Baker's timid behaviour in the consultations provides some evidence of the link between distress and shame. His presenting complaint was a pain in the ball of his foot, an area as far removed as possible from his testicle which he did not dare name and which he was concerned about. When he became tearful, he felt embarrassed and apologised for his watering eyes as if they were betraying an insufferable exposure of his weakness and lack of control. According to Tomkins this distress/shame bind occurs in children when they are treated with contempt, rejection or indifference by their parents whenever they cry in distress. Tomkins observed that the experience or threat of shame every time distress is activated or anticipated, constitutes a radical increase in the toxicity of the distress experience. Sickness or fatigue, difficulties in problem-solving, threats of loss of love or any occasion of loneliness become doubly difficult to tolerate when shame is added to the distress. Under such conditions the individual is constantly prompted to apologise for his own existence, heaping contempt upon himself and others whenever anything is in any way distressing. He may further try to avoid such experiences by denying that there are any reasons either for himself or others to feel distress. Such an individual will find it doubly difficult to tolerate physical pain or frustration in problem-solving or loneliness.

The problem of emotional unawareness.

Mr. Baker's symptoms disappeared after the second consultation and he gave the credit for his improvement to drinking a glass of sparkling water! Later, when I was reflecting on our interaction, I realised that I felt not only impatient with his lack of insight, but also disappointed because I experienced his remark as devaluing my therapeutic work. Fortunately I knew that the doctor who is using a psychodynamic approach to treat a patient who is not emotionally aware might experience the patient's lack of emotional understanding as a personal rejection. It is recognised that trying to help patients who are not psychologically minded psychotherapeutically, can activate negative feelings in the doctor who, in his turn might adopt a rejecting attitude or a defensive adherence to a purely organic approach.[11] Therapists have retaliated by calling these patients, heart-sink,[12] antianalysands,[13] normotics,[14] normopaths,[15] immature personalities,[16] and emotional illiterates.[17] The emotional unawareness of these patients has thwarted conventional psychotherapeutic approaches, and has become the focus of intensive research. Sifneos, an American psychoanalyst, coined the term *alexithymia* from the Greek roots, *a* = lack, *lexis* = word, *thymos* = emotion, to describe this

personality dimension of psychosomatic patients.[18] Graeme Taylor, a Canadian professor of psychiatry, has devised the Twenty-Item Toronto Alexithymia Scale (TAS-20) that measures the three most enduring features of alexithymia: (a) difficulty in identifying and naming emotions, and distinguishing between feelings and bodily sensations of emotional arousal. (b) difficulty in describing feelings to others and (c) limited capacity for using imagination, and stimulus-bound, externally oriented thinking.[19] A patient whose score is within the alexithymic range is less likely to respond to conventional psychodynamic approaches such as offering interpretations of repressed instinctual wishes or of the supposed symbolic meaning of the somatic symptoms. This patient requires a modified approach which may need concurrent pharmacological and physical treatments such as physiotherapy, massage, biofeedback and so on.[20, 21, 22]

When I first met Mr. Baker, his unawareness of grief made me think that he possessed the alexithymic personality characteristics. I was very surprised therefore when I discovered that his TAS-20 score was well within the normal range! I wondered whether he did not answer the questionnaire honestly in order to present to me with a better image of himself, or whether his difficulty with emotions concerned only the affect of distress and therefore it was not picked up by the questionnaire, or whether it was only me, his doctor, an authority figure to whom he could not admit his distress.

In retrospect, I think that the result was accurately reflecting his ability to weep and therefore his potential to get in touch with his feelings and benefit from a psychodynamic approach. In this case I would have to consider his emotional unawareness as the result of a repressive defensive style, rather than the result of alexithymia which is a stable personality trait and consists of a cluster of deficits in the capacity to process emotions cognitively. Obviously this is a fascinating area for research in general practice which may facilitate the process of choosing the right therapeutic approach for emotionally unaware patients.

The capacity to mourn

Sigmund Freud has identified mourning as a psychic process, a normal function of bereaved individuals, which helps them master the feelings of grief and come to terms with their loss.[23] Helene Deutch in her classic paper, *Absence of grief*, maintained that mourning strives for realisation, and that the unresolved process of mourning must in some way be expressed in full. The expediency of the flight from the suffering of grief by omitting the emotional response is but a temporary gain because she believed that the necessity to mourn persists in the psyche.[24]

Henry Krystal, an American psychoanalyst who worked extensively with severely traumatised patients, such as drug addicts and survivors of Nazi concentration camps, has emphasized however, that there are certain prerequisites for the capacity to mourn.[5] First of all, there is a limit to the kind and number of losses an individual can deal with through successful mourning. There is a limit, for example to how much loss the survivors of the Holocaust could absorb through grieving. Also good affect tolerance is needed in order to be able to carry out the process of mourning without it snowballing into a maladaptive state of depression. The affects that are tolerated best are adult-type of affects, that is affects which are not overwhelming, whose physiological components are minimal, which are mostly idea-like and can be used as information to the self. Adult-type of affects are the result of an extensive cognitive processing and symbolic elaboration of emotional arousal. It follows therefore that a requirement for succesful mourning is an awareness of and a capacity to tolerate grief.

How to respond appropriately to patients who are not emotionally aware.

Henry Krystal has pointed out that the greatest obstacle to our clinical and therapeutic conceptions has been metaphors that refer to the discharge of emotions.[5] Psychic pleasure and the idea of emotional discharge has been modeled on the idea of discharge in male ejaculation, and confused with the idea of orgasm and the idea of foreplay. From his experience of treating alexithymic patients, he came to the conclusion that once we renounce the idea that we can help anyone to be rid of emotions, we are glad to find that we can be helpful in other ways such as helping patients to name and identify their emotions, and to obtain maximum information from them. Studies indicate that the art of labelling emotions can have a soothing effect on the nervous system, helping the patient to recover more quickly from emotionally upsetting incidents.[25, 26, 27, 28] So the doctor can be of great help to the patient by assisting him in his handling of both the physical and emotional aspects of their affects.[20, 29] Patients need to get acquainted with their emotions as signals, often unpleasant but manageable and essentially self-limited. In this respect, the doctor belatedly supplies a function that the patient's parents failed to perform. Like a teacher, the therapist should help the patient to learn to recognise, label, interpret and organise his own feelings.

Emotion coaching

John Gottman in his book, *The Heart of Parenting: How to Raise an Emotionally Intelligent Child*, uses the term emotion coaching to describe an attitude of the parents which promotes emotional intelligence.[30] Emotional intelligence can be considered the opposite of alexithymia and is a concept that encompasses the cognitive skills that are required to effectively monitor and self-regulate emotions. These skills

are: (a) being able to recognise feelings, (b) being able to name them and distinguish between them, (c) being able to regulate one's moods, (d) being able to control the impulse to express emotions in action, (e) being able to keep emotional arousal from swamping the capacity to think, (f) being able to hope, (g) being able to motivate oneself, (h) being able to understand other people's feelings, (i) being able to persist in the face of frustration and (j) the ability to give credit to oneself.[31]

In his research of a hundred families with normal children, he identified five steps of the emotion coaching attitude:

Step 1: Being aware of the child's emotions

Step 2: Recognising the emotions as an opportunity for intimacy and teaching.

Step 3: Listening empathetically and validating the child's feelings.

Step four: Helping the child to verbally label emotions.

Step five: Setting limits to the child's behaviour while helping the child to problem solve.

Although there is an analogy between the parental role and the role of the general practitioner as providers of total care for their children and their patients respectively, the doctor needs to have acquired a special skill if he is to engage in emotion coaching with his patients. He must have undergone some emotion coaching himself, and he must have achieved some degree of emotional intelligence. The foundation of emotion coaching is the capacity for empathy.[32] It is the ability to put ourselves in other people's shoes and imagine how we would feel in their place. It is the ability to recognise and understand other people's feelings. The doctor can appreciate the emotional experience of others only in the context of an ongoing differentiated awareness of his own emotional experience, and only if he is capable of adequate reflective self-awareness and sensitive self-observation. Unless the doctor is able to recognise his own emotional states and name them accurately and use them as information to himself, he may not be in a position to listen empathetically to his patient's feelings. The empathetic listener uses his eyes to watch for physical evidence of his patient's emotions, and his imagination to see the situation from his patient's perspective. He uses his words to reflect back in a soothing uncritical way what he is hearing and helps his patient to label his own emotions. He also uses his heart to feel what his patient is feeling.

To engage however, with a child or a patient in emotion coaching, requires some degree of patience and creativity and most of all, parents and doctors need to be in a reasonably undistracted and calm frame of mind to do well.

Conclusion

I was able to engage in emotion coaching with Mr. Baker, which I believe contributed to an understanding and a resolution of his symptoms, only because of all the information I had gathered in six consultations of twenty minutes each, over a period of two years. This was possible because of my interest in problems of emotional communication and expression, and my readiness to become emotionally engaged with him by creating the space for the unfolding of a relatively relaxed discussion. In our busy surgeries we are faced every day with patients who complain of symptoms which we cannot easily diagnose during our brief encounter with them. In this very short time we can tell them only what they do not suffer from, and that we cannot find the cause of their symptoms.

Some patients seem to be satisfied with the reassurance that we can find nothing seriously wrong with their bodies, but a few will insist on finding out the exact cause of their suffering. This is a crucial moment in the consultation, the handling of which depends on a variety of factors, and which can determine the subsequent relationship of the patient with the doctor. There is a danger that if the doctor is overwhelmed and harassed by large numbers of patients pressing to be seen immediately, and they are not particularly psychologically minded, that there may be a shift in the motivation of the doctor from sympathetic understanding of the patient to personal survival.[33] Under these circumstances, he might respond dismissively by fobbing the patient off with a plausible diagnosis or a prescription. Also a rigid adherence to a biomedical model can only lead to a futile pursuit of more and more tests in search of an elusive disease, which might confirm the patient's fears that he is suffering from a deadly condition that is difficult to diagnose. Alternatively the doctor can play for time, order some tests and invite the patient to return at a quieter time and with a longer appointment. It may then be possible to use this time as an opportunity for emotion coaching. This approach includes paying attention to the patient's cues of both his conscious and unconscious agenda, and encouraging the patient to identify his concerns, fears, and expectations, and express them in words that accurately identify his emotional state.[34] When these conditions prevail, an accurate diagnosis of the presenting physical symptoms may become possible, and the patient more effectively helped to understand why he '... still has the pain.'

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The Balint Society Prize Essay, 1998

The Council of the Balint Society will award a prize of £250.00 for the best essay on:

"This won't take a minute, doctor ..."

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 three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

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

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

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 name 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 put the name of the file on disk. Please send three hard copies with the disk.

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 29th Annual General Meeting in 1998.

Entries must be received by **1st April, 1998** and sent to: Dr. David Watt
Tollgate Health Centre,
220 Tollgate Road,
London E6 4JS.

Ars Moriendi*

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Introduction

As a medical student approaching my finals, I feel that I can reflect objectively on my years of training and conclude that I have really enjoyed almost all aspects of medicine. There have been times when I have felt frustrated, upset, angry and disillusioned, but these have been equally balanced by the episodes of happiness and immense satisfaction. I have learned a little over the years about people, although I know that I have barely skimmed the surface and I hope that I will continue to have an interest in patients and their lives.

Only in the last few weeks, however, have I had the responsibility for the first time of being directly involved in patient-care. This new experience revealed many personal inadequacies in forming a good doctor/patient relationship, and also the lack of teaching in this art that appears disseminated throughout the British medical schools. I hope to use my experiences to demonstrate the widespread apathy among hospital medical staff about training students in the skills needed for communication, and I will discuss potential improvements that could be made for the future.

Exposition

I was introduced to John Smith (a fictitious name) by my consultant one Friday, after a routine ward round. He was a sixty-four-year-old retired engineer who had been admitted through the Accident and Emergency Department the previous evening, with increasing shortness of breath on effort, and a productive cough with green sputum. He had been 'handed back' from another team and consequently I had only briefly read through his notes. It was therefore the third team of doctors to approach and examine Mr Smith since he was admitted to hospital. To be passed from one consultant to another must have made him feel quite vulnerable and confused. Mr Smith had suffered from chronic obstructive airways disease for many years and still continued to smoke about twenty cigarettes a day. It was difficult to find out why he could not stop smoking, if it was to relieve stress or simply an addictive habit he could not break. My consultant felt that since this gentleman had many physical signs, he would be a good model on which I could practice my clinical skills in the examination of the respiratory system. Chronic bronchitis is a very common condition in heavy smokers and exacerbations of the disease will often precipitate an admission to hospital which explains why it was important for me to be able to recognise the respiratory sounds on ausculation associated with it. John was one of those many patients who are often willing to allow students to learn from them, and he was very agreeable. Although he was breathless at rest he seemed to be quite comfortable. He allowed me to examine him and commented that 'everyone has to learn some time'. I came away feeling contented because John had been so co-operative and friendly, and we anticipated that he would be home after the weekend. I felt hopeful that a course of antibiotics would quickly clear up his chest infection and he could resume his normal activities.

The following Monday I undertook what we loosely call a 'student *locum*' which means that final year students undertakes the basic duties of the house officers while they are away, omitting such things as prescribing and being on-call. The student should be under the guidance of someone senior throughout this period. My team included a registrar and consultant who were more inclined towards research and only held two clinical ward rounds a week. I did not feel that I was totally alone, however, since there were other doctors available whose advice I could seek if I needed it.

On the ward round I discovered Mr Smith's condition had deteriorated and he had been moved to the Coronary Care Unit again, having had some passive ventilation. He was stable at the time we saw him, although he was obviously in some distress and found talking difficult. I remember thinking how helpless he looked and that he was depending on, and trusting strangers to do their best for him. He remembered me and smiled in recognition. I was busy doing the menial jobs of filling out forms and writing in the notes, so I barely spoke to him and concentrated on recording his vital signs.

