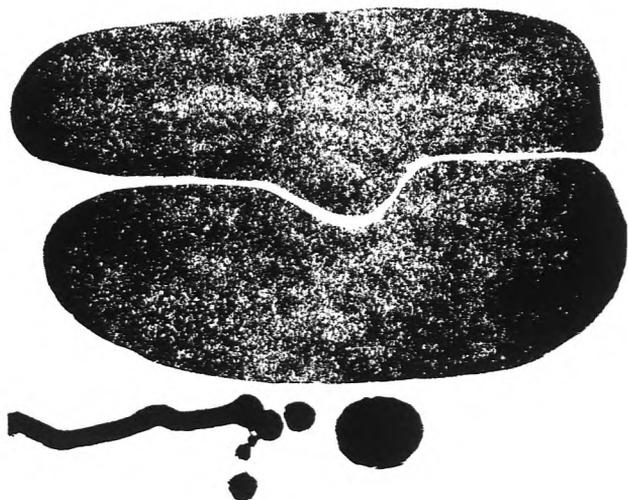


# Journal of the Balint Society

2006



Vol. 34

# JOURNAL OF THE BALINT SOCIETY

Vol. 34, 2006

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Assistant editor: Mary Salinsky  
Editor emeritus: Philip Hopkins



**Balint Weekend at Whalley Abbey, Lancashire, June 2006.**

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## **The Balint Society:**

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is an annual residential weekend at Oxford and at Chester. Occasional weekends and study days are held elsewhere in the country.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

# Programme of Meetings of the Balint Society for the Thirty-seventh Session, 2006-2007

## Lecture series 2006-2007

All lectures are held at the Royal College of General Practitioners

14 Princes Gate, London SW1 1PU

Time: 8:30 p.m. (with coffee from 8.00 p.m.)

Dr Diana Bass, psychotherapist and Balint group leader  
'Cross-cultural psychotherapy' Tuesday 24 October

Dr Helen Halpern, GP and therapist  
'Narrative approaches to supervision' Tuesday 21 November

Dr Cecil Helman, GP, anthropologist and author  
'The narratives of medical consultation' Tuesday 13 February

Dr Gill Baker  
'Skin and psychosoma' Tuesday 13 March

**The 17th Michael Balint Memorial Lecture:**  
**'Psychoanalytic models of the mind in primary care'**  
will be given by **Dr Kenneth Sanders, psychoanalyst and former GP** on **Tuesday 17 April**  
Preceded by drinks and buffet from 7.30 pm

**The Group Leaders Workshop** will meet at the Tavistock Clinic, Belsize Lane, London NW3 at 8.30 pm on 5 December, 22 February and 22 May

There will be a new **Balint Weekend in Newcastle** from 20-22 April 2007

**The Lancashire (formerly Chester) Balint Weekend 2007** will be held from 15-17 June at Whalley Abbey, near Clitheroe.

**The Oxford Balint Weekend 2007** will be held at Exeter College in September  
(Exact dates to be announced)

The **Annual Dinner** will be held on Tuesday 26 June 2007 at The Royal Society of Medicine

Further information from the Hon. Sec. Dr. David Watt.

## THE BALINT SOCIETY WEBSITE

The Balint Society has its own internet website.  
The address is [www.balint.co.uk](http://www.balint.co.uk).

Unlike some addresses, this one is very easy to remember and to find.

When you have located it on your computer (if in doubt ask any eight year old child)

You will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news

about the next International Congress. See also the INTERNATIONAL BALINT FEDERATION WEBSITE:  
[www.balintgesellschaft.de/ibf](http://www.balintgesellschaft.de/ibf)

- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on [www.balint.co.uk](http://www.balint.co.uk) you can easily go to the American, German, Finnish and International Balint websites. More are coming all the time.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to [www.balint.co.uk](http://www.balint.co.uk)

## Editorial

### Room for Balint in the curriculum?

The Royal College of General Practitioners has produced a draft curriculum for education which is available on the College website. Those with an interest in GP education were invited to comment on the draft and thus contribute to its final shape. This consultation closed in January 2006 and at the time of writing the final version has yet to be published. Although the curriculum details many 'competencies' that the future GP should quite rightly be able to demonstrate, it also has an extensive section discussing what sort of person a GP needs to become with the help of this education.

If our Society was asked to redesign the GP curriculum we should be in no doubt about the priority. We would wish to help our young doctors to understand the importance of the emotions in clinical practice; to be aware of their own feelings as well as those of their patients and to be able to manage those emotions without being overwhelmed or disabled. We would provide this education by offering at least a year of Balint group experience to all trainee family doctors. After all this can be done in Germany (Otten) and increasingly it is happening in the USA. (Johnson) Why couldn't it happen here, in the land where Balint groups began?

We already have, in the network of half day and day release courses in Vocational Training, a perfect setting for Balint groups to take up residence.

All GP registrars and SHOs have at least half a day a week away from hospital wards and practices in which to come together for education. Small group work is already encouraged, thanks, almost certainly, to the earlier influence on the culture of Balint pioneers. Most of these groups are not Balint groups as we know them and they do not have Balint trained leaders. Some course organiser group leaders would indignantly deny any connection with Balint. All the same, many of them provide ongoing emotional support in a confidential setting, surely one of the most important functions of our own groups. Could we not help them to go a little further and learn how to guide a group towards a better understanding of the emotions that complicate the doctor patient relationship?

Here we begin to encounter difficulties. If we talk to GP educators, and read some of the many books on consultation skills, what do we find? First of all we are pleased to discover that Balint work is respected and its importance is readily acknowledged. But only in a historical context. Balint, they imply, is to the consultation as John Logie Baird is to television: right ideas but hopelessly outdated technology. Balint, they say, taught us that the consultation should be patient-centred; but nowadays we can see consultations on videotape and there is no need to spend hours discussing them at second hand. (I

say videotapes but by the time you read this the registrars will probably be recording them on their mobile phones.)

Can work on consultation skills really teach you about the emotions? We don't think so. You can learn to recognise the signs of emotion (a catch in the voice, brushing away an unformed tear) and how to respond appropriately, but this is not the same as learning to manage one's feelings. A patient's feelings may be potentially devastating and the doctor's reaction may be simply to shut down his limbic system while continuing to provide the correct responses at the behavioural level. At times he will be ambushed by a potent interaction between the patient's emotions and his own, and all the rules will be forgotten.

What is needed is an opportunity to discuss these encounters with a group of one's peers under the guidance of a trained group leader with some knowledge of psychodynamics and what is now called 'emotional intelligence'. Looking at a video and ticking off the required behaviours is no substitute for the application of intelligence to an emotional experience.

Having disposed of the 'Balint has been replaced by video' argument we may come up against further objections. There is still a subterranean prejudice against Balint which lurks in the minds of many GPs. These doctors view the idea of doctors sitting round in a group discussing their feelings with suspicion and distaste. The phrase 'navel-gazing' crops up. The practice encourages too much introspection and fruitless speculation. It can't be healthy. These doctors should get out in the fresh air more often. Then some of our critics tell us they have 'heard stories' about group members who have been subjected to psychologically damaging interrogations by insensitive group leaders who have forced them to disclose details of their personal lives. Although this sort of thing may happen in some unregulated groups, anyone who has been in a group recognised by the Balint Society or the International Balint Federation will know that we don't behave like that. Our group culture and our group leader training guidelines regard protection of group members as paramount. So why do these stories persist? Perhaps they are related to the equally widespread negative feelings about psychoanalysis and the belief that Freud's ideas have been totally abandoned. The truth is that while formal psychoanalysis may be out of the question for more than a tiny minority of patients, Freud's ideas continue to inform the way we think about our emotions and our relationships. To give only one example, we all recognise that our 'unconscious' feelings have a powerful capacity to emerge and take us by surprise.

How should we respond to the tendency

for Balint work to be relegated to the museum by medical educators? Can we convince them that our groups are not dangerous, have a vital role to play in GP education and can easily fit into the present structure? Should we not speak out at this time of seismic curricular upheaval? You will be pleased to hear that we have done so and had a cordial reception. As a result of the Society's submission Balint has been favourably mentioned in the curriculum and recommended, although not actually prescribed. You can read the Balint Society's response to the draft curriculum on

page x. You will also find in the Journal the American Balint Society's statement on the way Balint training actually teaches some of the competencies required by the curriculum for family medicine training in the USA. We urge our readers to take every opportunity to discuss the benefits of Balint with GP educators.

#### **References:**

- Otten H. Balint work in Germany. *J Balint Society* 1998; 26:16-19.  
Johnson A H et al. The current state of Balint groups in US family practice residencies: a ten-year follow-up 1990-2000. *Family Medicine* 2001; 32: 672-677.  
The New RCGP curriculum [www.gpcurriculum.co.uk](http://www.gpcurriculum.co.uk)
-

# A response to the 'consultation' section of the RCGP draft curriculum for GP training, 2005 from the Council of The Balint Society

1. We welcome the draft curriculum as a very thoughtful setting out of the personal qualities, educational background, responsibilities and competencies which make up the kind of doctor that all general practitioners at the present time should aspire to become.
2. We were pleased by the recognition in the curriculum statement of the importance of the emotions in medicine and the consultation. In the words of Ian McWhinney:  
'There are good reasons for patients to pay attention to the emotions... Once we learn to listen our clinical method requires us to listen to the emotions in every case. It cannot do otherwise. We will no longer be able to live with the affect-denying clinical method that dominates our medical schools.'<sup>1</sup>  
In the draft curriculum the importance of the emotions is underlined in the following sentences:  
'Patients have strong feelings when they are ill and consult a doctor'.  
'A sick patient is not a broken machine'.  
'The doctor should show a constant willingness to enter the patient's 'life world' and to see the issues of health and disease from a patient's perspective.'
3. We would like to see some space in the curriculum devoted to the teaching of 'emotional intelligence'.<sup>2</sup> It seems to us that, while we have become expert at teaching behavioural skills in the consultation, we are neglecting (at our peril) the powerful emotional component of the doctor patient relationship. This is important not just to provide good single consultations but to achieve good continuity of psychological care.
4. Consultation skills may enable a GP to recognise distress in a patient, but the recognition may be purely intellectual. The doctor's own emotions may switch off as an automatic defence.<sup>3</sup>
5. To respond effectively, the doctor needs to have an emotional response himself but one that does not get out of control and disable him e.g. by making him feel overwhelmed by the patient's grief, or too angry with him to function properly.
6. The doctor needs to listen but also to hear and to absorb the emotions without breaking down or reacting negatively. The doctor must be able to act as 'a container' for powerful feelings such as distress, grief, anxiety or anger, much as a mother is able to contain the crying of her baby.
7. To meet these needs which occur frequently in general practice, GPs need education in emotional intelligence, that is the ability to be aware of emotions in oneself and others, to contain them safely and to respond in ways that are empathetic and constructive.<sup>2</sup>
8. We do not believe that the present system of teaching consultation skills teaching is sufficient because it is essentially behavioural i.e. it teaches behaviours rather than the awareness and management of emotions. How might these more subtle qualities and skills be taught?
9. The curriculum already acknowledges the value of small group work in the vocational training release course. These groups are already in place in most VTS schemes and they provide a ready-made setting and structure for this kind of education.<sup>4</sup> But the small groups need to be led in a way that focuses at least some of the time on emotional education. Educators need the necessary skills.
10. The Balint group is a highly developed and tested method of small group consultation analysis which aims specifically to focus on the emotional content, not just of single consultations but of ongoing doctor-patient relationships.
11. We would recommend that the Balint group or something like it has an important part to play in teaching the new curriculum.
12. Michael Balint was a psychoanalyst and the first Balint groups were led by psychoanalysts or psychotherapists. Many group leaders in the UK are now experienced GPs. We would be very willing to help with training for small group facilitators including VTS course organisers which will equip them to lead a group according to the principles and practices developed by the Balint Society.
13. The aims of a Balint group (as recognised by the Society) are:

- To provide a safe environment where group members are able to talk in confidence about the feelings aroused in them by their patients.
  - To encourage the doctors to see their patients as human beings with a life and relationships outside the surgery and a history going back to childhood which has helped to determine what they have become.
  - To help the doctors to explore in detail the emotional content of their interaction with a particular patient: to understand how their behaviour and reactions have been unconsciously affected by the feelings projected by the patient and resonating with those of the doctor.
  - To help them to learn how to contain a patient's feelings even when these are uncomfortable and to tolerate feelings such as helplessness and anxiety.
  - To help them to understand how a distressed patient may need to be held and supported in ongoing therapeutic relationship in a series of consultations with the same doctor over a period of time.
14. Doctors who have had the experience of Balint training will attest to the life long benefits that it can bring in terms of interest in patients' lives, self knowledge, job satisfaction and prevention of 'burn out'. A growing body of research evidence supports the effectiveness of Balint training in many countries.<sup>5,6,7,8</sup>
15. Objections to Balint.  
Some GP educators seem to dismiss or distrust the Balint method in spite of its obvious advantages. Some acknowledge Balint's important historical role but regard it as too time consuming and impracticable. There is a widespread view that it has been 'replaced' by the analysis of recorded consultations. A more extreme view is that the Balint group can be psychologically damaging. This view holds that the group and especially its leaders may be too intrusive in doctors' personal world, upsetting their stability and damaging their defences. Some people recall 'incidents' in which a group member was pressed into a personal disclosure which he or she found upsetting and had cause to regret. In any case, too much introspection and 'navel-gazing' is seen as self indulgent or even unhealthy. The influence of psychoanalysis is seen to be harmful. It is not 'evidence-based' and its practitioners are thought to be reliant on outmoded theories.
16. The reality of Balint groups today is somewhat different. Groups are organised and regulated by the Balint Society whose founder members were GPs trained by the Michael and Enid Balint. They also contributed to the ranks of the first generation of GP course organisers and helped to establish the tradition of small group work in Vocational Training Schemes.
17. Balint Society leaders are trained to respect the emotional safety and integrity of all group members. They do not go in for psychological intrusiveness and they protect the group from any activities of this sort from group members. They establish a culture of confidentiality, safety and respect. The focus is always on the doctor patient relationship and not on the doctors' personal lives. Everyone is free to use their imagination to explore the meaning of the clinical material presented. Interpretations based on a particular theory are rarely heard. Jargon is discouraged. Everything is very down to earth.
18. Nevertheless the discoveries of psychoanalysis remain an important influence as they do in psychotherapy, counselling, social work and teaching. Not all of Freud's ideas are out of fashion. Most psychologists and educators would agree that:
- Parts of the human mind are active below the surface of consciousness with a capacity to trip us up by betraying our true feelings.
  - Truths may be expressed as metaphors
  - We often attribute our own unacceptable thoughts and feelings to other people.
  - One person's emotions may affect another more powerfully than is realised at first
  - We can all hold opposing desires or attitudes at the same time.
  - Patients will frequently respond to the concerned attention of a clinician by transferring to him or her, some powerful emotions which originally belong to parents or other important figures from childhood.
- To summarise we believe that:**
- **Emotional Intelligence needs to be taught and provision for its teaching should be included in the new GP curriculum.**
  - **The Balint group method provides an excellent method for teaching emotional**

intelligence to GPs in training.

- **There is good evidence both from personal experience and research of the beneficial effects of Balint group participation.**
- **Balint work can be fitted in to the existing structure of small group work in VTS courses**
- **Course organisers and others can be trained in the principles of Balint group leadership with the help of the Balint Society.**
- **The objections to the Balint method that it is too rooted in out dated psychological ideas are misguided and unfounded.**

We would like the curriculum group to consider including a recommendation that Balint group experience should be included, where possible, in the small group work provided in vocational training for general practice.

On behalf of the Balint Society:

John Salinsky, Editor,  
The Journal of the Balint Society

Lenka Speight, President

David Watt, Secretary

Paul Sackin, past President

Andrew Dicker: member of council

Heather Suckling: General Secretary of the  
International Balint Federation

**February 2006**

#### **References:**

- 1 McWhinney I. (1998) The Physician as Healer: the Legacy of Michael Balint. In: *Proceedings of the 11th International Balint Congress*. Limited Edition Press: Southport, pp. 63-69.
- 2 Goleman D (1996) *Emotional Intelligence*. Bloomsbury: London.
- 3 Salinsky J and Sackin P (2000) *What are You Feeling Doctor?* Identifying and avoiding defensive patterns in the consultation. Radcliffe Medical Press: Oxford.
- 4 Gidekel L, Topolevski L, Abecasis G and Giovannoni A (1998) Balint group operation in Internal Medicine Residents of an Emergency Hospital. *Proceedings of the 11th International Balint Congress*. Limited Edition Press: Southport, pp. 134-150.
- 5 Matalon A, Rabin S and Maoz B (2005) *Communication, Relationships and Balint groups*. In: *Proceedings of the 14th International Balint Congress*. International Balint federation and the Swedish Association of Medical Psychology: Stockholm. pp. 25-29.
- 6 Kjeldmand D (2004) Balint training makes GPs thrive better in their job. *Patient Education and Counselling* **55**: 2: 230-235.
- 7 Samuel O, Sackin P, Salinsky J, Suckling H, McKee A and Pinder R (2004) Balint in GP Vocational Training Schemes. *Work-Based Learning in Primary Care* **2** 26-35.
- 8 Pinder R, McKee A, Sackin P, Salinsky J, Samuel O and Suckling H (2006) *Talking about my Patient: the Balint approach in GP education*. Occasional Paper 87: RCGP Publications: London.



# American College of Graduate Medical Education (ACGME) Competencies and Balint Work in Family Medicine Residency Programs

Meda Rebecca, Richard Addison, Frank Dornfest, Mary Hall and Donald Nease  
*(reproduced by kind permission of the American Balint Society)*

The ACGME and the American Board of Medical Specialties require that residents demonstrate competency and minimum skills in specific content areas. Under the ACGME plan, all medical specialties share the same six Core Competencies and twenty-five associated required skills. In order to meet these requirements, residencies use a number of teaching methods. Balint is a method that addresses many of the ACGME core competencies and associated skills. Because Balint work can train resident physicians in both ACGME core competencies and RRC curricular goals, the American Balint Society supports making Balint training a mandatory part of the Family Medicine residency curriculum.

## 1. What is a Balint group?

The Balint group process is an experiential model in which residents meet regularly to examine the doctor-patient relationship. Group members listen to the presenting doctor's story and then discuss the case, with a concentration on the physician-patient relationship. The purpose of the group is to help the physician understand the physician-patient relationship rather than to advise the physician on treatment options. This process may also provide important information about the patient's feelings. Balint groups are a unique way to examine difficult situations in a non-threatening way. The group provides the opportunity to sit with uncertainty and complexity without pressure to arrive at an answer and without diminishing one's sense of self-worth as a physician. Being able to tolerate uncertainty is a necessary and important component of the maturation of physicians. In addition, resident-physicians frequently understand the doctor-patient relationship in a more empathic way, and so are able to rekindle therapeutic efforts with patients. As a result of working in a group over a period of time, resident-physicians can recognize their habitual patterns of behavior with various types of patients. Balint work encourages self awareness and self reflection and helps residents to learn when to examine their reactions to an interaction with a patient.

## 2. How does the Balint Group satisfy the ACGME core competency requirements?

The numbered list below enumerates the skills and attitudes enhanced or encouraged by Balint groups. The list of core competencies in the following table indicates the various ways these skills satisfy the ACGME core competencies.

1. Improves listening skills with both patients and colleagues
2. Encourages integrative, creative and divergent thinking leading to novel approaches to recurring problems
3. Encourages empathy; empathic skills are modeled; residents are able to experience themselves in the place of both the patient and the physician
4. Improves observation skills
5. Develops and encourages a repertoire of behaviors that may be therapeutic for a variety of patients
6. Increases sensitivity to and skill in addressing psychological aspects of the patient's illness
7. Improves ability to hear and react to difficult cases of colleagues in a supportive manner
8. Demonstrates a method for appropriately expressing frustration, pain and joy
9. Encourages camaraderie and intimacy among group members, thereby enhancing team work, communication and mutual support
10. Encourages self-reflection
11. Encourages self-evaluation
12. Improves satisfaction of practicing physicians

PATIENT CARE (1, 2, 3, 4, 5, 6, 10, 11, 12)

MEDICAL KNOWLEDGE (2, 5, 6)

INTERPERSONAL AND COMMUNICATION SKILLS (1-11)

PROFESSIONALISM (1-4, 10, 11, 12)

SYSTEMS-BASED PRACTICE (2)

	1	2	3	4	5	6	7	8	9	10	11	12
<b>PC</b>	X	X	X	X	X	X				X	X	X
<b>MK</b>		X			X	X						
<b>ICS</b>	X	X	X	X	X	X	X	X	X	X	X	
<b>P</b>	X	X	X	X						X	X	X
<b>S-BP</b>		X										

3. How does Balint meet the Behavioral Science curriculum goals required by the RRC?

Having a Balint Group experience in the curriculum satisfies curricular requirements listed in the program information form used to prepare for an RRC site visit. The following competencies are listed in the PIF and are part of the Balint group experience:

- components of family structure
- family structure and dynamics
- development
- end-of-life issues
- role of the family in illness care
- emotional aspects of non-psychiatric disorders
- the physician-patient relationship
- normal psychosocial growth and development in individual and family
- stages of stress in the family lifecycle
- sensitivity to gender, race, age and culture differences in patients
- medical ethics including patient autonomy, confidentiality and issues concerning quality-of-life
- factors influencing patient compliance
- growth and development from newborn to

adolescent

- management of emotional problems in children
- socio-cultural parameters in the older patient

The American Balint Society offers two pathways for training in Balint group leadership. A Balint Leadership Training Intensive is a four-day didactic, experiential and analytic course to introduce and refine the skills of Balint group leadership for physicians, residents and behavioral science educators. To develop more complete skills, leaders are encouraged to apply to the Balint Leaders Credentialing process, which provides developing leaders with supervision in the attainment of more in depth skills. The Council of the American Balint Society endorses leader training to ensure integration of the ACGME core competencies and the RRC curricular goals into Balint training for residents.