The consultant gave him a mini-lecture on the dangers of smoking and stressed the fact that it would be difficult to provide him with oxygen at home if he continued to smoke. John shrugged and said that he had tried many times to give up but was resigned to failure now and felt that it was too late for him to try again. It seemed that the consultant was rejecting John at this point by taking on the role of the authoritative adviser and indeed John submitted by giving up at this point. It is possible that the rejection John experienced may have forced him into submission and to accept the final illness.

I also met John's wife who was at his bedside. She was very upset about his condition and expressed concern that he would never stop smoking. They reassured her that it probably would not make that much difference at this stage anyway. Mrs Smith was a woman who obviously cared very deeply for her husband and I could see

* Winning Essay for shared second prize International 'Balint' Award from the Foundation for Psychosomatic and Social Medicine, Ascona, 1997.

that it was very hard for her to have to watch him suffer in this way. Maybe at this point I should have tried to discuss with her the difficulties she must be facing, but it did not seem my place to do that.

Over the next few days, John slid gradually into respiratory failure. Every day I saw him he seemed worse than the day before and it eventually became clear to me that he was not going to recover. The team had a meeting with his wife and daughter to discuss his lack of progress, and the dilemma of whether he should be resuscitated. It was explained that John's lungs were so severely damaged that even though he may improve from this episode he would most likely deteriorate rapidly again and it would be difficult to continue treatment unless he was put on full ventilation, from which he could never be taken off. Mrs Smith seemed to comprehend the situation fully, and agreed that in the event of respiratory failure, her husband should not be resuscitated.

The next time I saw John, he was cyanosed and breathing very rapidly. I sat down next to him and held his hand. He was still being jovial and kept asking when he would be moving back to the ward. I think this may have been his way of coping with the situation and he was over-compensating the seriousness with humour.

My consultant decided that John should be taken off all medications except morphine and oxygen, since he was not responding to any of them. I queried this decision and we discussed the options. He said that 'the art of medicine is knowing when to stop'. I felt as if we were giving him up, and could not accept that we were going to sit back and watch a sixty-four-year-old man die. It did not seem fair and I felt a sense of hopelessness.

John had never asked if he was going to die and consequently no-one had told him. I was advised that if patients do not enquire, then it is best not to tell them they may die, since they may feel they should give up on living and spend their last few days scared and depressed. I was not sure if I agreed with this, but obviously respected the wishes of the family and my seniors. The same afternoon I happened to see Mrs Smith outside the ward. We had a chat and she asked me directly if John was going to pull through this. I had to respond that I really did not think so, and that we should not be too hopeful. She went on to say that the hardest part was accepting it because he had been so active and well in recent months and they had been able to go on various holidays. I agreed with her that it was very difficult to come to terms with the speed at which he had declined but that they were lucky to have such good memories of their time together. She said that the caring attitudes of the doctors and nurses involved had made everything much easier and she thanked me gratefully.

The last time I saw John was barely a week after I had first met him. He was not fully conscious and I do not think he knew I was in the room. He was breathing rapidly, and it was the first time I had seen a patient who was so close to death. I did not stay in the room long. John died a few hours later.

Reflexion

As a student-*locum*, my role in the care of this patient was extended to that of a doctor while the house officer was away. Initially, John was a tool by which I learned and it was not until I had to become involved that our relationship changed. I assumed a different role, one which both distanced me from the more personal aspects of his life and yet thrust me into a position where I was relied upon and became an authoritative figure. I like to feel needed, as I am sure many of those in the medical profession do, and with the worsening of John's health I suddenly assumed the position of carer. As part of the medical team, I had to support both John and his family, and was introduced to a fundamental characteristic of medicine which is to care as well as cure. The experience was in some ways exhilarating since this was the first time that my opinion had mattered and yet I concurrently felt as if I was floudering out of my depths.

I felt that my relationship with Mrs Smith was closer than to John. In retrospect I can only suppose that I was frightened of talking to John in case he directly asked me about his prognosis or wanted to know something I could not answer. I was uncomfortable about getting close to death and dying. It was easier to talk with his wife because she knew the situation and really only wanted a sympathetic person to listen to her problems. I could easily fill this role, as I have had a great deal of practice in it. There were barriers, however, which I hoped she would not cross and many questions I did not want her to ask. I think that as long as she continued only to expect me to fulfil her requirements of a confidante then I could cope with it. The registrar and consultant were there to answer any of the more technical and ethical issues she may have wanted to raise, such as the question of resuscitation and they treated her with respect and sympathy. I noticed that they were also reluctant to spend much time with John and avoided any discussions of his illness with him. It was almost as if we were all colluding in denying the truth, and I wondered how much John had known about his imminent death and whether he had wanted to ask questions but felt unable to do so, due to our actions of denial. Death is the unspoken taboo in modern society which is only of the reasons we find it so difficult to talk about.

The consultant was always friendly and positive with John, but I did not feel that any of us really knew John or had attempted to understand how he might be feeling. One is taught to avoid engaging too closely with patients as self-protection against the emotions we might feel if they were to die. As a defence mechanism, the less doctors know about a patient, the easier it is to accept his death when it comes. I think my

consultants's attitude towards John affected the relationship I had with my consultant, and I lost some of my regard for him. I felt that his relationship with John had lacked warmth and kindness. I may, however, have been naive to expect a consultant to become intimately familiar with every patient. But I believe that all consultants should strive to form a good rapport with their patients. If we do not attempt to identify with the patient, it would be very difficult to understand them.

Nurses play a vital role in the care of patients and in this cse they were very important in allowing John to die with dignity. They were involved in his day-to-day care as well as helping the family to come to terms with his condition. I had some communication with the nurses on the ward and they would tell me how the family were coping and any problems that arose with John. Many deaths occur in hospital, and patient rely on the medical team to support them and their relatives at times of overwhelming need. It must be very difficult for anyone to die in a strange place among strangers. They do not have the comfort of their own general practitioner whom they may have known for years and they are suddenly cut off from all things familiar to them. A doctor may briefly see them once or twice a day, but it may not even be the same doctor. The nurses may be the only constant factor and their role is a hard one. It is easier for a general practitioner who knows his patient well and would be able to judge how much they would want to be told about their illness.

It is a fine balance when developing a student/patient relationship between trying to be a friend and yet authoritative enough to let the patient have confidence in you. I usually find that I am relaxed and interested in taking the patient's history, but have more difficulty in examining the patient when my role becomes more clinically orientated. I think that students are perceived as being different from doctors, and will often find that patients confide in them more, partly due to less pressure of time and also because many people are intimidated by the doctor status and do not want to bother them with 'trivia'. I enjoy being a student and feel that I have benefited from many discussions with patients, but in John's case I think I reverted to the role of a 'busy doctor' and I wonder how things would have been different if I had remained in the student-role.

Action

I experienced many demands from both the patients and relatives as well as members of my team. The patient was putting his/her life in my hands and I was the key communicator between the senior doctors and the patient. John became my responsibility and although he did not overtly demand anything of me, I felt that I had to do my best for him. I tried to care for him in an empathetic manner but I know that my inexperience impeded my actions.

Mr Smith sought reassurance and understanding from me, which I felt was because although the consultant had explained the medical prognosis, she needed additional support from someone willing to give her the time to talk events through. This has often been the case after a ward round, that a distressed patient may ask me to explain exactly what the 'chief doctor' has said. Medical students are targeted for this task and it may cause some difficulties for us to know how much to say and how to describe things in layman's terms. It always amazes me that even after only five years in the medical world, I find it difficult to remember that to most patients the medical language is foreign and can be quite frightening. When I contemplated how to respond to Mrs Smith, I tried to imagine that it was someone telling me that a close relative was going to die. I found that I was naturally inclined to want to give her hope that he may still improve but I know that this would be both unwise and unfair. On reflection, I realised that I had handled it in the best way I could. However, I felt very uncomfortable when she thanked me for everything I had done. I thought that nothing that I was doing was enough and I wished I could do more. These feelings are probably due to an integral part of my personality and as I gain more experience they will probably be lost and replaced with the idea that I have done my best for my patients.

It was a difficult situation for me to be in, since I had to come to terms with my first encounter with a dying patient, together with my own beliefs and false assumptions about death, in addition to taking the role of advisor to the grieving relatives. During this week I also had two other patients die quite suddenly. Although they were both elderly and everyone had accepted that they would die, I still felt personally responsible and it seemed as if I was struggling alone to cope with it all. My registrar appeared relieved that we now had less patients to look after, which may seem callous but was obviously his way of avoiding coping with his emotions. After one death I had to break the news to some relatives who had come to visit him, since there was no-one else on the ward at the time. They were grateful to me for taking a few minutes to explain what had happened, but I felt very inadequate and 'new' at this type of thing. The relatives were upset because they had wanted to say their farewells to him, but I was left distraught, having been placed in a position for which I felt that I had not received any training to deal with it. I think that all these events affected my view about John and I grew to dread going to see him because I did not want to witness someone die. This was a counter-transference of my feelings about death in general to the way I felt about John.

There were demands on me from my consultant to carry out his wishes and look after 'his' patients. I was pleased that my consultant had discussed with me the decisions involved in the care of Mr Smith but I could not help feeling that medicine was letting him down. There was

nothing we could offer him now, except care and concern – and a peaceful death (if it exists). I understand that this is part of a doctor's role but it is an aspect that is never talked about or taught. We are always lectured on curing the illness and very little about caring for the patient. I did not like sitting back and watching Mr Smith die, although I knew that death was an inevitable event as life. Perhaps if death was regarded as acceptable and seen as a natural conclusion to a fulfilling life instead of a 'taboo' subject, I could have dealt with my feelings as well as those of John and his family.

It has been suggested to me, since these events, that maybe I should have spent time with John during his last few days by getting to know him better, and listening to his whole life story, his triumphs and regrets and developed a better relationship with him. I have learned that John probably needed someone to sit with him and care about him.

Progression

In the light of the expanding world of modern medicine, it is becoming more difficult for medical students to learn all the basic principles, both pre-clinically and clinically, as well as keeping up to date with new developments. To try to teach in addition to the intricacies of forming a good relationship with patients, is almost an overwhelming task. That is not to say, however that students should not be gently introduced to the concepts of the importance of communication and indeed, the Balint method of training. I think that a return to the ideas of humoral medicine and regarding the patient as having emotional, as well as physical problems, is very favourable.

The way in which this should be done though, is more controversial. During my training I had a programme of teaching by the psychology department on 'how to interview a patient', which involved role play and videos of our interviewing skills which we all constructively criticised. This was useful in a clinical approach and taught us the subtleties of using non-verbal communication, but we never discussed anything out of the structured guidelines.

It is not until one has had more experiences with patients on an individual basis that one begins to encounter difficulties and ethical issues that may need discussing. I feel that it is at this point that the medical school may be able to provide a service to help students. For example, I was learning surgery at a district general hospital and my consultant was quite a fearsome character who held the patients and members of staff's respect, but was not always liked. He had a brusque, no-nonsense way of handling patients. On one occasion, during a ward round, I remember him telling a fifty-year-old man that he had cancer, and they would 'chop it out' the next day. The man broke down in tears and the surgeon moved on to the next patient while the house officer was left to pick up the pieces. Another gentleman on the ward, Mr R., with whom I had developed a good relationship, had a malignant tumour which was particularly difficult to assess. He was in his late seventies and did not necessarily need an operation, he could have continued in his present state for many years. The surgeon, however, encouraged Mr R. to have this major operation, without explaining fully the hazards of surgery, or giving him the option to decline. When Mr R. sought my advice, I could do little but indicate that the surgeon knew best. Mr R. died a week later from complications following the operation. I desperately needed to discuss this with an unbiased third party at the time, and resorted eventually to my colleagues who has as little experience as I did in these matters.

In cases like this I feel that it is the blind leading the blind. We, as medical students, refer to each other for help and advice because there is usually no-one else to turn to. Other doctors may be too busy or intimidating to talk to and people outside medicine do not really understand the problems we face. I regret that I did not ask my consultant why he had not given this patient all the details, but at the time I felt that there was a pressure to remain silent throughout the consultation. It would help if medical students were encouraged to play an active part in the discussion of a patient's condition and to question any of a senior's actions. This would greatly help us to learn and may also benefit the patients.

I can understand why it may be impossible to teach psychotherapy to a group of fresh medical students since they may lack the necessary enthusiasm for it. As Balint said, 'A general practitioner has the inestimable advantage over a medical student of having been knocked about by life ... He has had time to test in his own practice what he was taught in his medical school and hospital, and he has thus become both less dependent on authority and less rebellious against it, that, more humble.'[1] Experience seems to be the best teacher, especially in the art of communication. We learn the scientific side of medicine from the first year, and since these are our initial steps into the world of healing, it is not surprising that the idea of the patient as an individual may be hidden from our view. This is a well recognised phenomenon whereby, 'In the course of his training the medical student for the first time approaches the body as an object – a body completely depersonalised, stripped of those awesome aspects that constitute the unique nature of individuals.'[2] We were always told to try to refer to patients by their names, and not their conditions. I always believed I would do this and was very disappointed in myself when I told a friend about the 'gall-bladder' lady, a year later. I think it is important for these messages to be reinforced over the years of training and a course of a week's seminars every year would be very helpful to us. Another suggestion I would make is that a discussion group, led by a psychoanalyst, should be offered for students, to enable them to talk about their problems and patients' feelings

and perhaps offer advice. It may not be practical for this to occur every week, but every month or so, would be a tremendous help.

Other ideas for future medical training include videos in which patients talk about their experiences, both good and bad, with the medical profession. We could learn a lot from these because they would be more realistic than mere role-playing. I think that discussions of real-life situations would also be of benefit, such as what you should do if a patient asks you if he/she has cancer? Medical students also need to be offered a sympathetic ear by their seniors who train them, and in addition they need to be enlightened about the art of establishing a good doctor/patient relationship, by specialists.