The American Balint Society website is:  
<http://family.musc.edu/balint>

# A Conversation with Ruth Pinder

(Ruth Pinder is the principal author of the recently published RCGP Occasional Paper No 87: *Talking about my Patient: the Balint approach in GP education*. She was talking to John Salinsky)

**JS:** Can you tell me first of all how you came to ethnography?

**RP:** It's quite hard to pinpoint a particular moment when it happened. I started my academic career quite late: late 30s, early 40s. I started off with sociology and law and found myself uncomfortable with the level of abstraction with which sociologists often work. They seemed to have no relationship with what goes on in everyday reality, the messy world. They talk in abstractions that go careening above real life and I found myself drawn increasingly to anthropology. Anthropologists use ethnographic understandings much more. And in the last ten years or so I started to teach at the Open University. It's quite a good course. It comes from cultural studies rather than anthropology so it's quite Euro-American. It doesn't have beginning and end points. I honestly can't remember when I became fascinated with ethnography. But I get very cross if it's seen as a set of techniques. I think it's a lot more than that: it's keyed into some important debates about how we go about representing others and the problem of translation. For me it's a way of doing life almost in the way that I began to think that Balint was a way of being and doing as well. An embodied kind of understanding of the world. Not an application of techniques.

**JS:** Did you know anything about Balint before you started our project?

**RP:** Well I had heard of him, you got me wrong there! I remember I'd seen the book somewhere. But I hadn't done much with it. I remember there were some quite derogatory references to it in sociology! So yes I rather bypassed it. And then this colleague of mine told me about the post and said he didn't want to do it which was interesting in itself; I'm not sure what reverberations that set up in me but I thought it would be interesting to do.

**JS:** So how was your reception by the Balint world?

**RP:** Difficult! Well, you would remember it yourself probably. Rushing in to inscribe, I did that too quickly. The sort of things that happen to ethnographers there are the sort of things that are actually happening already. In a sense you act as a kind of catalyst for them. The idea that Balint only takes place in proper Balint groups, that it can only be known in a single place. You do Balint all the time, as I do ethnography. We do old things in new places. One of the things I found very difficult was the privatising of emotions, with all the stress on being the

individual person. Because of the stress on the individual doctor and patient you lose a sense of a person's history and the context in which they think about things. I suppose I think to deprive somebody of their history is the very stuff of objectifying people.

**JS:** How did you feel sitting in with the registrars' Balint group?

**RP:** I didn't mind that. I think it was difficult for the group leaders to have anybody in. Terrible stress from evaluation; one of the things I did think was happening was that 'what Balint is' seems to be increasingly shaped by the evaluation industry. I noticed this at the Stockholm International Congress. One of the presenters was asked, well did it have an effect? I didn't think Balint was about having an effect. At least the kind of effects one can produce are the easy things.

**JS:** But sometimes people will say, I learnt something that I hadn't thought of. I'll try that.

**RP:** I suppose that's fair enough. But I tend to think how long things take to say what they mean to us rather than how quickly. They are mostly long after the fact. And they only ever come in fragments.

**JS:** But there is a pressure to show that what we are doing can achieve results.

**RP:** I understand the pressure but I think it's unfortunate because it seems to compress the value of what you have to offer. Make it almost banal; make it dance to a tune that is not meaningful to it.

**JS:** We should really be trying to interest our paymasters in a different tune or the value of a different way of doing it. You can't really reduce it to a set of numbers anyway, so why pretend that you can.

**RP:** Well not even to a set of numbers, to a set of invariant responses. The single invariant response; that's not the way the world works. A set of determinate answers. But all is flux, is it not, all the time. The essence of knowledge is that it is continually being turned topsy-turvy with the ground shifting under your feet. I guess I found the search for determinate answers difficult with the project.

**JS:** Well I think that is largely the result of this kind of outside pressure.

**RP:** Yes, I remember somebody in Sweden saying something about 'changing behaviours' and I think I was quite pious; I said I wasn't 'comfortable' with it. That word comfortable that comes from assertiveness language, which is a bit grim but we are trying to impose our own meaning systems on the world the whole time, are we not? And if I thought I wasn't in the business

- of doing that too, I'd be fooling myself. We're all in the business of trying to make the world over in our own image, are we not? Little tyrants, I think we are.
- JS:** So were there ways in which you were hoping to convert the Balint group? Point out different directions it might go in, certainly.
- RP:** Yes. There wasn't the bite to the research question that there should have been. Research worth its salt is supposed to have 'bite'.
- JS:** What sort of bite would you have liked to see?
- RP:** Nice question. Well I think we weren't even looking in the right place. So rather than thinking, what is the effect of Balint on general practice, perhaps we should have been thinking more, or at the same time, what's the impact of general practice on Balint? I think the two are always wrapped up in each other... We were doing a piece of research, not just a piece of advocacy. Trying to get the right research questions asked. It was like trying to extract teeth. It was actually very difficult because they were framed in this causal analysis way. So trying to turn those around and ask more process kinds of questions was very, very difficult. Causal reasoning always kills process reasoning.
- JS:** my impression was that you did in the end get some of your questions asked.
- RP:** Some of them. I think one of the questions we should have been asking was: why was it that Balint was seen to be unchanging, while the whole world was in flux.
- JS:** If we see it as unchanging, is it that we in the movement don't want to change it; or is that the outside world regards it as unchanging, fossilised...
- RP:** Perhaps a bit of both. You don't meddle with the ancestors! In fact, we nibble away at them all the time, don't we? Can't let them rest...
- JS:** I think it's the question of change and how things ought to change that will interest readers most. Balint people anyway will notice the things that you say: that we are closing things down when we say we're opening things up; certain things are not to be talked about. That was one of your conclusions, wasn't it?
- RP:** I didn't want to be prescriptive. One thing I was pondering on the train was, for me, the uncomfortable relationship between pedagogy and research. Did I come to understand or to tell? There was a product, we had to work towards a product and I was thinking to myself, would that make the difference. Does that make didacticism all right? I don't know. And it's much more into emancipatory research; that we empower people. But I feel ambivalent about that also. The group is perfectly capable of empowering itself! What do you think about it?
- JS:** I'm just struggling to understand it at the moment. Do you mean that, as a result of what we learned from the research, we were empowered to –
- RP:** – go and do it yourself. We've taught you skills about methodology.
- JS:** You've taught us about skills. Whether we are capable of using them ourselves, I don't know. A different way of looking at things, certainly.
- RP:** Then there was all the dance between attraction and repulsion. That's one of Freud's things, is it not. As fast as we seem to be working together, the different people in the group are separating themselves off. Oh, no, no, no, it's not like Balint at all. You would watch people draw back and then somebody else would come in and find similarities. It's that kind of imaginative projection. A minuet. And then: oh, no, we don't want to get too close again!
- JS:** Well. Let's unpack that one. Who is getting too close?
- RP:** Too close for comfort. Perhaps this is the point, because almost all the cases in that group we were supposed to be doing research on were about making appropriate emotional and other boundaries, between doctor and their patients. Boundaries are always ambiguous and dangerous. You can look both ways. And so, in the group that I was observing, people were trying to draw nice clear lines around what a doctor should be able to communicate with his or her patient. And boundaries of a very different sort were being articulated in our group [the Balint researchers group]
- JS:** Can you tell me what can be learned from that?
- RP:** Well, maybe to ask another question, it's really to ask, what is the role of an academic in a group like yours? What did you expect of me?
- JS:** (pause...sigh...) Well I suppose we started off hoping that you would be able to tell us whether we were any good. Whether what we were doing was productive in any way. Or was it just 'navel-gazing' as our critics say. Pointless introspection. We were hoping that you would say 'I'm an expert, I'm an academic and I can see that you are doing some good here'. To put it in very basic terms. Or, if you did it like this you would be doing it even better. Which, to some extent, I think you did say.
- RP:** You want simple answers to complex problems.
- JS:** I'm afraid so, yes!
- RP:** It must have been quite a disappointment.
- JS:** Maybe it was, at first. I personally didn't find it disappointing. I found it interesting that things turned out to be more complex than I thought they were as far as your discipline was concerned.

**RP:** The thing I found difficult with Balint first of all was this intense concentration on the doctor-patient relationship as though it was an isolated, bounded unit. Which didn't leak! I couldn't get my head round that. As if it could be pulled out and examined as though it was the jelly on the end of a microscope. There was that sort of feeling. Not all the time, but sometimes. And then you got caught up in the fascination of the thing.

**JS:** Well that was Balint's big idea. That the doctor-patient relationship could and should be examined. I don't think he saw it quite like that – being pulled out and examined. When we are leading trainee groups, our feeling is often that they are not thinking about the doctor-patient relationship enough and need to be brought back to it. Whereas your perspective was that there are all sorts of other things that are on their minds which they need to talk about and the leaders are preventing them from doing this. Would that be right? I think that is one of the things in the paper that is going to be talked about and debated.

**RP:** I suppose my feelings were always to take the person and look at the whole play of influences on a person, of which Balint is one, but only one. And how meanings can be negotiated between all sorts of different influences rather than taking Balint as the epicentre which is what an Impact study does. They always exaggerate the importance of what it is that they have to offer. Its only when you go out and look at the 'what else' factors, what else people are doing, that you get that sense of perspective. And so hence what I said earlier: that what we should be looking at is how much does GP impact on Balint as much as the other way round. It is not just a one-way traffic. It's a mutually reinforcing constitutive thing. I think that's more to do with analogical reasoning.

**JS:** Tell me the difference.

**RP:** Well, with linear causal reasoning, you have an external precipitant, Balint, and that impacts on a supposedly passive or inert recipient. An external trigger. That's how Western reasoning works. Why it's so powerful. Some Eastern cultures might find that much more difficult to live with, though I'm crudely polarising things here. It's why I really liked the conversation I had with 'Dr Ling' [subject of one of the case studies] because his reasoning was partly different. I could see the two conflict in him. It might provide at least some of an answer as to why apparently Balint 'takes less well' with people from different ethnic groups; I don't know whether it does or not but that's what I was told.

**JS:** What happens in non-causal reasoning?

**RP:** You bring different perspectives and you don't try and 'trump' them. You know, the

bird's-eye view that has all the answers. You are bringing all sorts of perspectives into the social space and not making a judgment about them.

**JS:** Right. And not drawing a conclusion?

**RP:** Or being much more tentative about the conclusions that we do draw. And for the Occasional Paper, authoritative conclusions were wanted. Quite properly so.

**JS:** So you have to live without authoritative conclusions

**RP:** Yes! That's exactly what I'm after. Leave people to draw their own conclusions. I would see ethnography as trying to do as much justice as you possibly can to all the different points of view. It's about valuing diversity. I don't know quite how to approach it. So you are not sitting there as an adjudicator.

**JS:** And yet some judgments –

**RP:** – have to be made.

**JS:** Do they have to be made? I thought you were just saying that they didn't

**RP:** Well yes, there's the contradiction. Isn't it more about deferring judgment? Or certainly being less severe in the judgments we do make. It doesn't mean that I do it, of course! It's much easier to judge than to try and understand. Those contradictions! The idea that we have to resolve them! It's trying to be more at home with ambiguities.

**JS:** We have presented the research several times now but I expected people to be more disconcerted by what we've come up with.

**RP:** Why?

**JS:** Because of things like: Balint groups claim to be opening up areas for discussion but in fact they close some of them down; you can't talk about race, you can't talk about this or that; people feel that they have to please the group leaders, fit into the group.

**RP:** The conformity.

**JS:** Yes, the conformity. Whereas we feel that we are liberating; go where you like and so on. But Balint audiences didn't seem to be upset by these observations.

**RP:** So we were imagining difficulties that weren't really there? The world is Janus faced, isn't it? Whether it's 'Balint groups are liberating and transgressive', or 'Balint groups are quite authoritative and conformist.'

**JS:** Yes, we liberate you in some ways but you have to obey our rules in others.

**RP:** I think it depends which side of the bed you get out of. Which way you flip and flop. The condition of freedom is that we accept the constraints. Take a discipline like yoga for example. Or ballet. You wouldn't get the glorious apparent freedom of movement if there hadn't been the hours and hours of discipline.

**JS:** It does terrible things to their feet.

**RP:** Yes, it does.

# Subjectivity and Objectivity Revisited

Michael Courtenay

Tom Main, in his Balint Society Memorial lecture of 1978, wrote: 'When our patients are under strain we subjectively experience something of that... and no amount of ability to study, name and classify their strains in objective ways can set us at a distance from our experiencing something of their subjective strain. *Objective understanding itself involves, by definition, a refusal to reckon with subjective facts.* Thus, it contains a distancing defence against subjective encounter, such as our professional egos mobilise whenever our tension is too great to bear. I will return to that point soon, but meanwhile want only to emphasise the inevitability of strains in our objective craft, things which the pure scientist... need not experience nor notice.'

This passage came to mind while reading a book by a pure scientist, whose memory was honoured in an essay in the journal *Nature* recently, it being the centenary of his birth. His name is Hermann Weyl. He was a mathematician involved in the evolution of quantum theory in the 1920s but became increasingly engaged in the field of philosophy. His book: *Philosophy of Mathematics and Natural Science* (1) was particularly remarked on by the essayist. It is out of print but I obtained a copy from the British Library. The foundations of the book first appeared in German as a contribution to R. Oldenbourg's *Handbuch der Philosophie* in 1926. His contribution dealt almost exclusively with physics, for as he says: 'it is the only branch of the natural sciences with which I am familiar through my own work.' His definitive book was published in 1949 by the Princeton University Press, where he had settled after having to flee from the Nazis.

The book is divided into two parts; entitled Mathematics and Natural Science respectively, followed by no less than six appendices (all fascinating and not to be missed). Now mathematics is not my forte (to say the least!) and in attempting to follow him there were only little oases of familiarity such as when he touched on Husserl and Frege (the latter built a huge edifice seeking to explain the nature of numbers but when Bertrand Russell read it he pointed out that proposition five had a fatal flaw and so the whole edifice collapsed. In spite of that, they remained friends!) However, the second part, on Natural Science, was largely within my intellectual grasp. But, in addition, the book is peppered with splendid allusions as chapter headings. In fact, the Preface begins with a quotation from T.S. Eliot's *Four Quartets*:

Home is where one starts from. As we  
grow older  
The world becomes stranger, the pattern  
more complicated  
Of dead and living. (East Coker, V.),

While Part Two is headed with a sentence from Heraclitus:

'The Lord whose is the oracle at Delphi neither reveals nor hides but gives tokens.'

But it is in the first chapter entitled 'Space and Time' that the pearls begin to appear: 'The doctrine of the subjectivity of sense qualities has been intimately connected with the progress of science ever since Democritus laid down the principle, "Sweet and bitter, cold and warm, as well as the colours, all these things exist but in opinion and not in reality."'

Thus the objective state of affairs contains all that is necessary for the subjective appearances. There is no difference in our experiences to which there does not correspond a difference in the underlying objective situation...It comprises as a matter of course the matter of the ego as a physical object. The immediate experience is *subjective* and *absolute*. However hazy it may be, it is given in its very haziness thus and not otherwise. The objective world, on the other hand, with which we reckon continually in our daily lives and which the natural sciences attempt to crystallise by methods representing the consistent development of those criteria by which we express in our natural everyday attitude – this *objective world* is of necessity *relative*. It can be represented by definite things (numbers or other symbols) only after a system of coordinates has been arbitrarily carried into the world. It seems to me that this pair of opposites, subjective-absolute and objective-relative, contains one of the most fundamental epistemological insights which can be gleaned from science. Whoever desires the absolute must take the subjectivity and egocentricity into the bargain; whoever feels drawn toward the objective faces the problems of relativity.

The postulation of the ego centrality, of the 'thou', and the external world, is without influence upon the cognitive treatment of reality. It is a matter of metaphysics, not a judgment but an act of acknowledgment or belief. Yet this belief is the soul of all knowledge. From the metaphysico-realistic viewpoint however, ego-hood remains an enigma. Leibnitz believed that he had resolved the conflict of human freedom and divine predestination by letting God assign existence to certain of the infinitely many possibilities, for instance, the beings Judas and Peter, whose substantial nature determines their entire fate. This solution may objectively be sufficient, but it is shattered by the desperate outcry of Judas, 'Why did I have to be Judas?' The impossibility of an objective formulation of this question is apparent. Therefore no answer in the form of an objective insight can ensue. Knowledge is incapable of harmonising the luminous ego with the dark, erring human being

that is cast out into an individual fate.

So there we are! Our subjectivity as doctors is absolute and part of the way the world works. No longer need we feel that the approach to Balint work is in any way second rate

compared with so-called objective facts. Both are necessary.

#### Reference

1. Weyl H. (1949) *Philosophy of Mathematics and Natural Science*. Princeton University Press, Princeton.
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# Professional Identity Development and the Psychotherapeutic Function of a Residency Balint Group

by John R. Freedy, MD, PhD<sup>1,2</sup>

## Overview

### *Personal Background*

I began my medical education in my late 30s as a second career. My initial professional path was to complete training as a PhD Clinical Psychologist. Following the completion of my doctorate, I practiced as a psychologist for nearly a decade before starting my formal pursuit of a medical education. My reasons for pursuing Clinical Psychology were many: the intellectual challenge, diverse job skills leading to a varied and stimulating professional life, opportunity for self-knowledge, and the opportunity to help people. My reasons for the pursuit of medicine as a second career were similar. In addition, I had begun to feel limited in my role as a psychologist. I wanted more professional knowledge and skill. I wanted more career options.

The experience of becoming a physician held some surprises for me. The most fascinating aspect of my medical education lies in what I found to be the most difficult aspects of the experience. I did not find the intellectual or physical demands, despite long, grueling hours, to be the most challenging. Personally, I found the psychological experience of being molded into a physician to be the most difficult thing. This essay reflects my intrapsychic experience in becoming a physician. This transformational process has been supported by a number of factors including: my prior psychological knowledge and skills, several knowledgeable and supportive mentors, and the process of participating in Balint groups as a second and third year family medicine resident.

## Our Focus

This essay attempts to describe the intrapsychic conflicts inherent in becoming a physician. The words presented represent my own construction of this internal process that I have arrived at by blending my temperament, psychological and medical training, and Balint group experiences in an effort to understand and apply this internal process to my work as a physician. While the thoughts presented reflect my unique experiences, it is my hope that they also reflect something universal about the inner struggles faced by many men and women who choose to become physicians.

My thesis is that Balint groups can be an essential catalyst in the intrapsychic development of physicians. I recall my own 24-month experience in a Family Medicine residency Balint group to illustrate the evolution of typical intrapsychic changes that may occur in the context of such groups (Brock, 1990; Brock &

Salinsky, 1993). I suggest that Balint group work assists resident physicians in resolving their professional 'identity crisis' to emerge with stable, realistic, and therapeutically useful attitudes and behaviors with regard to their clinical encounters (Campbell, 1989). Relatedly, I make the argument that Balint group participation may go beyond creating what Michael Balint termed 'a significant though limited change' in personality (Balint, 1971). I argue that well run Balint group experience contains the essential elements of a psychotherapeutic process (Frank, 1974). I contend that viewing Balint work as psychotherapeutic is a more accurate way to conceptualize the potential potency of this approach.

## My Experience with Balint Groups

We all have our own story regarding how we were introduced to Balint groups. My story begins when I was a third year medical student completing a two month clerkship in Family Medicine. This included a mini-Balint experience together with two other medical students and two faculty preceptors meeting weekly for a month to discuss 'troubling cases'. I recall being pleasantly surprised to find that Family Medicine was a field where psychological insights and interpersonal relationships were valued as legitimate topics for study.

As a Family Medicine resident, my Balint experience continued as a second and third year resident based on the structure of my training program. In my training program, first year residents did not participate in Balint groups based on the premise that their in-hospital clinical demands, including call, were incompatible with the time and psychological energy required by Balint group participation. Beginning in the second year of residency training together with my classmates I commenced a 24-month Balint group experience. This group was limited to residents from the same year and was co-lead by two credentialed Balint group leaders.

I recall commencing my residency Balint group with high expectations. Based on my background in Clinical Psychology I anticipated that this group experience would cover familiar ground and provide an opportunity to feel reassured and supported in the midst of the many challenges involved in being a resident physician. Once my residency group started, to my surprise I felt somewhat stifled by the group process. In retrospect, I think my professional background gave me expectations for the group that were different from those of many of my classmates. While I was ready to examine my feelings, the

patients' feelings, and the doctor-patient relationship, many of my classmates struggled to feel safe enough to explore such issues. I recall a dichotomy developing within the group with one camp being more empathically attuned to the patient's experiences and the other camp being more aligned with the doctor's point of view (even to the point of anger and wanting to punish the patient in some fashion).