Conclusion

I have presented a personal account of a relationship that I formed with a dying patient, and also with his relatives. I have examined this relationship and analysed my reactions to both the patient and his relatives, and to death. I concluded that there is a noticeable difference between the student/patient relationship and the doctor/patient relationship which, it seems is an inevitable change in the role of students as they develop. I may have over-estimated the position I was in as a student *locum* and reacted to the increased responsibility by pushing the patient away.

I have reflected on the rapport I developed with John, one of mutual respect and friendship, and feel that I let him down in many ways. I isolated Mr Smith by avoiding talking to him because of my own feelings about his impending death. I am very sensitive to situations of grief and I would have found it hard to cope with my own feelings, let alone those of others. With some distance between us, I found it easier to listen to his wife and help her instead, without my emotions interfering with our relationship. It seemed acceptable for me to show sympathy with her but it would not have been fair to burden her with my feelings of helplessness about her husband's impending death. This example of this type of case occurs every day in hospitals and in the community, and it is clearly something which requires careful training in order to prevent it from happening.

I have also discussed the relationship between the consultant and the student and the difficulties faced by the student when they need to ask seniors for advice. I stress that not all hospital consultants are unapproachable and indeed many of them will go out of their way to help their students. However, the old adage of 'teaching by humiliation' does not encourage students to confide in their teachers. The demands placed by consultants and other members of staff, who may not fully understand the doctor/patient relationship, also add to the emotional and physical burden that house-officers and students, have to bear. Anything that helps them deal with this, will help them to develop their skills in making the best possible use of the time they can spend with their patients, and so lead them to do more for them. This, it seems to me, is what Balint-work is all about.

I have shown how I have dealt with any difficulties I encountered, and highlighted areas in which medical training could improve. I have outlined a few ideas that I feel may help improve the current teaching of realistic care aspects in medical school and I emphasised that there is scope to introduce, at an early stage, to medical students a sensitivity to patients' needs, before the scientific approach to a patient becomes too heavily ingrained. There are sadly many inadequacies in the teaching of the art of doctoring and the use of the doctor as the 'drug'. These may easily be rectified, however, and Balint-groups offer a positive move towards future awareness.[1]

Hippocrates described the nature of the student/teacher relationship in a beautifully simple way when he said, 'The growth of plants forms an excellent parallel to the study of medicine. Our characters resemble the soil, our masters' precepts the seed; education is the sowing of the seed in season and the circumstances of teaching resemble the climatic conditions that control the growth of plants. Industrial toil and the passage of time strengthen the plant and bring it to maturity.'[3]

Acknowledgements: I would like to record my sincere thanks to Dr. Peter Graham, President of the Balint Society (1994/1997), for his kind support and guidance.

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My Learning Experiences as a Medical Student Involving a Student Psychotherapy Scheme*

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Introduction:
I am a fourth year medical student at University College Hospital in London. During our clinical years we are offered a chance to participate in the student psychotherapy scheme. This enables us to begin to understand such an important field of work whilst improving our doctor/patient communication skills. I would like to share with you my experiences. Writing this essay has given me a lot of time to reflect on what I have learned. I hope that you will enjoy reading my words as much as I have enjoyed putting my thoughts down on paper.

Exposition:
I have been seeing my patient since March 1996. We meet once weekly for her psychotherapy session. I would like to introduce my patient as Sarah (not her real name). The reason she was referred for psychotherapy is because she suffers from a chronic illness. Sarah has had a very troublesome past and there were questions as to whether there was a psychosomatic element in her illness. She was also having regular tests for multiple sclerosis and felt she had no one to talk to about them. Although she was afraid therapy might raise more upsetting subjects than she wanted to bring up, it was thought that therapy would help with the grief about her mother's death and her continuing concern about her non-identical twin, who suffers from schizophrenia.

Her symptoms vary in intensity from week to week but they focus around left sided jaw ache, orbital pain, 'burning in the ear', and tooth pain. She also occasionally suffers from numbness down the left side of her body. The pain first arrived four years ago when she was working in a very stressful job at a top London hair salon. It appeas psychological factors do play a large part in her illness whereby changes in her life alleviate the pain for episodes. This occurred when she changed departments at work and when she subsequently gave up the job when she was unable to cope with the pain. We have even seen the symptoms emerging in sessions when she talks about particularly painful episodes in her life.

She has undergone many medical investigations in order to find an organic cause for her pain. Her differential diagnosis has varied from time to time but has included, multiple sclerosis, trigeminal neuralgia, an epileptic focus, thalamic pain, atypical facial pain as well as psychogenic facial pain. I feel it is important at this point to relay the results she has had from her multiple tests in order to show how confusing her case really is. She has had three cranial M.R.I.s which show multiple foci in the cerebral white matter. These are sometimes seen in multiple sclerosis, or may be non-specific. Her visual evoked potentials showed some half field asymmetry suggestive of a post chiasmal lesion. All her other tests have been normal and neither the electrical tests neither/nor or the lumbar puncture support a multiple sclerosis diagnosis.

Sarah has found the varying tests very frightening. She has recalled in some of our sessions just how terrified she has been. She had two failed lumbar puncture tests before the third one was successful under x-ray guidance. The doctor who first tried had never done a lumbar puncture before on his own, and was openly as anxious as she was. She heard the nurse suggest that perhaps another doctor ought to try. They left her in the room by herself at which point she got up and saw all the iodine, needles and blood, 'freaked out' and left the room. She could only return once she had calmed herself down. Much of her fear was due to the length of time it took to get a sample which she describes as 'the longest year of my life'. On her visits to the hospital for the tests, she came across two ladies with M.S. in the late stages. She was convinced she had the disease and that in no time she would be bed-bound and incontinent.

It has been very useful for Sarah to talk to me about her tests, her anxieties and her encounters with members of the medical profession. Not having anyone to talk to had increased her burden and had brought back memories about how she has had to take care of herself during particularly trying times in the past. For my part it has been fascinating to see a patient with a chronic illness. I had no idea how often patients think about their illness, and how much it projects into their everyday life. Every single session started with Sarah relating exactly the symptoms she had experienced all week. Her medical appointments were also described in vivid details and I will look at how she experienced different medical approaches later on. I have seen a lot through my patient's eyes as well as the truly personal experiences of our relationship.

Some very important work has occurred throughout our sessions. Sarah spent one whole session talking about her mother. The following week she reported how she had been to find her mother's grave. She often now goes to visit this site and has numerous conversations with her mother. I believe that she is coming to terms with

* Winning Essay shared second prize for the 'Balint' Award given by the Foundation for Psychosomatic and Social Medicine, Asconca, 1997.

her grief about her mother's death. Sarah suffers from a great deal of guilt about her twin, who is schizophrenic. She feels she dealt with her twin very badly when the symptoms of 'madness' first emerged. She often says how guilty she feels when she is enjoying herself whilst her twin is so ill. At one meeting she arrived and told me that she is going to help a girl whose sister is also schizophrenic. Sarah said that she really wanted to tell this girl that it is not her fault and that she should not feel guilty. I saw this as a very positive step (although I feel she is still unable to be so kind to herself).

Laying down her past has been very difficult and many sessions have been very painful. She now seems to have a clearer framework to work from and is locating feelings such as anger appropriately. Sarah also talked a lot about the present. She talked about the struggle and financial difficulties encountered when living on an income from the social services. She was particularly worried about the accommodation available for her schizophrenic twin. There was one particular hostel that her sister was in during our early sessions. I was inwardly shocked to hear about the decrepit hostel where the residents lived an 'animalistic' lifestyle. She was also particularly worried about her living around the corner from her home and the possibility of her twin finding out where she lived. I have come from a privileged background and found it very important to learn about financial constraints that can occur during day-to-day living. I have also gained huge insight into the system of ''Care in the community' for mental illness and the logistics of having a schizophrenic relative.

I believe that both Sarah and I have gained greatly from our student/patient relationship. There is much material that Sarah has covered that is not in the scope of this essay. As I move the onus from Sarah onto myself (something greatly different from our practical relationship) I would like the reader not to forget all the hard work Sarah has done and without whom this essay would not be possible.

Reflexion:

The relationship between myself and Sarah was very different from anything that I had experienced before. I felt myself in a very responsible position and I was very worried that I might say the wrong thing and possibly do more harm than good. I spent most of the first sessions reluctant to say anything apart from encouraging her to talk and sympathising with her difficulties. I found it very difficult not giving advice and refraining from self-expression. The most truly amazing experiences emerged from this. For the first time in my life I was truly listening to someone without thinking what I would say in reply, or how her situations related to mine.

Both Sarah and I were new to psychotherapy and I do not think I used all the transference that went on between us to its greatest effect. I felt embarrassed when she asked me personal questions and usually answered them truthfully and abruptly. I did not really enable her to explore her fantasies about me properly. She often wanted to know whether I had a boyfriend, how long we had been together, if we were going to spend Christmas together etc. I now realise that this could be important in how she views relationships and their bearing on the ability to be pain free, successful, and thus the therapist (how I felt she saw me). The logistics of my own personal life did not matter and I could have done a better job allowing her to put her own ideas to me and evaluating why she saw me in certain ways.

Certain parts of the transference were very beneficial. I flipped between being a maternal figure and her twin sister. In later sessions she described how she had come on so much in the year. She believed that this was with the help of Prof X. (who had finally given her a diagnosis – one of atypical facial pain) and myself. I believe she saw Prof X as the practical father sorting out the problem, and me as the gentle sympathetic mother who listened to her anxieties and whom she could trust.

This is a woman who has been through some very difficult episodes on her own. At nineteen, just after her mother died, her twin sister and best friend became schizophrenic. This is probably the worst thing she had to compe with on her own. She feels that she was very strong and had to cope. Sharing her memories with me throughout the year has enabled her to recognise how important help would have been around that time especially from a 'mother'-like figure.

Using me as her twin has enabled her to deal more adequately with the guilt she feels about her real twin. By interacting with me she can recall their own relationship they had before her twin became ill. Once again she has a confidant of a similar age. Sarah has talked of the grief about the loss of an adult relationship with her sister. I think the reminder of me as her twin causes her to bring up her guilt and look at it in her therapy.

It is much harder to analyse counter-transference. I am not a very self-confident person and I like positive feedback. Sarah must have picked this up, because often in sessions she would mention how much they were helping and at the end thank me for listening. She was looking after my feelings. I think this is very typical of Sarah who has had to learn to give but finds it very hard to take. I think she was confused by my continual presence, listening skills and reliability. I hope through our work together whe will go on to allo others access to her conflicts and not always remain the 'giver' in relationships.

My working relationship with my supervisor was very good. I found it a relief to go through my sessions with him. I learned how useful criticism is, especially as before this scheme I had found it very difficult to deal with. I felt our interactions were intelligent, academic

and a learning experience with no boundaries. We both found the case fascinating not only from a psychotherapeutical stance but also from a medical one. It was good to share time with someone who also wants to care for and understand people.

Initially we had a group of four students who each had their own patients. It was very useful having the moral support from the other students. Before my first session they took me out for a coffee and tried to relieve some of my fears having themselves had patients for nine months. We also learned a lot from looking at each other's sessions and it was very helpful hearing different views. Unfortunately their therapies finished after three months of my joining and I was left alone with my supervisor for six months until others joined. On reflection, I thought it was much more beneficial having a group of students there as the input was more varied and the support better.

The work environment for psychotherapy was on the fifth floor of U.C.H. Casualty, in the Department of Psychotherapy. We had a private room sitting in two big chairs angled towards one another. The room was quite bare and lonely when I sat in there by myself wondering what a session would bring. Soon it would be filled with thoughts, images, voices and memories. I was then thankful for the seclusion of the room enabling these to surface. This room corresponds so vastly from the normal hospital setting. I feel that important lessons about privacy were learned. I noticed myself closing curtains more often when on the wards. This enabled me to share patients' anxieties in a hospital setting. I also got to know the patients for the real people they are sometimes down to the family photos.

Sarah gave me a comprehensive account of all her appointments with different doctors. Although I never interacted with them myself I feel as though I had an indirect relationship, most importantly through Sarah's eyes. Sarah had a lot of the medical profession working on her illness. These included her general practitioner, neurologists, the maxillofacial unit, the pain clinic, her dentist, an acupuncturist, an alternative Tibetan medic and myself. It became apparent to me just how desperate she was for a diagnosis and possible treatment. The confusion was added to by the different opinions of the various medical teams.

When I first met Sarah she had been told by a previous neurologist that there was no chance she had M.S. after her lumbar puncture tests were clear. She was also on carbamezepine to control the facial pain. She had three monthly appointments with the neurologists and felt that these were too far apart. Sarah was undergoing a heart valve test to see if there was a possibility of small emboli being thrown off as a result of her previous heroin abuse. At her next appointment she was seen by the registrar. He also confirmed that there was only a 1 in 1000 chance of her having MS. She was not given the results from the heart valve test. She felt that the meeting was too short and because time was so restricted she had been unable to ask the questions she had wanted to.

Sarah then sat down and wrote a letter to ask the questions which were on her mind. She wanted to know what was wrong with her and why she was being treated with epilepsy tablets if they did not know that epilepsy was her diagnosis. She wrote that she wanted to stop these tablets especially as she wants to have children in the near future and she knows that they have 'bad' effects on pregnancy. She received a letter in reply from the consultant suggesting that she *increased* the dose of the Carbamazepine. This caused Sarah to wonder if the neurologist had read her letter at all. He also stated that she had some areas of inflammation on the brain sometimes seen in Multiple Sclerosis (MS). He suggested further tests for this disease and recommended the possibility of her seeing an M.S. specialist. The M.S. diagnosis and all the anxities that went with it were brought up again. We had some very difficult sessions when she was very anxious especially about who would look after her if she became ill. After having all the tests, she returned for the results. The MS diagnosis was not brought up at this meeting which Sarah assumed meant that she did not have it. The neurologist referred her on to the pain clinic for acupuncture.

This series of events with the neurologist only happened during six months of our therapy. I dread to think what had occurred in the four years before I met Sarah. The communication between the neurology team was not very good and I think the doctor/doctor communication needs to be vastly improved. In such a complicated case as Sarah's it would have been more ideal for her to be seen by the same doctor, preferably the consultant, at all her appointments. If this was not logistically possible it would help if the team wrote down what they had told Sarah. Hopefully this would prevent her being told on one occasion she only had a 1 in 1000 chance of having M.S. and then she was recalled for more M.S. tests. Communication between her general practitioner and the neurologists was also poor. Every time Sarah visited her general practitioner she reminded Sarah that there was still the possibility she had M.S. due to the plaques on her brain. Sarah found this very disconcerting especially as she felt the neurologists should have told her general practitioner that M.S. was ruled out at this point. Sarah believed the general practitioner always said this to cover her own back. She felt the constant reminder was not beneficial as she believed she did not have M.S., and wanted to stop worrying about it.

Sarah was unable to get an appointment with the pain clinic for four months which she found very disappointing as she had been ill for so long. When she phoned to see if her appointment could be put forward the receptionist said, 'Do you think that you should be put in front of someone with cancer?' She went off and had

some acupuncture privately and found this very expensive. During her search for an acupuncturist she found a 'doctor' of Tibetan medicine. She started taking his formulas and like many dissatisfied with conventional medicine had much hope in this doctor. He spent much more time with her and she was able to discuss all her problems. She felt he really cared and although he did not cure her she was very satisfied with the way he had acted and related.

In vast contrast to the neurologists and her general practitioner, Sarah found a doctor, Professor X at the maxillo-facial unit who was very strong and positive. He told her to stop listening to all the other doctors and that she should put herself in his care and trust him. He told her that she had atypical facial pain and that she should stop taking the carbamazepine straight away. She mentioned to him that her general practitioner thought that it might be M.S. He said 'Then get a new general practitioner; this is your new diagnosis and we will treat it with anti-depressants'. When she first started taking lofepramine, she had many side effects, especially feeling shaky inside. She returned to him complaining of this and he said 'That's just you Sarah'. She felt that he was always in a rush and not very sensitive. However he has now gone up in her opinion because the anti-depressants are working well.

When she finally got her appointment with the pain clinic, the doctor said that he could have told her that it was atypical facial pain four years ago! On returning to the neurologist with her new diagnosis and hoping for discharge, he said 'Well, we will treat it as that for now.'

Action

The psychotherapy scheme placed many demands on me and I hope to describe them adquately in this section. The sessions involved a supervision group at 4.00 p.m on Wednesday afternoons, followed by my meeting with Sarah at 6.00 p.m. The sessions also had to be written up and I decided to do this immediately after them. Often I had to leave some clinical work to attend the supervision group, this involved explaining the scheme to the relevant consultant. Most of the time this was easy although occasionally the consultant did not take kindly to my leaving early, due to the preconception of psychotherapy being a load of old rubbish. I learned to explain something that I believed in strongly and not to be sensitive to the judgemental attitudes sometimes received. I believe medicine involves many aspects and that it is fundamental to trust and believe in what one is doing and not to be swayed by those in authority.

The commitment element of the psychotherapy brought with it new experiences. It involved having to be in one place at a certain time, never late and often having to rearrange one's social agenda. Medical students do not really have many time commitments especially ones that invade their own free time. I enjoyed attending the weekly sessions and found myself becoming more oganised on the session days than on any other day of the week. I realised that commitment to time and place could be a good thing and saw how basic it was to psychotherapy that I was a reliable corner-stone in her world full of chaos. It also gives me great pleasure that I gave my free time in this way and in return how much I learned. In medicine surely, it is that extra piece of yourself that you are not required to give that can make all the difference.

I was quite nervous before my first session with Sarah. I knew that she was older than me, in her thirties, and not keen on psychotherapy. Her first question took my by surprise and confounded my anxieties. She barked 'Have you done this before?' In reply I said that I regularly attended a psychotherapy supervision group. The truth was that I blurred her vision into thinking that I had some experience of psychotherapy. To this day I still wonder if I should have done this, or had any right to. If there is justification it lies in the fact that for the first few sessions her trust in me had an advantageous starting point. There will be many 'first times' in the future and I am glad that I can take with me the need to gain the trust of the patient. I also realise that there are things one can say to ease patients like Sarah who are subjected to so much uncertainty elsewhere. I hope always to take each situation in its own right and to maintain an insight into the dilemmas. Experience and compromise shall inevitably play a large part.

During the first few sessions I was very worried about the pauses that were occurring quite often. I tended to say something, when I felt that they had gone on too long. My supervisor advised me to recognise the importance of pauses. I will never forget the first time I let a pause run its course. After about eight minutes, Sarah revealed something that was very difficult for her. It was a very compelling moment and ever since, I have enjoyed the use of gaps in conversations.

Sarah saw me as one of the medical profession. She knew that I was a medical student and believed that I had a vast knowledge of illness. Often when describing her symptoms, it was apparent that she was looking for a diagnosis. I realised that this was not my role in our sessions and that an examination of her anxieties related to her illness was much more important work for us. I felt that she was often quite angry about this and felt bullied for my medical opinion. Only once did I lapse, commenting that perhaps there would be no miracle pill which would work as a cure for her pain and perhaps we could think about the pain never going away. Although at the time I felt it was an important point, on reflection I saw myself as yet another 'doctor' giving my opinion, when she already had enough doctors confusing her. Perhaps her general practitioner might also have been better off had she recognised how perplexing the whole situation was for Sarah and dealing with that, while putting her own medical opinion in the background.

During my own medical training, the clinical years became quite stressful. I noticed that instead of my anxieties being subdued by alcohol, I started nail-biting, and experienced sleepless nights together with peri-oral paraesthesia. I became very worried that perhaps I was picking up symptoms from my patient. Was it possible that having become stressed myself I was imitating the facial discomfort Sarah had experienced while working at the hair salon. I will never know the true answer to this and like to suspect it would have come on regardless. I felt this a huge demand on myself. Should I stop the scheme because I might be jeopardising my own health, or carry on the benefits outweighing the costs. After a visit to my general practitioner who talked of hyperventilation causing the symptoms, I decided just to accept the 'coincidence'.

During quite a few of the sessions Sarah brought up her disapppointment with the doctors. She often looked to me to endorse her criticisms. I felt this was a very difficult situation because I knew that her case was very complicated and felt uneasy about judging my colleagues. Many times it would have been so easy to say, 'I can't believe they did that.' I never colluded with her criticism, but listened to what she said, and learned more important strategies. I realised that a patient's dissatisfaction can arise from poor communication skills. However, it also became apparent that distaste can also arise from the angry patient not being given answer and a cure. Doctors should be hesitant about judging one another in front of a patient because the true scenario may be added to by the patient's anxieties and underlying transferences.

Having said this, my main criticism of the way that her case was handled is the lack of openness. Doctors are too frightened to say that they do not know. I think that it was good that Sarah was encouraged to seek several opinions. However there was a need for some central co-ordination, at least one doctor should have taken the time to explain what was going on with the various tests and medications. I believe that this is the role of the general practitioner who could have contacted the various specialists and given Sarah a clearer view of what they believed her medical status was. I think that it was excellent that Sarah was recognised as needing someone to talk to and was therefore put forward for psychotherapy.

Progression

The medical student psychotherapy scheme was started at University College Hospital in 1958. It was in response to the challenge of Michael Balint's work with general practitioners. Just as Balint helped general practitioners to learn more about the way they related to their patients, so Wolf and Tredgold hoped they could help medical students to learn more about, and value their capacity to relate to patients.[1]

I have found the scheme particularly useful in developing my communication skills in an atmosphere where factual knowledge does not add to the burden of what I am trying to achieve. The scheme also gave me an insight into my own emotional reactions in relation to my patient. Learning to listen has become my most useful tool. I also now appreciate how short doctor's appointments are and the need to look for what exactly the patient is trying to tell you. I do not know how good a doctor I will be, but I hope that my increased awareness will steer me in the right direction.

I would encourage more medical schools to develop the psychotherapy scheme. At the moment only three such schemes exist, at U.C.H., University of Toronto and the University of Heidelberg. The University of Lausanne (Switzerland) is starting one at present. I also think that medical students, should have the opportunity to support a patient with a chronic illness. I appreciate that some students may have already experienced this within their own families, but others may not recognise how much the illness impinges on everyday living. There is no better way to learn about how much patients need a sympathetic doctor and how important this contact is, than from patients themselves.

During my first clinical year we did a two day communication course. It involved actors in a role-lay of clinical situations. Sessions were video-recorded during the course and then played back to the rest of the group for feedback. I found the course to be very useful, as did many of my colleages. It would be a shame to lose this experience if those that thought it was a waste of timie were the only voices to be heard. I also think that there could have been some improvement in the course. We were taught by psychologists who had not experienced the topics that we were covering. This caused a lack of respect and I think that it would be better if interested general practitioners could become involved in the course. I am not sure that actors were necessary, and I think that more could be learned by the students themselves taking both doctor and patient roles. Acting is such a powerful medium and the students could experience some of the feelings and emotions of being a patient. We also received a report from the course, but it was disappointing that these forms contained only an attendance grade and no feedback considering the course was about communication.

During my oncology placement, there was a weekly group which encouraged us to talk about our interactions with patients. The supervisor instructed us to talk to patients and families about the illnesses. Similar to the psychotherapy scheme, the supervisor was present each week to discuss with us the difficulties that we encountered and the emotions that we had been exposed to. It was very beneficial having someone take an interest in how we felt as students experiencing other's illnesses. I think that this has a knock-on effect, causing us to question how the patients and their families feel.

There is something fundamentally wrong in the lack of support for medical students. The attitude of 'toughen-up and get on with it' then gets passed on to our patients because it is the only coping mechanism that we know. I would encourage much more guidance and sympathy for medical students from tutors aware of the difficulties of the course. If we could remove the taboos of learning about ourselves, we would have a much better chance of understanding our patients.

In conclusion, I feel very lucky to have participated in the student psychotherapy scheme. I think the group-setting with a supervisor was very helpful. I would like to see more of the doctor/patient communication teaching based around this idea with a student-centred approach. My final thank-you goes to my supervisor Dr. Shoenberg who believes so strongly in the psychotherapy scheme and has given me many pointers in the right direction.

Reference:

1. Shoenberg P J 1992. The Student Psychotherapy Scheme at the University College & Middlesex School of Medicine: Its role in helping the Medical Student to learn about the doctor/patient relationship. *Journ. of Balint Soc.* **20**, 10-15.

International Balint Award 1998 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, 1998** to the following representative:

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

The presentation of prizes will take plce at the Monte Verita Centre, in Ascona, Switzerland on 12 April 1998

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

A Psychosomatic Dialogue

John Salinsky
General Practitioner, London

PATIENT: There is something wrong inside me. It feels bad. It feels dangerous. I can't breathe. I feel sick. I can scarcely swallow. Awful things are twisting up my stomach. My heart thumps and turns over. And why am I always so tired?

DOCTOR: Your symptoms form no pattern that I recognise. I examined you and found that all is well. Your tests are entirely normal. There is nothing to worry about.

PATIENT: I don't feel right. Please help me. What is causing this disease?

DOCTOR: There's no disease. Mental forces, emotions working in your mind have produced, through the mediation of the autonomic nervous system, the physical symptoms of which you now complain.

PATIENT: So you don't believe I'm really ill?

DOCTOR: I think your illness is emotional. You are depressed and anxious, there's no doubt. You suffer from unresolved grief, unconscious anger and hidden conflicts present since your childhood. If you would only accept this, you would get well.

PATIENT: I hear what you say but I don't understand. Something is wrong inside me, I can feel it. I couldn't have imagined it – but that is what you think. My illness is not in your books, you don't know how it feels and so you don't believe me. I feel desperate. Why has this happened to me? Have I been eating the wrong foods? Is it an allergy? Please help me.

DOCTOR: I see that you are not yet ready to accept a psychological explanation. You have no insight. You are severely somatised and I cannot as yet reattribute your symptoms. Instead I shall treat each symptom with symptomatic medication and your depression with the latest antidepressant.

PATIENT: I've taken all the tablets but I feel no better. What now?

DOCTOR: Well, I'm not surprised. I didn't really think that drugs would help. What you need is to change your lifestyle. Learn relaxation (listen to this tape). Work out in the gym, take up yoga, meditation. Get out more socially and make new friends. And cognitive therapy, I've heard that's very good. I'll write you a referral.

PATIENT: I'll try anything to get well. But what is really wrong with me? Please tell.

DOCTOR: I have told you. It's your childhood. Perhaps your folks abused you.

PATIENT: I don't think so. I had a happy childhood, although Dad was always busy. I never used to feel like this. I'm really frightened. I get so breathless. Am I dying. Can't you tell me?

DOCTOR: These fears are what we doctors call anxiety. Try breathing into this paper bag.

PATIENT: I have these pains, I feel so awful. Surely there is something wrong?

DOCTOR: I'll tell you what is wrong. It's you! You are a tiresome, demanding manipulative person. You are obsessed with your wretched bodily functions. You have an immature and dependent personality. I suspect you secretly enjoy all the attention I give you; the benefits of the 'sick role' and its associated secondary gains. You take up too much of my time and you never listen to what I tell you.

PATIENT: I've made you angry.

DOCTOR: You make me angry and frustrated. Although I don't know how to help you, you persist in coming to remind me that I'm useless.

PATIENT: I don't think you're useless. I know you're trying. You want to be sympathetic but you find me hard to understand. I don't want to upset you and to waste your time. Perhaps at the hospital a specialist would know what's wrong. Someone with more experience of my condition?

DOCTOR: I can't do that. There's nothing they could do. And since there's nothing wrong with you they would think I was a fool. I don't want to be humiliated. Some of these consultants were my teachers when I was a student.

PATIENT: Well, what about an X-ray or perhaps a total body scan? A comprehensive check-up makes good sense to me. Surely then we'd see what's wrong inside?