As a resident physician I participated in two intensive leader training sessions. I found these intensive leader training experiences to be profoundly different from resident group participation. The seasoned practitioners were even more eager and willing participants in the Balint group process than I found myself to be! In the course of one weekend, they were able to construct a safe environment within which to examine the doctor's feelings, the patient's feelings, and the doctor-patient relationship. Meaningful insights and the ability to discuss and accept even the most sensitive of topics were directly experienced in a non-threatening environment. These intensive weekend experiences validated for me the profound importance and potential of Balint group experiences when the group is able to mature to the point of doing meaningful work together.

I returned to my residency Balint group with a new more realistic and patient-centered perspective. I began to understand that it would take time for my fellow residents and me to bond to the point of feeling safe enough with each other to explore feelings and experiences that touched psychological vulnerability (Brock, 1990; Salinsky & Sackin, 2000). In a sense we were directly experiencing the type of anxiety that our patients may feel in our presence. I started to believe that the investment of time in Balint would eventually lead to my resident group being able to do the type of work that I experienced during the Balint Intensive weekends. I began to look at my resident Balint group as a place where important lessons would be learned. It was my hope that these lessons might allow me and my fellow residents to become more compassionate and psychologically sophisticated physicians.

### **Lessons Learned**

During my initial experiences with Balint groups, I recall repeatedly being told that these groups were not equivalent to psychotherapy. We were reminded that group participation might produce 'significant, though limited change' for the physician (Balint, 1971; Salinsky & Sackin, 2000). The group leaders were charged with the task of keeping the group members focused on the goal of professional development rather than personal self-disclosure and exploration. The co-leaders of my residency Balint group kept our sessions safe, focused, and productive. However, having completed my 24 months of residency Balint training, I remain doubtful regarding the accuracy of these initial disclaimers. I suspect that the Balint group process has the potential to make

profound and meaningful changes in the intrapsychic lives of physicians who remain meaningfully engaged in a Balint group for a sufficient period of time. I believe that the 24 months duration of my residency group was long enough to allow for meaningful intrapsychic changes within myself and I suspect within several of my residency classmates as well.

In the interest of clarity, I would like to discuss the lessons that we learned during that experience together. I will organize these lessons learned according to four developmental phases that from my perspective seem to characterize our Balint group experience:

1. Induction and engagement;
2. Defensive maneuvers;
3. Working through; and
4. Consolidation.

Similar sequential phases of Balint group work have been proposed and discussed elsewhere (Brock, 1990; Salinsky & Sackin, 2000). Each of these developmental stages can be likened to the process of undergoing individual or group psychotherapy. This fact underscores the thesis of this essay: Balint group work, when properly conducted, holds the potential to create profound and meaningful changes in the intrapsychic lives of physicians who remain meaningfully engaged in a well-run Balint group for a sufficient period of time.

### **Induction and Engagement**

As noted by Michael Balint, group consultations need to engage physician participants at both intellectual and deeper psychological levels (Balint, 1971). First, there is an intellectual connection that needs to occur between the group participant and the overall group process. This intellectual connection has to do both with establishing group rules and with showing the relevance of these rules to the group process. Typical topics include: how often the group meets, how long each meeting will last, what will happen in each group (e.g., who speaks, who listens, etc.), confidentiality expectations, the goals/purpose of the meetings, etc. While there is some variability in the degree to which new Balint group members understand and adhere to group rules, it is a relatively straightforward matter to most new group members to make an intellectual level connection to the overall group process in the first one to two months of group participation. (Brock, 1990).

The second, more difficult, aspect of group engagement has to do with a new group member making a psychological connection to the group process (three to twelve months for most resident physicians; although some resident physicians never seemed to become engaged). Within my residency Balint group experience, it was my observation that group participants varied widely in their capacity and willingness to engage in the Balint group process with regard to the psychological dimension. The aforementioned dichotomy between resident physicians more

accepting towards a 'troubling' patient and other resident physicians who were more protective of the doctor's point-of-view seems to me to be an outward expression of different initial levels of psychological engagement with the Balint group process.

It is of interest to consider the dichotomy that emerged within my resident Balint group. Once again, this dichotomy involved resident physicians spontaneously forming an alliance with either that patient or the physician-presenter. Of note, there was a degree of cognitive rigidity that characterized the proponents of either point of view. This rigidity suggested to me the habitual and defensive nature of their positions. Our group leaders worked to make it safe and legitimate to voice either point of view within the group. In terms of parallel process, the group seemed to be acting out a conflict that existed within each of the participating resident physicians. Some of us over-identified with the patient, while some of us over-identified with the doctor. The process of psychological engagement involved our group co-leaders getting each of the physician participants to engage in group discussion with regard to our psychological point of view. Such group engagement provided the substrate for both individual and group examination of underlying psychological processes.

This discussion of intellectual and psychological engagement can be considered from another vantage point. We should ask the question: How is this like psychotherapy (if at all)? Many answers are, of course, possible. However, one of the more inclusive answers was provided years ago by the psychiatrist Jerome Frank. He argued that psychotherapy was a form of personal influence that was commonly practiced across many different cultures in varying circumstances. He proposed a triad of elements as defining all forms of psychotherapy:

1. a trained, socially sanctioned healer;
2. a sufferer who seeks relief from the healer; and,
3. a structured series of contacts between the healer and the sufferer in which the healer with the assistance of words and related activities tries to modify the thoughts, feelings, and actions of the sufferer for the better (Frank, 1974).

Based on my experiences both as a clinical psychologist and a family physician, it is difficult for me to see Balint group work outside of the context of a form of psychotherapeutic work as broadly proposed by Jerome Frank's definition. First, Balint group leaders are trained, and socially sanctioned leaders of their respective Balint groups. In the United States, a rigorous series of steps is required to qualify as a group leader accredited by the American Balint Society. Second, Balint group participants are told to present their 'troubling' patients to the group. It is understood that what may be troubling to one physician (based on the physician's own psychological make-up) may or may not be

troubling to another physician (Salinsky & Sackin, 2000). In short, presenting physicians are suffering in their ability to understand and manage their more troubling patients and seek relief from the group leaders and by extension the group. Third, Balint groups consist of a structured series of contacts between the group leaders and members with the goal of modifying the thoughts and feelings (attitudes) we hold and the actions that flow from our inner life.

### **Defensive Maneuvers**

Earlier in this essay I stated that I found the psychological experience of being molded into a physician to be troubling, and at times painful. I do not believe that I am alone in this experience. I will borrow from the psychoanalyst Erik Erikson in trying to elaborate my meaning here. Erikson speaks of a series of eight stages in personality development that people navigate from infancy through maturity. He holds that growth and development remains possible throughout the lifespan. Each of his eight developmental stages allows for the dichotomous possibility of a healthy v. a conflicted outcome. In terms of the development of a physician's professional self, it is instructive to consider Erikson's fifth stage of Identity v. Role Confusion. The popular term 'identity crisis' comes from this stage of Erikson's model of personality development (Campbell, 1989).

In my residency Balint group, participants were invited to examine and develop their own professional identity as a physician. This examination is, by its very nature, anxiety provoking (often, extremely so). Resident physicians must intuitively sense the dichotomous possibilities of an integrated professional identity v. professional role confusion when participating in Balint group. The resident physician is required to release the idealized role of physician (e.g., all powerful, all knowing) and forced to accept the more realistic limits inherent to the role of physician (e.g., witness, container, teacher, target, etc.). Accordingly, resident physicians resist moving too quickly in their Balint groups in an effort to protect themselves from professional role confusion and associated anxiety.

So, how did this resistance work present itself in my own resident Balint group? As I stated previously, early on there appeared to be a dichotomy developing within my resident Balint group. About half of us over-identified with the patient (e.g., altruistic identification, relieving the patient of too much responsibility for their attitudes and actions), while the other half over-identified with the doctor (e.g., projection of our psychological discomfort onto the patient and thus seeing the patient as excessively irrational or demanding). For several months, these two camps more or less respectfully stuck to their positions while the group leaders made members of each group feel that either point of view was probably legitimate

for a particular case under discussion. By holding fast to one's habitual defensive pattern, the resident physician was more able to minimize feeling anxious due to the role confusion that would result from a deeper thinking through of the psychological issues involving the patient, the doctor, and their relationship.

Other defensive patterns, of course, emerge in the context of Balint group work. These possibilities have been discussed in detail elsewhere (Brock, Johnson, Koopman, Chessman, & Sack, 2005; Salinsky & Sackin, 2000). Other defensive patterns that I observed in my own resident Balint group included: habitual lateness to meetings, skipping meetings, silence during meetings, and disruptive comments. My main observation would be that such maneuvers should be seen not only as defensive, but also necessary as the individual and group titrate the degree to which the necessary psychological engagement can be tolerated. This psychological engagement must be sufficient to allow for the safe examination of the three issues we always consider within the context of Balint groups: the doctor's experience, the patient's experience, and the nature of the doctor-patient relationship. However, if an individual or the group becomes overwhelmed with anxiety, role confusion will result, and defensiveness and resistance will flare until the individual or group feels sufficiently safe to attempt psychological engagement once again.

### **Working Through**

In traditional views of psychotherapy, the early stages of psychotherapy involve issues such as building trust and identifying key issues that will be the focus of ongoing work between the therapist and patient (Weiner, 1975). Similar developmental tasks characterize the early stages of Balint group work (Brock, 1990; Salinsky & Sackin, 2000). In the context of my resident Balint group, I believe it took nearly 12 months for most group members to have developed sufficient trust (in the group leaders, group members, and group process) to allow us more consistently to focus on the working through process. This raises an important question: What were we 'working through'? Our group co-leaders often asked the question: What kind of doctor does this patient need? Stepping back a few paces, as a group we were being asked to examine, understand, and manage the process of transference and countertransference as applied to our clinical work with patients. We were beginning to look at the doctor-patient relationship as a clinical tool that could be strategically employed for either desirable or undesirable ends.

As a technical matter transference can be defined as follows: '...displacement of feelings, attitudes, or impulses experienced towards previous figures...onto current figures to whom they do not...apply.' Similarly, countertransference can be defined as: '...thoughts, feelings, and impulses that are not

justified in reality by anything the patient has said or done.' (Weiner, 1975). So, supported by our mutual trust of the group leaders, each other, and the group process, my fellow resident physicians and I began to understand that our habitual reactions towards 'troubling' patients were not objective pictures of these clinical encounters. Instead, it became apparent that our thoughts and feelings (attitudes) were subjective impressions representing the starting point for further discussion and exploration. We further explored the psychological reactions of the patient, the physician, and the nature of the doctor-patient relationship. Our goal was to see all three elements in a less troubling light and to be in a position to be more of the type of physician that this patient might need at a certain time.