DOCTOR: Now look, we've been through this before, how many times? There's nothing wrong with your body, it's your mind.

PATIENT: I feel that I could die before you understand me. And when my body's opened you will see at last: too late.

DOCTOR: Now I'm really angry. You're so helpless and pathetic, yet you make me seethe with rage. I know what you're doing – trying to make me feel guilty. Well, I'll not put up with that. Leave my list and find another doctor!

PATIENT: I can see that I've upset you. That's the last thing that I want. Please don't send me packing; you're my doctor and I need you.

DOCTOR: All right, all right. I'm sorry. Perhaps I went too far. The fact is that I'd really like to solve this. My curiosity is aroused. My intellect is challenged. My feelings are engaged (as you have noticed). Actually, I quite like you. Although, I have to add,

sometimes I hate you. Because you're weak and helpless, like a baby, which upsets me, but when you say you need me, as one human to another, that gets to me. To that I must respond, it's what I'm here for.

PATIENT: Oh good, that's better. I'm so relieved you haven't sacked me. But I won't take up any more of your time today. I must be quite a strain for you to deal with. And I don't want to make you ill, like me.

DOCTOR: Perhaps we could continue; some time next week?

PATIENT: Thank you, thank you. That would suit me. We could talk about my childhood if you like. Perhaps I'll join the relaxation classes. And, you know, those yellow tablets may have helped a bit, I'll take some more.

DOCTOR: I feel calmer. Some appreciation does a lot to help. Perhaps you will get better one day. No reason why you shouldn't. Those symptoms might just fade away. I have a feeling it will be a long haul though. I hope you won't get too dependent.

PATIENT: Till next week then ...

THE BRITISH BALINT SOCIETY

in association with The International Balint Federation

will host the

XIth International Balint Congress

in Oxford, 9th - 13th September, 1998

Accommodation will be in the Gothic Style Exeter College, renowned for its excellence of food and wine.

The main theme will be Doctors and Patients in the 21st Century and its main features will include:

Keynote lectures by invited speakers
Short papers from the participants
Balint-group experience for all with experience
Group-leaders from around the world

In addition, there will be

A Reception in the Exeter Fellows Garden and a Banquet
A Concert in the Sheldonian Theatre
A conducted tour of the City of Oxford

Full details available from:
Dr. John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG.
Telephone and Fax: 44 181 904 2844.

Churchill Travelling Fellowships

Each year the Winston Churchill Memorial Trust offers opportunities for British citizens to travel overseas to undertake study projects related to their profession, particular interest or trade. Thus, they widen their experience, make contacts abroad and bring back knowledge to this country for the benefit of their work and the community.

These Travelling Fellowships are available to applicants of any age and from all walks of life, irrespective of academic or professional qualifications.

Please send a self-addressed stamped envelope (22 cm x 11 cm) **before 23 October 1997**, for an application from and full details of this unique opportunity to:

TheWinston Churchill Memorial Trust, 15 Queen's Gate Terrace, London, SW7 5PR.

Please write if you have any questions,or telephone 0171 584 9315.

Obituary

Jean Pasmore, MRCS (Eng.), LRCP (Lond.)

22.06.1909-26.11.1996

Jean Pasmore was a great friend and much respected colleague. She died of a stroke on 26th November 1996. She was born 22nd June 1909, went to Wycombe Abbey School, and later studied medicine at University College Hospital. She married Stephen, a fellow student, shortly after qualifying in 1933, and joined him in general practice in London's Kensington, where they worked together throughout the Second World War, first in Chepstow Villas W.11 and then at 21 Edwardes Square, W.8. At first, her medical work was limited as she needed to run the house and raise a family.

Later, her main work was connected with Family Planning Clinics, where she and her colleagues found difficulty in helping their patients who wanted to discuss their marital and sexual problems, as well as birth control. Jean felt the need to develop these interests, so when she saw the announcement placed in the medical press in 1954 by the Tavistock Clinic, inviting general practitioners to attend seminars which would help them deal with their patients with psychological problems. Jean decided to apply. She was so impressed by Balint's approach on her first attendance, that she persuaded Stephen to attend the next meeting with her, and so they became one of the very few married couples to attend together. Their group existed in the early stages of the seminars when members of the staff of the Tavistock Clinic gave them short lectures to the group after the tea-break, but Michael Balint always maintained that he did not give lectures as they were no part of his method of training.

This glimpse into the nature of Balint-work at that time is extracted from the tenth Michael Balint Memorial Lecture, on the legacy of Michael Balint to general practice which they prepared and delivered jointly to the Society in 1993.[1] Jean became deeply involved in the Balint movement within general practice, attending such conferences as that in Leiden in 1960. In fact, she attended all the International Balint Congresses up to, and including the sixth which took place in Cologne, to which I had the pleasure of driving her and Stephen, an event of which I still hold fond memories.

Her parallel involvement with birth control clinics in the Family Planning Association (FPA) had alerted her to sexual problems presented by the patients. As she recounts in the Memorial Lecture, she met with a few colleagues in 1951 to discuss the problems of which they were now aware. They continued to meet in that discussion group. After two years, Jean, Sylvia Dawkins and others persuaded the F.P.A. to invite Michael to start a special seminar for psychosexual problems. She became a member of the first of Michael's seminars in the field of psychosexual medicine, and at that time she also started in analysis with Enid Balint.

By 1958, Michael was so impressed by their progress, that he encouraged some of them, including Jean, to go into the provinces and run further seminars on their own for the F.P.A. doctors working there.

Jean was working in the Marital Difficulties Clinic run by the F.P.A. in Westminster when I met her, joining her in the work soon after. We soon became members of the parallel, second generation, Balint Research Seminars inquiring into the treatment of psychosexual problems.

In 1961, Dr. Tom Main, who had been closely connected with Balint's seminar-work, asked Jean to start a Marital Clinic at the Cassel Hospital. Of course, she was delighted to accept the invitation, and worked at the hospital with medical and lay therapists, under Tom Main's direction, and using both the physical examination technique derived from the seminars and the interaction technique derived from the Family Discussion Bureau at the Tavistock Clinic, which had been started by the late Enid Balint. This technique comprised two therapists working with each married couple, seeing them separately, but discussion each session with a psychoanalyst supervisor, usually Tom Main himself. The interaction between the therapists helped them to understand some of the ways in which the patients interacted. Jean went on to become the Head of the Marital Clinic at the Cassel Hospital, under the continuing direction of Tom Main (1961-77).

Michael Balint died at the end of December, 1970, and Tom Main took over all his Seminar-work. He continued to promote the Seminars and build up an organisation for training doctors as well as training Leaders. In 1974 when he learned that the National Health Service intended to take over the F.P.A.'s clinics, he decided to set up an independent organisation. This proposal was approved by the F.P.A. doctors and a steering committee was set up in 1975, and met at Jean's house in Edwardes Square, with Jean in the Chair, and Dr. Margaret Blair as Secretary. The new organisation was called The Institute of Psychosexual Medicine. Jean retired from the Cassel Hospital in 1977, but as one of its Founder Members, she continued to serve on two of its committees.

As a result of her training under Enid and Michael Balint, and Tom Main since 1954, Jean played a very active part in communicating what she had learned, to other doctors concerned with family planning and marital problems, through her leadership of training seminars in various

centres throughout Southern England. In addition, she read very many papers at a number of conferences, including the International Balint Congresses, as well as some of the International Congresses of Psychotherapy abroad, at the Hague, Wiesbaden and Oslo. She had many papers on marital therapy and marital problems published in many journals, including the Journal of the Royal College of General Practitioners and The Practitioner.

As a result of all this work, Jean came into contact with very many doctors, both general practitioners and others working in F.P.A. settings, who soon realised, appreciated and benefited from her outstanding skill, as well as the warmth of her humanity.

She was a delightful companion, her facade of great seriousness overlay a great sense of humour. We shared many things apart from a common interest in the application of Balint-work to psychosexual medicine; poetry, music, drama and travel. She rose above the difficulty of her failing vision magnificently, and my memories of her will always be of her combined strength and sensitivity. Her husband, Stephen, and their two daughters survive her. She will be sadly missed by them and all who knew and worked with her.

MIKE COURTENAY

Reference:

1. Pasmore, J. and S., (1993) The Legacy of Michael Balint to General Practice. *Journ. Balint Soc:* **22**:4-11.

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.

For the Practice Library

HOW WE DIE. Sherwin B Nuland. 1994. Hdbk. pp.278. £15.99p. ISBN 0-7011-6169-8. Chatto & Windus, London.

THE WISDOM OF THE BODY. Sherwin B. Nuland. 1997 Hdbk. pp.395. £16.99p. ISBN 0-7011-6672-X. Chatto & Windus, London.

It seems right to think of these books together, although their publication has been separated by several years. Perhaps I was waiting to see if the author could maintain the high standard he set at first; now it seems that he has. Few medical writers can keep the pages turning as Nuland can. These anthologies are unique, emotionally powerful analyses of some of the classic biopsychosocial problems in Medicine. Nuland's style is to address topics by discussing the physiology, and then to illustrate its clinical significance by a case-history of such human and literary immediacy that it leaps from the page; it could hardly be more vivid in the cinema.

For the doctor, the medical information may, to some extent, be familiar, but the literary exposition is exciting and challenging – here is an example worth emulating. For the reader from allied professions, working in a medical setting, these portraits of human distress could be profoundly illuminating. Few writers have captured both the scientific and organic problems together with the human anguish entailed, and held these experiences together for the reader.

Here is a clinician who is profoundly moved by the tragedies and miracles experienced by his patients, and can think around these experiences sufficiently to write an account that includes Thomas Jefferson, Edward Jenner and Samuel Johnson in the index!

Although Nuland does not discuss Balint, he asserts that 'the relationship between a patient and his primary doctor will remain the core of the cure, as it has been since the days when Hippocrates set down his reflections upon it'.

THE SICKENING MIND: BRAIN, BEHAVIOUR, IMMUNITY AND DISEASE. Paul Martin. pp.370. Hbk. £16.99p. ISBN 0-00-255683-9. Harper-Collins, London.

All doctors who have been involved in Balint-work will be fully aware of the psychosomatic approach in medical practice, especially of the importance of what has become known as 'whole person pathology' and the need for reaching an 'overall' diagnosis.

Indeed the use of commonly spoken simple expressions such as 'Oh, him, he's a pain in the neck (or some other part of the anatomy!)'; or 'he give me a headache ...' or '... he just died – he was broken-hearted, you know when ...?'; 'it was such a shock, I went cold all over ...'; and scores of other such references, show how people have been so observant of the possible effects of the mind on the body, for a very long time, and these colloquialisms followed.

Even the more commonly heard expression after the patient has told her doctor about her recurrent skin infections, or sore throats ... 'I feel so run down, doctor, ...' has now been shown to have a scientific basis. Measurable changes in the function of the immune system have been found.

The good news is that late twentieth century science is finally catching up with the age-old understanding that the mind can influence the workings of the body, and that in the same way, the body's biological machinery can impinge on the mental state.

Paul Martin, who is a Fellow of Wolfson College, Cambridge, reminds us in this well researched and beautifully produced book, the belief in an intimate connection between the mental state and physical health had had a decidedly rocky history in Western medicine, despite its promising beginnings in the civilisations of China and Greece more than two thousands years ago.

The book includes useful discussions about topics such as the evidence that psychological factors can influence the immune function. He challenges Descartes' dualist legacy which has encouraged scientists to neglect emotions, and emphasises the links between the more modern understandings of the role of affect in neuro-science. He also acknowledges the significance of the findings from attachment and developmental research.

We live in exciting times, psycho-neuroimmunology is emerging as a field of research that supporters long-held psycho-dynamic/psychosomatic ideas, and the author writes, '... all illnesses have psychological and emotional consequences as well as causes, ... there is nothing shameful or weak about the intrusion of thoughts and emotions into illness ... that our social relationships with other people are central to our health ...'

It might not be too fanciful to include the relationship with one's general practitioner in the list of determinants of health and disease outcome.'

This book will be a most popular addition to the practice library, and the demand for it from all members of your team could well lead to your needing a second copy.

NEW ANALYSIS: JOURNAL OF PSYCHO-ANALYTICAL SOCIAL STUDIES. Published by Open Gate Press.

The first issue of this new quarterly journal appeared in January this year. The stated aims of its editors are to lay the foundations for a psycho-analytic social science, and to act as a stimulus for the regeneration of psychoanalysis, both in its clinical field and as a method of social analysis.

We are reminded in their introductory notice that Freud cherished the hope that the discoveries of psychoanalysis would make a significant contribution to the understanding and

resolution of the irrational, aggressive and destructive drives in society. Sadly, this hope has not been fulfilled.

Even more unhappily, the first part of a prediction which he made in his old age, that if this were not possible, our culture would be submerged in ever great catastrophes, has proved and is still proving to be all too accurate.

The second part of this prediction, that failure to understand and resolve the destructive drives would eventually lead to the destruction of mankind, is all too likely to prove to be accurate if the leaders of the world's governments fail to take it seriously, and continue to neglect the warning unheeded for far too long.

The intention to examine some of the aspects of psychoanalytic theory and practice which have been shown to be inadequate, and to point the way to new work which promises to transform psychoanalytic practice, without neglecting the fundamental insights which have made psychoanalysis unique among the psychological sciences is valuable.

Finally, the intention to re-assess the potential of psychoanalysis as a social study, and to define its ability to throw new light upon social and cultural processes can only be welcomed.

The contents of the first two issues are varied and extremely interesting, and readers of this Journal can safely be encouraged to write for a complimentary copy – and an order form to:
Open Gate Press, 51 Achilles Road,
London, NW6 1DZ. or FAX: 0171 431 5088.

THE UNKNOWN SELF: George Frankl. 1990. Hdbk. pp. 227. 160pp. £16.50p ISBN 1-871871-05-0. Open Gate Press, London.

EXPLORING THE UNCONSCIOUS: NEW PATHWAYS IN DEPTH ANALYSIS. George Frankl. 1994. Hdbk. pp. 173. £12.95p. ISBN 1-871871-06-9. Open Gate Press, London.

Four of George Frankl's books have been published by the Open Gate Press in their series, *Psychoanalysis and Society*. The first, *The Social History of the Unconscious* in two volumes, were so remarkable that reviews were published in this *Journal.* Volume 1, *The Archaeology of the Mind* (1992.20,22) and the Volume 2, *Civilisation: Utopia and Tragedy,* (1992.21.27).

In *The Unknown Self* (1990), Frankl deals with the psychological development of the individual, and introduces the reader to the complex processes which take place in the psyche from the first days of life, and helps him to understand the conflicts in the unconscious mind as he develops. He describes the origins of a wide range of mental and bodily disorders, and provides profound insights.

In *Exploring the Unconscious (1994),* Frankl describes his use of hypnoid depth analysis which he has developed over the thirty-five years since he started practising as a classical psychoanalyst. In the first section he describes the origins of psychotherapy, from hypnosis through magic to science and psychoanalysis; and through a further nine sections dealing with a huge range of topics from body language, the unity of psyche and soma, the unconscious self-image and on to the treatment of psychotics in hospital. Here are two books which are written in a beautifully concise and precise style which will be of great help for doctors and other health workers who are interested in the psychosomatic aspects of medicine, and should take their place in the Practice Library.

SUSAN M. HOPKINS
PHILIP HOPKINS

The Oxford Balint Weekend

15th - 17th September 1996

From September 15th to 17th, 46 participants met at Lincoln College, Oxford for the society's twentieth Oxford Balint Weekend. After a demonstration-group on Friday evening, they were divided into five small groups, constant over the weekend.

The weekend fulfils the needs of various types of participants. Firstly, as usual, there are people attending who have had no previous experience of Balint-work; hospital doctors, general practitioners and medical students, as well as occasional visiting psychologists and psychoanalysts. There are also other doctors who may have been in a Balint-group many years ago, but are 're-visiting' Balint, and those who attend the Weekend and other meetings of the Society, but may not have had the opportunity to be in an ongoing Balint-group.

In addition, there are leaders-in-training as well as leaders who benefit from the Group-leaders' Workshop during the Weekend.

A very welcome feature of this year's Weekend was the presence of an entire Balint-group from Sweden, with its leader, Dr Henry Jablonski. A less welcome feature, however, was the lower than usual standard of accommodation, but this will be rectified in 1997 when we will be moving to Exeter College, which is next door to Lincoln College (see page 32), and again in 1998 when we will be hosting the Eleventh International Balint Congress (see page 27).

Again, many commented on the value of the recreational pause in work on the Saturday afternoon which gives people a chance to re-charge their emotional and intellectual batteries in any way they wish, including the chance of joining John Salinsky's now traditional and entertaining Walking Tour of Oxford.

Most important about the Weekend, of course, is the work done in the small groups which are always noted for the way in which the members of each group so quickly settle down to work so well together, and demonstrate the ease with which they come to trust each other, and can share their feelings about the problems their more difficult patients present to them in their every day practice.

Some of the comments written every year in the assessment forms show how worthwhile the Weekend experience has been for them. Some refer to the '... supportive and caring environment'; and 'it was hard working'; and for some, it was unique '... to share the fantasies of other doctors about one's patients'.

Polly Blacker, a psychotherapist, noted that 'I feel everyone worked very hard; very difficult cases were discussed with input from all group members, which was generally found to be helpful. The group expressed very positive appreciation of the experience. Maybe I felt it was a very intensive weekend as it was the first time I have led a weekend series of group sessions and worked with a co-leader. I was quite tired after it all, but I had learned much and felt rewarded.'

The plenary session which always ends the Weekend's activities, was made unusually short, in order to allow time for the Society's first Annual General Meeting to be held in Oxford and, as expected, this was attended by far more members than have attended the recent Annual Dinners held in London. The meeting was brief and to the point, and the proposal that our Annual General Meetings should be held at our future Oxford Balint Weekends was welcomed by all.

I hope many more members will attend next year to enjoy it with us.

DAVID WATT

A revealing experience of the medical world outside the hospital walls.

I had never heard of the Balint Society until I noticed a pamphlet at my medical school, advertising the Oxford Balint Weekend. I was intrigued by the concept of a group whose primary aim was to improve the doctor/patient relationship and communication. I must admit I was curious, since the whole idea had an air of enigma about it and I decided to find out more about it.

I was extremely nervous entering the austere banquet hall of Lincoln College on Friday, but was immediately put at ease by some friendly doctors who had approached me. The food was out of this world and certainly a welcome change from normal student 'grub'. The conversation was equally rewarding and I found myself relieved that for once I was not being intimidated by a high-ranking consultant who did not care for the opinions of a mere junior.

The discussion-group that evening was extremely interesting and eased me gently into the Balint method of training. I was impressed by the honesty and courage that the participants showed, and felt a little overwhelmed at the thought of doing that myself the next day. It is always so difficult to imagine that your input into a conversation can enlighten and help to reform the ideas that others may have fixed in their minds. This, however, seemed to me, to be the notion of the Balint Society.

I was to discover the next day that not only did the others listen to my thoughts but welcomed them as well. We were a very close group of both old and new Balintians who seemed to communicate very well. The cases presented were both interesting and revealing of different characters, and ways of practising medicine. I experienced a whole range of emotions including humour, tragedy, frustration and despair. It was a delight to have such experienced leaders who managed to direct the group with as little direct intervention as possible.

The conference dinner was very enjoyable (which may have been helped by the moderate quantities of wine consumed), and I appreciated being able to talk to general practitioners from many different types of practices. The speeches were most entertaining and I especially congratulate the Norwegian speaker who grasped the British humour in a commendable fashion.

I concluded a valuable weekend by presenting a case myself and being in the 'hot seat'. It was not quite as terrifying as I had imagined and in fact, it was a relief to be able to express my anger at the inadequacy of modern medicine to sympathetic listeners. There has been a sad loss of teaching of the art of culturing a good doctor/patient relationship, and I feel that the Balint Society is a positive move towards amending this. I hope that one day these concepts may enter the hospital walls and assuage some of the dissatisfaction lurking there.

LISA-JAYNE CLARK
Final year medical student
Charing Cross & Westminster
Medical School, London.

The Heart of General Practice

Oxford Balint Weekend

12th - 14th September 1997

Make sense of patients who are difficult to see and treat.
Experience group discussion about the doctor/patient relationship.
Groups, mostly made up of general practitioners, and led by experienced leaders, can explore the psychological aspects of their work with patients.
Group experience is not necessary.

Venue: Exeter College, Oxford
Conference will start on Friday evening,
and will end with the Plenary Session at 11 a.m. on Sunday.
The Annual General Meeting will be held at 12 noon
and lunch will be served after its conclusion.

Price: £205.00 (£185.00 Members), includes board and lodging.
PGEA approval.

Contact: Dr. David Watt, Tollgate Health Centre, 220 Tollgate Road, London, E6 4JS.

Nurses' Balint Study-Day

15 May 1997

Eight practice nurses, five funded via the Practice Nurse Adviser's office at ELCHA (East London & City Health Authority) met this year forming one group led by Dr. Pat Tate from Cambridge, and myself. The meeting was again held at the Wiseman Conference Centre, attached to the Hospital of St. John & St. Elizabeth in St. John's Wood. The facilities and catering were better than ever and contributed to the day's success.

The cases discussed centred around the nurse/patient interest. For instance a man who had recently died who had been completely unwilling to talk about death, another, a woman seeing a nurse for her fourth round of IVF injections, an elderly man making covert improper overtures to a young nurse, and a 60-year-old motorcyclist apparently willing to lose his legs to keep smoking in spite of his diabetes and peripheral vascular disease.

There was an overwhelming impression of enthusiasm and desire for more Balint-type group-work to be available though nurses to not feel able to commit themselves weekly (similar to what we found with GPs when the Society set up its current research-group). Two avenues are being explored. Perhaps the Tavistock Clinic via Andrew Elder will be able to arrange a more flexible Balint-group, or the Society may put on more frequent Nurse Study-Days. Having been present each year I can encourage members whole-heartedly to send their practice nurses to these days. It offers nurses a new arena in which there is a great deal of pent-up energy.

DAVID WATT

Balint Prize for the Field of Health and Nursing Care, 1998

To promote relationship-orientated care, based on the Ascona Model (WHO), prizes will again be awarded for papers in 1998.

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 March 1998.

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 in **27 June 1998** in the Monte Verità Centre, Ascona, Switzerland.

The International Balint Federation, 1997

Although the Balint movement started in Great Britain, we are not alone! There are flourishing Balint Societies in many other countries and a large number of active groups for family doctors and others in the helping professions. The International Balint Federation was founded in 1974 with the aim of helping Balint enthusiasts all over the world to keep in touch with each other and share their ideas. We also do what we can to encourage the formation of new groups and new Societies and organise an International Balint Congress every two years.

At present, there are Balint Societies affiliated to the Federation in Belgium, Croatia, France, Finland, Germany, Hungary, Italy, Latvia, Poland, Romania, Russia, Slovenia, Sweden, Switzerland, South Africa, the UK and the USA. We are also in touch with individual members in Iceland, Slovakia, Austria, Japan, Australia, New Zealand, Canada, Norway, Holland and if I have left anyone out, I apologise. And will visit you as soon as possible, because one of the best things about being International Secretary is that I get to travel to all these countries to meet up with my International Balint colleagues.

Last year we had a very successful International Congress in Budapest to celebrate Michael Balint's 100th birthday (see *Journal,* Vol. 24, 1996). Our next major event will be the X1th International Congress which is to be held in Oxford (yes, Oxford, England) from 9th-13th November 1998. We are expecting 150 delegates from Europe and the USA to attend and there will be an exciting programe of keynote lectures, symposia and, of course, case discussion in Balint-groups. Don't miss it!

In between Congresses, the Council of the Federation meets twice a year. The council consists of an executive (president, two vice-presidents, secretary and treasurer) and up to four representatives from each member country. We move the show around from one country to another and in October 1996, we met in Rome; mainly because our President (Frank Dornfest, USA) said he had never been there. It was also a good opportunity to contact our Italian colleagues of whom we had not seen much in the last few years. Our main business in Rome was a discussion about the Accreditation of Balint group-leaders (or 'Credentialling', as Frank likes to call it). A number of countries (France, Germany, Belgium, Italy) already have and are running procedures to decide who is qualified to be a recognised group-leader. Accreditation is a useful method to enable the leaders of 'real' Balint-groups to be recognised, so that those in search of the authentic group-experience will not be misled. It also helps those wishing to train as leaders to gain the appropriate experience and have their work supervised. We spent a long time in Rome discussing and trying to identify the characteristics of a good Balint-leader. (At the end of this article you will find an extract from my 'Accreditation Notebook' – some of the notes I made at the Rome meeting while ideas were bouncing around the room).

Our next and most recent meeting was in Dubrovnik (Croatia) during the annual Dubrovnik School of Balint Method organised by the Croatian Balint Society. Dubrovnik is a wonderful place, which is described on page 38 to 39.

At this council meeting, we returned to the theme of accreditation. Heather Suckling (UK) presented a draft copy of the 'International Guidelines for Group-Leader Accreditation' (also known as 'The Leonardo da Vinci Guidelines', because Heather, Erica Jones and I put them together at Rome's Leonardo da Vinci Aeroporto while we were waiting for our plane back to London. I can recommend the drafting of guidelines as an excellent way of passing the time whenever your flight is unavoidably delayed.)

We are hoping that the Guidelines will be officially adopted at the next Council meeting which will be in Transylvania (how about that for a Romantic destination?). Actually it is not only Romantic, but also Romanian although for historical reasons most of the people speak Hungarian, many of them speak English too. There is a thriving Balint Society in Transylvania, thanks largely to the energy and enthusiasm of Dr. Albert Veress who is organising an International Balint meeting in his home town of Miercurea-Ciuc (18th-21st September 1997). Four of us will be representing Britain and anyone else who would like to attend can be sure of a warm welcome. If you are visiting any other European country (or the USA) I would be happy to put you in touch with a Balint colleague. You would be able to meet a family doctor who feels just the way you do about general practice (maybe even more so). You will probably be offered warm hospitality and an expert guided tour. You might even take part in a Balint-group.

JOHN SALINKSY
General Secretary
International Balint Federation

Accreditation Notebook (Rome, October 1996)

Leadership Skills:

To be able to keep quiet.
To bring the group back to the work when it strays.
To create an atmosphere of freedom to work together.
To give the members freedom to think and say what they like and to contemplate.
To understand the doctor/patient relationship.
The leader can use his own feelings to help the presenting doctor to understand the relationship with the patient.
Is the leader a teacher?
He/she teaches both by participation and conveying information.
He/she models the doctor listening to the patient.
The leader should be able to stop the members from making too many technical psychoanalytic interpretations (e.g. shouting 'Oedipus complex!').
He/she may do this by saying: 'how do you feel in saying that?' Or 'Can you explain what you mean by that?' We do not need technical terms.
The leader should protect members from personal or destructive criticism.
Allow differences of opinion and alternative views but not personal attacks.
He/she should encourage members to acknowledge their feelings, but not allow unwanted intrusion into their personal space.
The leader might counter destructive comments by saying: 'that's your opinion'; or asking, 'well, what would you have done?'
Should the leader make group interpretations?
He/she might say: 'What is going on in the group now?' or 'The group seems very depressed.'
The leader's job is to help the group to help the presenting doctor discover why he brought his case, and why it went wrong. She should ask the group to think about the case. Even more important, to be aware of how they feel about the case. She should encourage people to own their own statements and to avoid generalisations.
The leader should keep a balance between listening and intervening; and between learning and teaching.
We should develop ideas about good leadership and then test them out as we lead our own groups; see if that is what we are doing; does it seem different in practice. Then refine our ideas.
The group must feel safe.
The leader should concentrate on the presenter during his presentation; help him if he is nervous.
The leader must also keep an eye on everyone.
After he has finished and dealt with initial questions, the presenter can move his chair back a little so that he can observe the group discussing his problem – and re-enter the discussion when he is ready.
How do we deal with laughter?