Of note, the types of 'troubling' patients presented by resident physicians were not random. Each doctor appeared to have a certain 'blind spot' and over time would present similar cases (seemingly reflecting the countertransference issues with which the doctor struggled). In my own case, I often presented middle-aged men who in some way were less than fully competent in fulfilling their life responsibilities (e.g., at work, as a spouse, as a parent). In retrospect, it seems obvious to me why I tended to over-identify or under-identify with such patients. As a resident physician, I was struggling with these same role issues (i.e., I was middle-aged, married, had young children). I was insecure in my own capacity to be a good enough doctor, spouse, parent, etc. Working this countertransference out over the course of many months of Balint group participation, freed me to address my patients' needs more accurately without excess interference from my own personal struggles (Bascal, 1971).

### **Consolidation**

The final stages of any meaningful learning experience involve an attempt to integrate what has been learned over the course of time. This applies to residency training in general, Balint group participation, and formal psychotherapy among other activities. In my own resident Balint group, one of our classmates was allowed to graduate six months early based upon credit for residency training completed prior to joining our Family Medicine residency program. I can remember a sadness and an excitement shared with this resident as they were able to leave our Balint group six months prior to the rest of us graduating. For several weeks following his departure, occasional comments were made within the group about what the missing group member would have thought (i.e., grieving his loss to the group). We also started to express some anxiety over not feeling ready ourselves to graduate in six months to independent practice. In any event, these experiences seemed to begin our resident group's attempt to consolidate what we had gained from our Balint group participation.

Another process began to occur in the

last three to six months of the group. This process involved several of my remaining classmates asking me if I would mind taking on one or two of their 'troubling' patients as the primary physician. This was going to be possible after graduation as I had arranged to stay on with the residency program as a junior faculty member following my graduation. My internal reaction to such invitations was confusing to me. Throughout residency, fellow residents and faculty members had sought me out on numerous occasions to ask my opinion about various patient-related mental health issues. Based on my credentials as a PhD Clinical Psychologist, this made sense. Previously, I had found this practice to be pleasant and even to some extent validating or flattering. However, as my residency training approached an end, I became increasingly uncomfortable and even irritated with this type of discussion. I was puzzled by the change in my feelings. When the topic came up again during a case presentation ('John, I hope you don't mind, but I'm planning to refer this patient to you when I graduate.'), I finally shared my concerns with the group. While the group was initially puzzled by my refusal to accept referrals, they were accepting of my request (no more mental health referrals to Freedy!). Through a process of calm questioning and discussion, my conflict with accepting mental health referrals from my departing residency colleagues came into clear focus.

Two issues bothered me. First, my schedule would become crowded with patients whom my colleagues found 'troubling'. At the time when I would be trying to adjust to having ten close friends and colleagues leave, I would be faced with helping patients who troubled these same friends. Stated another way, I was being asked to address the needs of patients who represented the 'blind spots' and weaknesses of my friends and colleagues at the same time that I needed to be free to grieve their departure. These 'troubling' patients represented the unresolved conflicts of my fellow resident physicians. I did not wish to remember my colleagues by being reminded of their unresolved issues on a regular basis. I simply could not help my resident colleagues in this way without hurting myself and possibly not serving the best interest of these patients.

My second concern involved my sense that some of my resident colleagues were taking the easy way out. By referring a 'troubling' patient to me, they would be relieved of the burden of having to say goodbye to a difficult patient (and be able to avoid whatever vulnerability in themselves that the patient exposed). I felt that to assist my fellow residents in such a process was providing them with false reassurance. The trouble that they wanted to refer to me existed in them (the referring doctor), their patient, or in their relationship to the patient. I came to understand that neither I nor anyone else could resolve such conflicts for the doctor or

patient. The appropriate focus was for the doctor and their patient to try to work out their psychological issues and relationship with each other without avoiding this work by sending the patient away with the (false) hope that another doctor would tend to the patient's needs.

## Conclusions

In this essay I describe a transformational process reflecting psychological themes common to developing physicians. My position is that Balint groups can serve as an essential means in assisting resident physicians in developing a mature professional identity (v. professional role confusion) (Campbell, 1989). I argue that this professional identity involves developing stable, realistic, and therapeutically useful attitudes and behaviors with regard to our clinical work. As such, Balint groups may contribute to something more than what Michael Balint described as 'a significant though limited change' (Balint, 1971). I suggest that Balint groups meet Frank's astute definition of what constitutes psychotherapy:

1. involvement of a trained socially sanctioned healer;
2. a suffering physician seeking relief to their confusion and frustration;
3. a structured series of contacts involving the exchange of words or other activities designed to modify both internal attitudes and external behaviors) (Frank, 1974).

I end by describing my experiences with four proposed developmental stages that seem to characterize my 24 month resident Balint group:

1. Induction and engagement;
2. Defensive maneuvers;
3. Working through; and
4. Consolidation) (Brock, 1990; Salinsky & Sackin, 2000).

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## References

- Balint, M. (1971). *The doctor, his patient, and the illness* (2nd ed.). Surrey: Pitman Paperbacks.
- Bascal, H.A. (1971). Training in psychological medicine: An attempt to assess Tavistock clinic seminars. *Psychiatry Med.* 2, 13-22.
- Brock, C.D. (1990). Gearing Balint group leadership to resident professional development. *Family Medicine*, 22, 320-321.
- Brock, C.D., Johnson, A.H., Koopman, R.J., Chessman, A.W., & Sack, J.L. (2005). A Balint study of difficult doctor-patient relationships that cause diagnostic and management dilemmas. *Journal of Balint Society*, 33, 6-10.
- Brock, C.D., & Salinsky, J.V. (1993). Empathy: An essential skill for understanding the physician-patient relationship in clinical practice. *Family Medicine*, 25, 245-248.

Campbell, R.J. (1989). *Psychiatric dictionary* (6th ed.). New York: Oxford University Press.

Frank, J.D. (1974). *Persuasion and healing: A comparative study of psychotherapy*. (revised ed.). New York: Schocken Books.

Salinsky, J., & Sackin, P. (2000). *What are you feeling doctor? Identifying and avoiding defensive patterns in the consultation*. Abingdon, Oxon: Radcliffe Medical Press.

Weiner, I.B. (1975). *Principles of psychotherapy*. New York: John Wiley & Sons.

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# Balint groups with young doctors in their foundation years at a County Hospital in Sweden.

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In 1996 I had the opportunity to gather somatic specialists in different groups in the County Hospital of Halmstad on the west coast of Sweden. The participants in these groups were on the same hierarchical level, but from different departments. Everything has a beginning – I got that task because I had just moved to the city, was privately unknown to everybody, and was at that time chair of the Swedish organisation for psychotherapy supervisors. Another factor that had a great impact on our work was that I had never been employed by the County Council, and therefore had no ideas about who was who in the organisation.

Senior consultants, senior registrars and specialist registrars from departments of intensive care, infectious diseases, ear, nose and throat, orthopaedics, internal medicine, neurology, gynaecology, surgery and paediatrics joined the groups, and in two of them there was an invited GP. The groups were put together so that there was a wide spread from different departments in every group. The doctors had permission to leave their ordinary job in order to come to the groups. They had no previous experience in either psychotherapy or supervision or Balint groups, and they were invited to join a group every fortnight for two-and-a-half years in order to get a forum to reflect upon their professional meetings. The background was that the doctors had complained about the fact that there was never any time for them to stop and think about their professional life. The goal was formulated as 'Together with persons at the same level in the hospital's hierarchy to be able to focus on each person's professional personality in the meeting with the patient.'

The groups were offered as an arena to talk freely on misunderstandings and mistakes in clinical practice as well as about problems in relation to other persons in the staff of the department. Time was offered to reflect upon ethical professional standpoints, feelings and thoughts about death, and to meet severely ill persons and their relatives. In order to feel confident to open up around these special issues, much effort was put into defining the boundaries of the groups. All in all I met about 100 medical specialists in this hospital in different groups during the years until I started with the doctors in their foundation years, whom I will call 'AT-doctors' as they are known in Sweden. Within the first years' programme where most participants were senior consultants I also had one AT-group. We met between 1997 and 2000.

The AT doctors have finished their medical school, and sometimes worked as locums

before they start their 21 months work here. This period consists of 6 months of surgery, orthopaedics and intensive care, 6 months consisting of internal medicine and paediatrics, 3 months of psychiatry and 6 months of General Practice. These first mentioned groups were an important door opener in order to later convince the senior consultants that there was a meaning for them to let the AT-doctors leave their job and go to the groups. Another background to our groups is that there had been some complaints on the AT period in this very hospital – the young doctors' trade union make sort of a consumers' list every year telling where it is good or bad to go for your foundation years. These groups together with efforts on better clinical supervision have made this hospital advance on that list. For every yearly announcement for foundation doctors there are usually 50-60 applicants. The AT-doctors come to the hospital through this competitive selection, and they come at intervals four times a year with four persons each time. At the same intervals four persons leave the group. Since 2002 there have been two groups in this new programme. As each group of four doctors leaves the programme another four start; so the group is open ended with gradually changing membership.

The AT-doctors are allowed to leave their ordinary job one whole afternoon every month in order to see me, and while I meet one group the others meet their director of studies to talk about different theoretical issues or they get information from different departments, and then we switch. Unfortunately we have not been allowed to meet every fortnight which was my recommendation initially and how the first years of the AT groups met. All departments have promised not to insist on keeping the AT-doctors when it is time for the groups to meet and the ATs must not have their beepers or mobile phones switched on during sessions. Participation in the Balint groups has been seen as an offer which means that you are allowed to leave your ordinary job at the emergency or some other ward on paid time one afternoon in order to meet each other – and me. So far the compulsory part of it has not been questioned during these seven years. I don't register their attendance anywhere more than for my own memory. The matter of passing or failure of the AT period does not apply to groups. This arrangement has had the effect that very seldom someone is absent from the groups – and sometimes they come even if it is their day off. We meet in a library which is a resort for the educational staff at the hospital and there is a teddy bear – belonging to someone in this staff – on one of our sofas. The bear is always in

somebody's lap and sometimes they pass it over to each other.

Balint groups in Sweden have traditionally been exclusively for GPs. Working with foundation doctors has never been done in any other part of Sweden – the previous kind of groups I had with the senior consultants from different departments were also unique. We work within an ordinary group psychotherapy framework as the boundaries are important to make room for a creative process. Like Winnicott's playground and intermediate area you need to have safe surroundings in order to play.