The Selection (Accreditation) Process
The selection should be the final part of the process; the candidate and his work should be well known to the committee. If he/she is clearly unsuited to group leading he should be advised at an early stage that his is not doing well or should perhaps give up.
We should have no 'co-leaders' (assistant leaders) who will never graduate.
(An extract from the Minutes of the International Balint Federation Council meeting in Rome, October 1996).

International Balint Federation
Guidelines for Accreditation of Balint-Group Leaders
(Draft version)

1. Leaders should have appropriate basic training e.g. Family Practitioner, Psychoanalyst, Psychotherapist, Psychologist.
2. Leaders should have prior experience of being in a Balint-group.
3. Leaders should have worked with an accredited leader for a sufficient period of time.
4. Leaders should have acquired an understanding of the doctor/patient relationship.
5. Leaders should received adequate supervision.

ALSO

Leaders should be able to demonstrate:-

a) that they create a safe and free environment within the group.
b) that they focus the work on the doctor/patient relationship rather than seek solutions.
c) that they create a learning environment rather than resort to didactic teaching

Balint in Dubrovnik, 1997

The Croatian Balint Society held its annual School of Balint Method in the beautiful and ancient city of Dubrovnik from 2nd-6th June, 1997, and I was fortunate enough to be able to take part. I travelled to Dubrovnik from London with Erica Jones and Heather Suckling and we stayed in the 'Villa Dubrovnik', a very pleasant, small hotel perched on the rocky edge of the Adriatic with a wonderful view across the clear blue waters to the city.

Dubrovnik is an astonishing and unique town. The old city is about half a mile across and it is completely surrounded by a formidable wall dating from the middle ages and rebuilt after an earthquake in the seventeenth century. You pentrate the wall through one of the two massive gates and find yourself in a fairytale Italianate city reminiscent of Venice, only without the canals. The main street is a wide thoroughfare, paved with marble stones worn smooth by millions of footsteps – and there is no motor traffic, except for an occasional delivery van. The street is lined with palazzos, churches and noble houses in Gothic or renaissance style. There are galleries and peaceful cloisters to wander round. There are little shops and pavement cafes, pleasant to linger in. On the north side, tiny narrow streets run up the hillside so steeply that they turn into staircases. On the south sides, the pattern is a little more irregular and broken up by squares and enticing corners. You can walk all the way round the city on the ramparts enjoying lovely sea views on one side and a bird's eye view of the city architecture on the other. Dubrovnik was shelled for several days during the recent war and a few buildings were destroyed. Those which were damaged less severely have all been repaired and the city now shows no obvious signs of the bombardment. We spent the Sunday before the conference having a good look round and soaking up the atmosphere.

On Monday morning the Balint School began in the Inter-University Centre, an impressive building just outside the old city which is used for a wide variety of postgraduate academic courses which are funded by universities in Europe and the USA. When we arrived we were greeted by Professor Muradif Kulenovic who teaches psychiatry in Zagreb and has been running these meetings in Dubrovnik for many years. Those present included our old friend and colleague Dr. Jack Norell, a veteran of the Dubrovnik Balint School who even came in 1992, undeterred by the very recent bombardment. We also found Marie-Anne Puel, president of the French Balint Society and Jean-Georges Romain, president of the Belgian Balint Society. Hungary was represented by Dr. Nellie Bobay who organised the Budapest Balint Congress so effectively last year. The other members of the school were family doctors and psychiatrists and one social worker from Croatia and three psychiatrists from Sarajevo (in Bosnia). Altogether we made up a group of 23.

The theme of the conference was 'The Difficult Patient'. Each of the visitors from Western Europe was invited to give a short talk and then to lead a demonstration group which was followed by a general discussion. I started the proceedings by listing the kinds of patient behaviour which doctors found 'difficult'. These mainly consisted of asking for things (such as letters, certificates, prescriptions and referrals) which the doctor felt unwilling to provide. In the group which followed, one of the Croatian doctors described a young man in her therapy group who had been captured and tortured during the war and who remained silent during the group sessions. It emerged that he had had nothing to eat for two days but was too proud (or ashamed) to say so. The doctor offered him some money, which he refused, and then managed to get the social services to provide some which he did accept. The discussion was mainly about whether the patient needed to be treated 'like a child' and whether the doctor should have maintained a more 'professional' distance. Those of us from outside Croatia and Bosnia began to realise that psychiatrists and general practitioners were still treating very large numbers of people who had been psychologically damaged by their experiences in the war. As someone said, the whole country was suffering from PTSD (Post Traumatic Stress Syndrome).

After a break for coffee, Heather Suckling talked about three of her cases who represented a Difficult Patient, a Difficult Illness and a Difficult Doctor. She then led a group in which one of the doctors presented a harrowing story about a patient with a cerebral tumour who was being offered a dangerous operation with little chance of success.

On the second day, Erica Jones presented a survey of the kinds of patient whom the members of her trainee-general practioner – group presented over a two year period. Death and bereavement were the most prominent causes of difficulty (and distress). The group which she led afterwards discussed another patient who made himself difficult by wanting to kiss his doctor. She was afraid that if she refused, she would lose him from her practice. There was an animated discussion about the need to set boundaries between the professional and the personal, and lots of urgent advice was given!

In the second half, Jean-Georges Romain presented a paper on the treatment of drug addicts (everybody's difficult patients). Jean-George had been unaware until he arrived in Dubrovnik that he was expected to give a paper. To add to his difficulties, it was to be his first paper in English. However, the English group had helped him to find the right words and idioms over dinner and a glass or two of wine on the previous day. The

result was a brilliant and provocative presentation which I hope you will have the opportunity of reading before long. Jean-Georges then led a group in which the presented patient was a heroin addict. He chose to lead the group in a sort of Gestalt style in which the leader was firmly in control and the group members were asked in turn to describe their feelings in the 'here and now'. Some of us found this a little disconcerting. It would be nice to see him leading in the 'classical Balint' style also. Perhaps he will do that for us another time.

In the evening, we were taken by bus to the little town of Ston where there is another remarkable mediaeval wall which snakes up and down a Dalmaltian hillside, looking rather like the Great Wall of China on a smaller scale. Ston has a celebrated fish restaurant at the edge of the sea where we enjoyed not one but three plates of shellfish, starting with oysters, followed by a selection of clams, mussels, etc. and finally a dish of shellfish and prawn cooked in 'black rice' whose colour comes from the ink of the octopus, which tasted wonderful. And then came the main course in the shape of a delicious white fish cooked to perfection. There was also plenty of white wine ...

On the third day, we transferred to the Hotel Lero, where most of the Croatian doctors were staying. Here we had the International Federation Council meeting (see Minutes) which was followed by Marie-Anne Puel's paper. She started with an elegant and witty play on the French word *'temps'* which can mean either the time (*'le temps qui passe'*) or the weather (*'le temps qu'il fait'*). Then she drew on the blackboard a series of horizontal lines, each representing the passage of time for a patient with a circle for each encounter with the doctor. Some consultations were sunny, some were cloudy and one produced an electrical storm. Marie-Anne then led a group with one of the Croatian doctors as co-leader. The case concerned an intellectually impressive woman patient who made her psychotherapist feel he was competing with a professor who had treated her previously. When she wanted to postpone an appointment he was unable (or unwilling) to give her an alternative date without a long wait, and she did not come back. By this time we all know each other a little better and the discussion was much more relaxed and free flowing.

On our final evening together, Professor Kulenovic arranged a bus trip to the village of Clilipi which had been badly damaged in the war, with the destruction of its folk museum and the mutilation of its church. We talked about the war with one of the doctors from Sarajevo who told us that it was worse than a war against an external enemy because you found that neighbours with whom you had lived in peace for years were suddenly wanted to kill you. Families were also subjected to intolerable pressures when, as often happened, husbands and wives were from different ethnic groups. The mood lightened when we arrived at a delightful restaurant in a converted water-mill and had another delicious feast. On the bus back to Dubrovnik the Croatian and Bosnian doctors sang folk songs together, ending with a selection of French ones as a compliment to Marie-Anne.

Erica, Heather and I had to leave early the next morning to fly back to London and get back to our practices. We had a very enjoyable time and met some lovely people. Perhaps next year we will go to Sarajevo and help to launch a Bosnian Balint group ...

JOHN SALINSKY

Balint at the Tavistock, 1997

The two general practitioner consultants to the Tavistock Clinic, Andrew Elder and John Launer, recently organised a week's course for general practitioners entitled''Mind and Body'. Each of the five days of the course was focused around a particular aspect of the Tavistock's work – childhood, families, adolescents and the impact of psychoses.

The remaining day was entitled 'Balint and the return to clinical values' to which I was invited to represent the Society. The day was run on much the same lines as a 'mini' Oxford Balint Weekend. There was a fishbowl session first, led by Andrew Elder and Jane Milton, a Tavistock psychoanalyst. Rob Hale, consultant psychotherapist at the Tavistock, chaired the 'outer' group and also the final ninety-minute plenary session of the day. In between there were two sessions of case-discussions in small groups. Andrew and I co-led one group while the others were led by psychotherapists.

One of the most heartening aspects of the course was that the majority of the forty or so participants were young and enthusiastic (and female). I hope they would have come on the course anyway, but the cynical side of me makes me wonder if generous funding by LIZ EI money might have made a big difference. The small groups clearly went well, though there was some uncertainty about what was special about the experience – 'weren't our discussions on our trainee courses much the same?' It seemed to me that helping people to get in tune with Balint-work is like nurturing a delicate plant. The small groups were mainly nutritive but the plenary was not. In true psychoanalytic style, the allotted 90-minutes had to be stuck to precisely and there were some long and difficult silences broken by one or other of the resource people, including me, I'm afraid making some trite comment. The fish-bowl went well, the presenter being a highly experienced general practitioner from outside London (one of the few). Yet both in the case-discussion and the outer group there was a tension between risking criticism or sticking with collusion and 'being nice'. The doctor felt he risked losing the patient if he was critical of her outrageous behaviour and I felt we risked losing our colleagues if we appeared less than enthusiastic with their tendency to 'keep it cosy'.

I congratulate the Tavistock for running such a good day and, by all accounts, an excellent week. But next time I feel they should risk letting Balint-work speak much more for itself – leave it mainly to the small groups which is what it is about. It is *our* anxieties that lead us to need philosophical discussions about the method. We need the courage to nurture our young colleagues' agendas which are mainly about coping in tough inner London practices. I came away humbled both by how well they are doing and by their humility in wanting to do it better.

PAUL SACKIN

From the Annual Dinner, held on 19th June 1997

Address by the President, Dr. Paul Sackin

We now come to the dreaded moment when spontaneous conversation stops and you have to start listening to boring people like me. This must be particularly difficult for Balint-style doctors who surely come to an event like this to take a break from the listening that they do all day. Even worse, I am afraid that I am going to keep you for just a few minutes before handing over to our guest speaker, Dr. Kenneth Sanders.

So much for the bad news. Now for the first of the pleasant tasks I have to do tonight. One of the ways in which the Society has tried to promote the teachings of Michael Balint over the years is to offer a prize for an essay on a theme central to Balint's approach. Indeed, the title of the essay has usually derived from a Balint aphorism. This year is no exception, the title being ' So if there's nothing wrong with me, why does it still hurt?'

I can't help thinking that, as well as applying to our patients, this situation seems to sum up many people's feelings about general practice today. Has the job really changed that much for the worse, that recruitment should have become the problem it now is? So far as I know, nobody has carried out any psychologically centred analysis to help us understand the situation. Just as Balint helped general practitioners to understand their patients and became a crucial factor in the renaissance of general practice in the 1950s and 1960s, so there seems a need now to help understand the doctors better.

Just what motivates people to become doctors, and why do they choose to be (or not to be) general practitioners? Perhaps this might be the next task for Dr. Sotirios Zalidis, whose fascinating essay has won this year's prize. I congratulate him, and I am delighted to present Dr. Zalidis with his prize.

My next pleasant task is to welcome our two special guests. First, Dr. Jane Milton, consultant psychotherapist at the Tavistock Clinic. The Tavistock has, over the years, continued the tradition started by the Balints and has run seminars for general practitioners. These seminars have been the mainstay of Balint-training in this country. Yet they sometimes seem to have operated quite independently of the Balint movement as represented by this society. This is now changing and I know that Jane is one of those keen to establish relationships with others, such as ourselves, so that we can learn from each other and try to pull in the same direction. The Tavistock has recently made the enlightened move of appointing two consultants in general practice, Drs. John Launer and Andrew Elder. This has already done a great deal to draw us together and John and Andrew's "first phase" of work will culminate in 10 days' time with the first general practitioner Study Week at the Tavistock, entitled *Mind and Body* – General practice and psychotherapies: learning from each other. I was delighted to accept an invitation to take part in the day on *Balint and the return to clinical values* (see page 39).

Our other guest is Dr. Robert Kendell, President of the Royal College of Psychiatrists. If Balint-work is hardly flavour of the month in general practice at the moment, the psychiatrists have seen the light and, I believe, made Balint-style seminars an essential part of training for their speciality. We are delighted to welcome Dr. Kendell, and I hope this will be one of many contacts in the future between our Society and the world of psychiatry. We were hoping that our own College (of General Practitioners) would also be represented here tonight but unfortunately all the College officers are gathering in Nottingham tonight ready for their Council meeting tomorrow.

I hope that the increasing contacts with others will help to move this Society forward and make membership more attractive to younger general practitioners. The Society has done a great deal over the years to fulfil its main aim which is to follow the teaching of Michael Balint. I just wonder if our aim as we go into the next century shouldn't be more to *follow* the teaching of Michael Balint. With what? Perhaps there will be some answers at the International Congress which we are organizing in Oxford from September 9th to 13th next year. I hope to see all of you there.

Finally, I am delighted to invite Dr. Kenneth Sanders to talk to us. Dr. Sanders epitomizes the link between general practice and psychoanalysis to which I was referring earlier. His book "Nine Lives" beautifully describes, as its subtitle suggests "the emotional experience in general practice". I found it a fascinating and most refreshing read. Dr. Sanders, thank you for joining us here this evening, and thank you for talking to us about *The doctor's dilemma.*

The Doctor's Dilemma

Address by Dr. Kenneth Sanders

Thank you for inviting me to your annual dinner, and for your resilience in listening to my after-dinner speech.

John suggested that I might begin with some account of how I changed my identity from general practitioner to psychoanalyst. It has given me a theme – the dilemma of identity and the problem of finding a language to talk about it.

Here is a partly mythological account of my experience. In 1954, I was twenty-six years old, and free to return to real life after two conscripted years in the Royal Army Medical Corps. We had married young, and by then had two babies.

My next career move was settled by an offer I could not refuse – an assistant in general practice with a vague promise of a partnership – the vagueness was not uncommon in those days.

The practice premises in Willesden were out-dated and becoming ripe for the demolition which eventually occurred. The method of conducting that practice had one foot in the grave long before the war and the National Health Service. There was a back entrance to a cramped waiting room for the proletariat, and a front door to an arm-chaired saloon for the ten-shilling private patients. The house was built in the 19th century as a doctor's residence with attached surgery. Now *we* were in residence upstairs, while downstairs a frustrated housekeeper was confined to a back-kitchen and a converted air-raid-shelter as bedroom. These she occupied rent-free in exchange for her unpaid services. but she had hoped that the upstairs flat would come to her, and understandably resented that her duties included preparing coffee at eleven for the *parvenu* assistant, as well as for the irritable principal. It was not long before I realised that the chief drawback to the work of a doctor is having to spend time with patients.

I mean patients who really complain, and do not have the grace to do it in verse like this:

I'm bitter, querulous, unkind
I hate my legs, I hate my hands
I do not yearn for lovelier lands
I dread the dawn's recurrent light
I hate to go to bed at night
I snoot at simple, earnest folk
I cannot take the gentlest joke
I find no peace in paint or type
My world is but a lot of tripe
I'm disillusioned, empty breasted
For what I think, I'd be arrested
I am not sick. I am not well
My quondam dreams are shot to hell
My soul is crushed, my spirit sore
I do not like me any more
I cavil, quarrel, grumble, grouse
I ponder on the narrow house
I shudder at the thought of men
I'm due to fall in love again

Symptom Recital D. Parker

To one morning surgery came a harassed mother with 6-years old Jane. Jane had let it be known that her Teddy Bear talked to her in bed at night – was this a matter for concern?. As a matter of fact she had not really taken it seriously until yesterday evening, when Jane had suddenly shouted 'Look Mum, there's our doctor on the telly.' Mother looked and saw only a picture of women soldiers on the parade-ground.

But I knew what that was about. My identity for the preceeding two years had been Captain Sanders, RAMC. During my posting to the WRAC depot, I had been filmed for a few seconds with a stethoscope round my neck, in a recruiting film. This must have been on the television the night before. I was able to be reassuring about that.

But later, it occurred to me that under the circumstances, it might have been a good idea to check up on that Teddy Bear.

In fact, the teddy bear question has been the subject of erudite debate by psychoanalysts for many years. Teddy bears and their more grown-up equivalents play a crucial role in human nature, there is an appeal in inanimate objects – or for that matter, for being inanimate – in that loss or damage rarely matters, compared to the depression associated with having lost or mislaid another human being.

In those early days in general practice in Willesden, the idea of depression as the premier problem to be understood was not clear to me. Here is a poem entitled,

A poem intended to incite the utmost depression

Cervantes, Dostoievsky, Poe
Drained the dregs and lees of woe
Gogol, Beethoven and Keats
Got but meagre share of sweets
Milton, Homer, Dante had
Reason to be more than sad.
Caesar and Napoleon
Saw the blood upon their sun
Martyr hermit saint and priest
Lingered long at Sorrows' feast
Paid with pyre and perishing
For every feather in each wing.
Well, if such as these could be
So foredoomed to misery
And Fate despise her own elect –
What the deuce do you expect?

Samuel Hofferstein

In those days, I hoped to find a solution to this doctor's dilemma in the jobs columns of the British Medical Journal, and scanned them before, or rather instead of reading any of the articles. That habit has altered – as a Life Member of the British Medical Journal, I still receive the journal but now only read the obituary columns.

One fateful day – a day that altered the course of my life – I saw the announcement placed by the Tavistock Clinic about seminars for general practitioners. As I drove in my black Ford Consul through the dark streets of Willesden, the brighter ones of Cricklewood, the lovely ones of Swiss Cottage, and the elegant ones of St. John's Wood to Marylebone – the Tavistock Clinic was then in Beaumont Street – my spirits rose with the proximity to Harley Street. At the clinic, I met Dr. Balint and Dr. Turquet, and having been introduced to their method, felt at once that sense of anticipation and relief that Dr. Balint has described in his famous book.

Perhaps I might after all grow into the sort of doctor for which Auden had expressed a need:

> Give me a doctor partridge-plump,
> Short in the leg and broad in the rump,
> An endomorph with gentle hands
> Who'll never make absurd demands
> That I abandon all my vices
> Nor pull a long face in a crisis,
> But with a twinkle in his eye
> Will tell me that I have to die.
> I felt I could do that.

The first case I took to the seminars was a quietly spoken, dark, handsome man only a few years older than myself. He had lost the use of a leg and could not drive his van. According to the hospital notes, it was nervous or hysterical. I began to talk to him in the prescribed way after surgery. He was gloomy and depressed and I felt sorry for him. Then a breakthrough – he confessed that he had been in prison for stealing money from his employers, and the limp came on after that. But this cathartic confession, to my disappointment made no difference, until I carried back to him Dr. Turquet's intuition that he was frighted that he would steal again if he went back to work. the patient agreed with this, his limp was cured and I did not see him again. I was most impressed – why didn't I think of *that?*

When I presented myself at the Institute of Psychoanalysis, they admitted me with some misgivings and shuffling of papers. The other applicants then, as now, were mostly young psychiatrists who greeted me, when we met, with variations on the theme of 'who let you in?'

In my second year there, Dr. Balint led a clinical seminar. He regarded me kindly but quizzically – I think he also thought that perhaps there was a mistake on someone's part.

The irony of the situation was that by the time I qualified as an analyst, I found that I loved general practice although the premises took a long time to improve, and the patients never did. I decided to combine both activities, until I retired from general practice ten years ago. The ghost of my identity as a general practitioner is as exotic to my analysands as the reverse case, when – as I expect you have experienced – if I spent more than two minutes with a patient in general practice about emotional confusions, they would ask suspiciously if I was 'a psychiatrist or something'.

In the preface to his play The Doctor's Dilemma, Shaw defines it as the absence of a National Health Service, compelling doctors, he says, have to make a living by inventing diseases and then over-charging for curing them. This enduring suspicion originally directed to the commercial instincts of the church, and passed from them to the doctors, has now come to rest in its proper place – the suspect practices of the psychoanalyst!

In honour of Shaw, I quote from *Man and Superman*

> 'The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man'.

The psychoanalyst and his partner on the couch, take account also of inner reality where if one is to get to grips with it, more unreasonableness is required – it is not a question of adaptation, but of tolerating a mystery. The doctor's dilemma I define for this evening as: how to converse with each other and our patients about the mind when we are not poets?

Here are two attempts by poets to tell us something psychoanalytical – the first is the familiar, William Blake's Infant Sorrow, illustrated by him with a coloured print of an infant resisting being picked up by an upset looking mother:

> My mother groan'd my father wept
> Into the dangerous world I leapt
> Helpless, naked, piping loud
> Like a fiend hid in a cloud
> Struggling in my father's hands
> Striving against my swaddling bands,
> Bound and weary I thought best
> To sulk upon my mother's breast

From this poem, we learn how people may come to analysis when they are truly desperate, 'bound and weary, thinking it best to sulk – upon the analyst's couch.'

Two hundred years later, a poem by Thom Gunn speaks of the link between birth and the awareness of the passage of time:

Baby Song

> From the private ease of Mother's womb
> I fall into the lighted room.
> Why don't they simply put me back
> Wher it is warm and wet and black?
> But one thing follows on another
> Things were different inside Mother
> Padded and jolly I would ride
> The perfect comfort of her inside.
> They tuck me in a rustling bed
> – I lie there, raging, small and red.
> I may sleep soon, I may forget,
> But I won't forget that I regret.
> A rain of blood poured round her womb
> But all time roars outside this room.

Like the infant in this poem, a patient complained to me of the noise from a neighbour – probably me talking. He noted with some confusion that I always seemed to take my holidays when he needed me most – he was unable to relate his separation anxiety to waiting for time to pass. He had not yet, in the poet's words, 'fallen from the private ease of the mother's womb'.

Confusion of identity continues after birth, when children with their gift for mimicry added to indomitable curiosity, both play at being grown-ups and if allowed, trespass on parental privacy and prerogatives. The establishment of boundaries to minimise confusion is therefore important to them.

This was the subject I chose the last time I was invited to speak to an audience of general practitioners. It was not as convivial an occasion as this. In fact they were attending a rather dreary course called 'Identifying psychosexual problems in general practice.'

One of the topics I identified was confusion in the minds of children about the difference between their own and their parents' sexuality, and suggested that children become over-excited if exposed to parental nudity and sexual activity. I realised during the question-time that followed, that there was a turbulence in the audience – a doctor speaking from near the back row wanted to know whether there was any support for his feeling that I ought to be reported to the General Medical Council? So I intend steering clear of sexuality in the rest of this talk and concentrate, not on the genital area, but on the oral aspect of psychoanalysis ...

Especially after this excellent dinner, it seems appropriate to speak of matters concerned with eating – and being eaten.

You will remember that after the unfortunate incident behind the arras, when Daddy Polonius was accidentally killed by Oedipus – Hamlet, he replied very cheekily to his step father's enquiry into the incident.

> 'Now Hamlet, Where's Polonius?'
> 'At supper.'
> 'At supper? Where?'
> 'He's at dinner – not where he eats, but where he is eaten'.
> Hamlet warms to his theme:
> 'A man may fish with the worm that hath eat of a king and eat of the fish that have ate of that worm'.
> 'What dost thow mean by this?'
> 'Nothing but to show you how a king may go a progress through the guts of a beggar.'

This model of metabolism applied to emotional experiences – the idea that they are subject to a kind of mental ingestion, digestion and excretion can be very helpful, in following the events of an analysis.

Here is a dream from a young man getting used to the idea that 'one thing follows from another and things were different inside mother.'

Near to the end of several years' work together, he was conscious of the 'roaring of time' – that is, that our time together was limited.

His dream was of a rendezvous with a girl in a bedroom, but when he threw back the duvet he found to his horror that at the front she was human, but the back-half was an alien creature resembling a lobster. I understood from this that he was experiencing some loss of emotional appetite.

Soon after, he dreamed that he was at a boarding school where the teachers were cannibals and were fattening him up. He leapt out of the window and escaped.

These dreams enabled us to discuss his confusion about the analytic mind-breast – where he eats or where he is eaten?

The distinction between eating the one you love and digesting the experience of love was in the process of becoming an unconscious revelation to him. Expressed in another way, if you don't eat the breast but just drink the milk, you escape from guilt and leave the breast undamaged for others to use after you.

Freud's greatest discovery was the transference, It is an impression left on the mind by the abrasive or affectionate contact with another; and if you can bear it, it leads to understanding the other's point of view. Because of the infinite variety in individual use of symbols, communication about emotions is the metier of the artist, rather than the physical scientist.

I conclude with a symbolic solution to the eat or be eaten problem proposed by a patient – the model of a dentist's mould or impression which you are invited to bite into to show where the trouble is with your teeth. But the mould – unlike another mind, or the mother's breast – is not sensitive, and it is the fear of causing damage to another person – even symbolically – that is such a potent source of anxiety.

We arrive at one possible way of stating the patient's and the doctor's dilemma – how to find a way that is bearable for both of them to expose themselves to the risk of being eaten, in order to digest the experience and allow the dialogue to continue.

To conclude, I hope that nothing I have said will lead you to think that the fellow in the audience last time was right and that I should be reported to the General Medical Council or, for that matter, to the Institute of Psychoanalysis!

Programme of Meetings of the Balint Society for the Twenty-seventh Session 1997-98

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. Chess DENMAN, Consultant Psychotherapist, Cambridge
'C.A.T. in General Practice.' 25 November 1997

Jane OGDEN, Ph.D., Health Psychologist, Department of General Practice
UMDS Guy's and St Thomas'
'For my patients, other GPs or myself: the role of self-other distinctions in making a diagnosis of a psychological problem.' 10 February 1998

Dr. Heide OTTEN, Secretary, German Balint Society.
'Balint-work at the Tavistock Clinic' (provisional title). April 1998

Other Events

The Oxford Balint Weekend, 1997 12-14 September 1997
Will take place at Exeter College, Oxford:
from Friday, 12th September at 6 p.m.
to Sunday, 14th September at 1 p.m.
and **The 28th Annual General Meeting of the Society will take place at 12 noon on 14th September 1997.**

London Balint-Day for Practice-nurses May 1998
at the Hospital of St. John & St. Elizabeth.

Balint Society Annual Dinner, 1998 23 June 1998
will take place at the Royal Society of Medicine
(Full details for these meetings will be announced later)

The XIth International Balint Congress will take place at Exeter College, Oxford on 9-13 September 1998
(For further details, see page 27)

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

Guidance for Contributors

All manuscripts 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.

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

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