There is a very special confidentiality in this group and we agree that the professional secrecy should be such that each one would assure the others not to tell outsiders what we have talked about. After one incident some years ago I also add that even if you in 'good faith' want to help a colleague by talking to someone outside the group, you have to refrain from that. Putting so much weight on how to behave and respect each other has an implication on how to handle delicate material from a patient as well. Further the newcomers have to promise to give priority to attendance and to be active in the meetings. Every time newcomers join we talk about the rules once more, and the elders serve as models for how to use the group.

Balint work is not psychotherapy. The participants are not my patients, which has certain implications. We always start out from something that has happened in their job – and if anyone reflects on that with material from their personal life it is all right with me – but I never bring the topic up. A Balint group represents for me the focus on the professional meeting and the equality among the participants and their professional independence towards the group leader. Since I am not a medical doctor they can use me only from my own professional background. On the other hand I have lived very close to medical doctors through all stages in a career during most part of my grown up life, so I have a cultural knowledge about their profession.

The general aim with a Balint group is to make the doctor more aware of the process of communication or lack of it between oneself and the other that may be threatening both parties' conscious striving to reach a good cooperation. It is a kind of mutual consultation in the group; they meet in order to understand their own work better, to understand what happens with themselves and the patient in the professional meeting. There is also a good learning opportunity to understand something of your own work even when somebody else is presenting a case.

When the ATs start working they are thrown into the deep end on the emergency ward, officially having an older colleague to ask for advice. They also have the possibility to phone a senior consultant and when it is during an ordinary working day it is easier to find them than when you work at night on Saturday or Sunday.

Formally there is always a second line on-call responsible for their work, but when they are alone and there is no time to find someone else they have to work very much independently.

I usually start by asking if anyone has met a patient. The group and the leader are silent during presentation. There is always a clinical focus and there is always something to talk about. My job as the leader is to create a safe and free atmosphere in the group and to make the participants focus on the doctor-patient relationship instead of seeking solutions.

It is also my job to create an atmosphere for learning rather than to be a didactic teacher. The group is striving to make the AT doctors realize how the unconscious shows itself in the patient as well as in the doctor in each consultation. We try to recognise the transference as well as the counter transference for the doctor, even if I very seldom use the technical terms. We also try to identify the projective identification when it occurs.

### **The foundation doctors as a group**

The doctors come from different medical schools. Some of them come from a problem based education, where they start very early with clinical training, and sometimes they have met Balint groups during this time. The majority come from ordinary Swedish medical schools with an early clinical experience, and a few come from more old-fashioned studies like in Hungary – where they don't have Balint groups in medical schools, and they don't meet any patients until their third year of studies.

### **Frequent topics**

I want to talk here about what issues come up in the Swedish groups. I will also say something about the differences I have noted when I compare the issues brought up by AT doctors and the GP groups I also lead in another town. The AT groups often bring up topics where the focus is more on themselves and their own feelings than those of the patients' feelings, when compared to the GP groups. A reason for this could be that they are so new in their positions and they need to struggle with themselves before they can get a deeper interest in the emotional life of the patients. It is very special to meet the AT-doctors as they are eager to find out what the profession will become for them; they are still in the phase where they are seeking a professional identity.

Most topics in the groups emerge from situations where the AT doctor feels subordinate or insecure or when there has been some kind of misunderstanding, either in the contact with a patient, the relatives or some personnel at the hospital. They are expected to be able to change environment constantly, meeting staff members who don't even bother to learn their names. In an environment like this it is a high-risk situation to get into parallel processes where the AT-doctor does not see the patient as an individual.

Here is a situation where the AT has felt

inferior in relation to the patient. A starts directly telling us about a patient he met today. She was a woman of 45 who came with a relative to the emergency room complaining about an intense pain in her shoulder. Before he went into the room a senior colleague said that she had fibromyalgia. 'I think that gave me reluctant expectations.' He further says that when he was performing the neurological examinations the patient was very irritated, making faces with her relative towards him and saying: 'Are you going to do a gynaecological examination as well?' Her shoulder aches and she says that she wants a cortisone injection. A says that he feels that she doubts his knowledge and perhaps his age, and he is bothered by that. He notices that the relative also has devalued his capacity. He further tells us that he went out to his more experienced orthopaedic colleague who very dismissively said, 'She is mad! – These patients are hopeless!'

We do a round reflecting on the patient as if each of them had met her; they share thoughts about her pain and how to trust and understand the connection between soma and soul. They also get into what happens when you distrust what the person says. B says that she is very determined that she wants to avoid these kind of patients as she feels that they are cheating her, and she says she has nothing to offer. Her idea of treating them is to pretend to agree in order to get rid of the patient. But that will also end up in not being content with oneself. C says that she has been sitting in with a GP who likes to work with just this type of patient and it seemed so interesting that this is perhaps the kind of patient that she will try to specialise in after the AT period.

The group continues reflecting on 'what happens to me when I meet someone that I can't cure? And how was it for this patient to come to the emergency room? Did she notice A's reluctance in the beginning?' They talk about what they think the patient is feeling, about her worry about not being listened to and about what degree of pain she needs to present in order to make the doctor become interested, not exaggerating her pain as that might arouse disrespect, and not saying too little as that might lead to her being ignored.

Michael Balint said that a sick person is someone who is appealing for attention and love. Most patients know how to get it. Like children, they know what the parents praise or punish, the patient has the ability to read the doctor and give him or her the kind of patient the doctor wants to have – this is so, at least with the neurotic patient. This seemingly strong and arrogant woman was perhaps taking care of her vulnerability by being offensive. Why did this grown up woman need a relative in the room? The group members are talking about the fragility of the patients while they themselves are preoccupied about being the vulnerable person.

They also reflect on another aspect of their role – how much to examine, when to stop, considering that this is enough, as the reason for

her pain is still unknown to the doctor, and very likely also for the patient. A says that he doesn't know why she didn't go to see her ordinary GP who usually gives the injections – had he refused and in that case – why?

An important aspect of this is that the AT-doctor, while working in the emergency room of the hospital, has a job where he probably will not meet this very patient again. They continue to talk about their upcoming 6 months as GPs and having to work on their own and being the only doctor in the room. In the hospital there is always somebody else to ask for advice after a while.

E told us he had met a man who was slowly suffocated by sarcoma and had told E, 'please do something'. E stayed with him until he died and it had been decided in the ward earlier that the patient was not to be resuscitated. But when E was sitting there, a nurse came and said, 'Couldn't you do more?' in front of the patient. We talk about the feeling of not being sufficient. Everybody is very attentive and sharing. We also talk about timing and being able to hold without plunging directly into something. Somebody says that 'We never learnt in medical school what to do and how to behave when a person can't be cured.'

They talk about difficult encounters, like giving bad news, either when you have had the time to prepare or not. 'I want us to talk about the difficult conversation,' says K, a young, very feminine looking woman. She tells us about a patient to whom she was ordered to bring a message, a fairly young man with an advanced terminal kidney cancer. There would be nobody else within the next three days to tell him about the test results and he was asking for them now. K tells about her resistance to getting into the situation, her idea that somebody else would have done it better, as she was bothered by not knowing enough about the disease. She found it difficult to mention the word 'cancer' but is sure he understood the seriousness of his situation. The day after their talk he had referred to her as 'he'. When the senior consultant came three days later and referred to K's information, the patient insisted on calling her 'he'. The consultant replied, 'you met Ms. K the other day', and the patient agreed by saying 'Yes I met him.' She speaks about the reaction from the patient of referring to her as if she was a man, and she understood it as if he so strongly did not want to hear what she said that he needed to wipe her out as a person. The group went into the feelings of the patient and that this neglecting of who she was did not mean that he will have no need for her later on, even if she is not the best when it comes to medical knowledge.

It is normal for the patient – and anyone – to behave abnormally in a stressful situation. When you are the one who has conveyed what is almost unbearable to hear, it is important to be present again and again to reply to new questions. K tells us that she has changed her mind as a result of the group discussion and will follow the

patient up even after he has been moved to the other ward.

### **The topic death is always present in the AT-group**

F said one day that she had been in a situation where a nine-month-old girl had died. F was in charge in the emergency ward and was the one to tell the parents. She said how sad she was and how it felt that her senior colleague had left. Could you be too sad, and how do others handle it? The group spoke about whether you are allowed to cry, if you are professional in certain situations, about being able to cry without loading the burden onto the patient. But F also speaks about being alone with one's thoughts at home. Everybody is active and F gets a lot of sympathy.

G tells us about a patient who is around 45 years old and has advanced Parkinsonism who said this morning that he wanted to die. Every morning this patient lies on the floor with intense cramps and he can't walk. The group works on what he wanted to convey by saying this to G – did he mean it, or was it a way to make G help in any special way? They all say something about how it would have felt if it was their patient, and they talk about feelings of hopelessness, to be true to oneself and not to say something you don't really mean, and how terrible it is to realise that one also has a hard time grasping why there is a reason for the patient to go on living. They talk about being young oneself, feeling that one's own death is so distant, about giving comfort, having the time just to sit down and hold the patient's hand, and to listen without being able to give hope of survival. M says there are things you do for the patient even if it is not obvious what it is. Our session ends by G saying that the group has helped him become more interested in having further talks with this patient, that his own curiosity about this patient has been awakened.

H tells us about her on-call evening that was like a nightmare. She only had four hours work and usually it is rather quiet, but this time there were three acute premature children coming in plus an acute caesarean where the baby was ill. She phoned her senior consultant when the third came and he had just left when the fourth patient arrived. After this she dreamt about a little rabbit standing close to a dangerous motorway. Everybody in the group was very empathic about her story and we all had a good talk about being so vulnerable, not having enough time and being forced to make priorities.

### **Treating friends and family**

D wants to talk about a consultation with someone who has a medical education and comes to the emergency room craving to get morphine medication. This leads the group to talk about being ill oneself as well as treating friends and family. Many feel it is a difficult situation when your friends start using you as their private physician. The group often comes back to issues around this theme. They also talk about how

difficult it is to be considered as the one supposed to know when the patient is a much more experienced older colleague.

### **Empathy**

There was an investigation in Sweden some years ago which was called 'supervision in empathy' which showed that especially male medical students after two years of study reduced their empathic capacity. This was considered to be because:

The one-sided emphasis on an intellectual way of learning meant that more multi-dimensional methods, that include understanding of emotions, were put aside.

The students' picture of themselves became more destructive as a consequence of an impersonal approach taught by their teachers and other hospital staff.

If you feel that you are of no value it results in the same feeling towards other persons. Self contempt results in despising others.

Strong emotional reactions are awakened by confrontation with suffering, death and tabooed situations and actions. This in turn activates the students' psychological defence mechanisms in order to eliminate or reduce the intensity in their own feelings. And all this has a negative impact on the empathic capability. (Holm/Strand/Söderberg/Bárány, *Läkartidningen* 15/1997)

When studying at medical schools you learn how to cut your feelings off in order to be able to work in areas that are considered taboo. By using the group it becomes easier to accept one's emotional vulnerability as something healthy and normal. I want to believe that the foundation doctors in the Balint groups have developed their ability to handle difficult situations and increase their empathic capacity.

M tells us that he is afraid he might become a worse doctor than he wishes to be. He is talking about old people being sent in the evenings to the emergency ward because some relative or a nurse from the city feels the old person needs nutrition, or rehydration. The patient usually has dementia, only stays overnight and is then sent back to where he came from. The feeling of being part of a game where you as a doctor do what nobody else wants to do, and at the same time agree that an old person is brought to a strange and confusing place where he does not get any substantial help. The group talks about the sense of powerlessness, about having no contact with the patient. They share the feeling that the medical system has an aim to get rid of the patients.

### **The GPs compared to ATs.**

The GP groups often discuss the subject of time or lack of it. It is much more difficult for them to get away from their surgeries and come to our group sessions, while the ATs have arrangements where they are always allowed to come. But GPs have a very tight schedule all day which is often

broken by something unexpected that destroys a good flow of the day. They talk about it in terms of shame and guilt, and the intense feeling that a patient is hindering their capacity to pace their work. This is a frequent theme in the GP Balint groups. Apart from giving a patient good help they always have to look at the wristwatch. On the other hand, they work with a hidden timetable in relation to the patient, who is never aware of how much time the doctor is willing to offer when they meet. We try in the groups to find out what kind of implications this has for the patient. This point of view has so far not been taken up in the same way by the ATs.

Another theme with the GPs is the patients who demand to be on the sick list and they speak a lot about how to handle and understand those who don't want to go to their work and start bargaining with their GP. GPs are more prone to activity than the ATs. If I say I want to hear about their feelings, the AT doctors are trying to reply to my question, while at least some of the older GPs are eager to give good advice to the one presenting the case. The GPs have been working for a long time and it is probably more important for them to show each other that they are experienced clinicians, while the ATs can rely on having the right to be in a learning position.

#### **On reports to the National Swedish Board of Health and Welfare**

During the period we have met there have been a number of doctors who were reported for mistakes to the National Swedish Board of Health and Welfare. The majority of the reports are within the area of misunderstandings in the consultation, that the patient has felt that the doctor ignores or avoids talking about aspects that are important for the patient. A mistake within the field of medical skill is a minor issue. In the Balint group you can process what has happened as an acute handling of the crisis. But above all, it is a way of being able to reflect on what really happened without feeling rejected. The group has an arena to talk about the shame and how you are understood in the eyes of colleagues. In our discussions we try both to avoid underestimating the incident and to prevent the doctor from feeling deskilled by his anxiety. The GPs use the Balint group intensively to process the reports. AT doctors are also reported, but in their case there is always somebody else who is ultimately responsible, unless they have avoided asking for help.

Gathering medical doctors in Balint groups is a fairly uncommon concept in Swedish health care. It is a way for the doctors to make their jobs more meaningful, but it also has implications for the patients' situation. At least in my country patients have become more actively interested in how they are being treated. They are no longer willing to be passive health care consumers. Whether you are a doctor or a patient, when you have the feeling that you can't decide

on matters that are important to you, the quality of life is decreasing.

Michael Balint, in his preface to his book *The Doctor, his Patient and the Illness*, wrote: 'The most important aspect covered by the present book is a changed appreciation of the general practitioner's role during treatment: listening, understanding and using the understanding so that it should have a therapeutic effect.' This could be understood as a therapeutic effect on both the doctor and the patient! It is valid concerning GPs as well as ATs.

As a young doctor it is possible to make yourself behave in a way that resembles what you think the patient's stereotype of a doctor is. Some of the ATs have talked about becoming afraid of the patient, not daring to say what they mean. Before you are experienced, it is difficult to be a real person to your patients. On the other hand the doctor has to develop sensitivity for the emotional meaning behind the patient's physical symptoms. The foundation doctors don't have to work totally on their own, but they have to learn how to formulate what they think in front of the patient and gain approval for it with their supervisor second on call line. They need help to understand their own strength and weakness in the occupation, which leads to a safer ground when choosing what to specialize in later. I would also say that attending the Balint groups for AT doctors is a vital part of creating their professional identity.

An important aspect of being in this kind of group is that, very early on, when you are still easily able to adapt to new ways of working, you start using your colleagues in a reflective way. It means that later – whether you belong to a Balint group or not – you have had the experience that it is possible to confide in someone else when things are about to go wrong. You get a strong message early in your career that it helps to be open and honest in front of both patients and colleagues.

If the doctor has a good time it favours the patient!

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#### **References**

1. Balint Michael. *The Doctor, His Patient and the Illness*. London: Tavistock Publications Ltd 1964.
2. Bengtsson K, Reichenberg K, Skott A. Balintgrupper för blivande läkare. Ett sätt att bidra till yrkesmässig mognad. *Läkartidningen* 1997; 94:1605-1611.
3. Hårdelin Lars. En avgörande men begränsad förändring... Om Balintgrupper och tillämpad psykoanalys i sjukvården. *Bulletin från föreningen för Medicinsk Psykologi* 1997; 2.
4. Jablonski Henry. Balintgruppverksamhet – fortbildning för effektivare läkavård. *Läkartidningen* 1992; 89: 2867-68.
5. Olander Elisabeth. Att leda Balintgrupp på somatisk klinik. *Bulletinen för Svenska föreningen för holistisk psykoterapi och psykoanalys* 1997; 48: 27-31.
6. Olander Elisabeth. Balintgrupper på somatiska kliniker. *Svensk Medicin* 1997; 54.
7. Winnicott, D W. (1971) *Playing and Reality*. Pelican Books, London 1985.
8. Balint Michael. *The Doctor, His Patient and the Illness*. London: Tavistock Publications Ltd 1964.

9. Bengtsson K, Reichenberg K, Skott A. Balintgrupper för blivande läkare. Ett sätt att bidra till yrkesmässig mognad. Läkartidningen 1997; 94:1605-1611.
  10. Härdelin Lars. En avgörande men begränsad förändring... Om Balintgrupper och tillämpad psykoanalys i sjukvården. Bulletin från föreningen för Medicinsk Psykologi 1997; 2.
  11. Jablonski Henry. Balintgruppverksamhet – fortbildning för effektivare läkarvård. Läkartidningen 1992; 89: 2867-68.
  12. Olander Elisabeth. Att leda Balintgrupp på somatisk klinik. Bulletin för Svenska föreningen för holistisk psykoterapi och psykoanalys 1997; 48: 27-31.
  13. Olander Elisabeth. Balintgrupper på somatiska kliniker. Svensk Medicin 1997; 54.
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# On leaders' creativity and passion in Balint groups

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## Abstract

This paper describes the importance of creativity and passion in Balint work. Specifically, it looks at the way Balint leaders may facilitate and integrate these features into their groups. Emphasis is laid on the importance of cultivating and encouraging passion and creativity, in order to allow for novelty, imagination and originality for patients, doctors and the group process.

## Introduction

The aim of Balint groups is to assist physicians with the psychological aspects of their patients' problems. Balint groups were at first seen as essentially dynamic work discussion groups with the doctor-patient relationship as the focus (Balint 1957). They lead to a deeper understanding of patients' psychosocial issues and may change how the doctor perceives him- or herself. This is done when doctors, with the guidance of one or two leaders, discuss various aspects of the doctor-patient relationship. The groups encourage the physician to listen to the patient instead of using the traditional style of history-taking (Salinsky 1984). Today doctors listen to themselves too, when factors in their work related to doctors' issues (e.g. relationships with colleagues, team conflicts) are also discussed.

Recently there have been further developments in Balint work with health professionals. For example, there are Balint groups for hospital nurses discussing ward related emotional issues or Balint groups for psychiatric residents to discuss dynamic aspects of their patients. The focus of these groups is somewhat less clear, in that the group members here may have a working relationship outside the seminar group, perhaps in the same workplace. This is however not the case with Balint work with family physicians who generally work in different, independent family practice clinics.

Group discussion enable doctors to improve difficulties in their relationships with their patients, by sharing experiences, enhancing self worth and increasing professional confidence (Maoz et al, 1992; Rabinowitz et al, 1994; Rabinowitz et al, 1996). Balint groups have been used widely among residents in family medicine. However, qualified family physicians and other health professionals in private settings, as well as those working in HMOs have found that attending fortnightly Balint groups is important to manage the pressures experienced in their work (Maoz et al 1992; Clarke and Coleman, 2002). Attending Balint groups has therefore been seen to reduce professional stress since these groups

have been found to be supportive in encouraging empathetic listening and questioning. (Maoz et al, 1992; Novack et al, 1997; Rabin et al, 2000; Clarke and Coleman 2002). This has been found to help doctors comprehend and manage issues raised in the group. Through group participation, realistic frustration may replace intense feelings of helplessness and strain as outlined in various research papers (Rabinowitz et al 1996; Pittman and Coman 1998). Successful Balint experiences may allow doctors increase their confidence and self-esteem, providing them with a more positive sense of meaning.

## Creativity for leaders of Balint groups

Creativity involves the ability to bring something new into existence through conscious, unconscious or preconscious processes. It can be construed as beyond the realms of scientific study, fundamentally non-logical, non-rational, and even mystical (Rabin 2006). Since creativity seeks out different possibilities and choices, Balint leaders' dogmatic adherence to specific psychotherapeutic ideologies may not be useful. The group moderators therefore need a different, more flexible mode, where knowledge alone is replaced by inventiveness, innovation, spontaneity and openness. Creativity involves the leader relying on intuition, based on past experience, knowledge and skills, the ability to take risks and trusting 'gut feelings'. In this way, intervention by the leaders and group members may become a creative interaction.

Creative people often use the presence of some other person to give potential to their creative abilities. (Wolf, 1988). The 'other' does not necessarily have to be physically present to enable the person to be creative. An example can be seen in the interchange of letters between creative people. The writing of letters is a well-known form of communication among writers, often becoming creative published literature. Today this correspondence can take place via emails through the Internet. In this context we find that Balint group leaders often write down what unfolds in their Balint group. These leaders' notes, often rich in character, may be another source for Balint creative experience. Here one can look at the form and content of the written word, the rich descriptive analysis in the development of the presenter's narrative, his/her and the groups' emotional reaction to the case presented, and the intervention procedures adopted. This area is worth further investigation.

For the group 'the other' or 'selfobject' (Kohut 1971) may be the Balint leaders

themselves, serving as role models for the group members. The leader's empathizing, non-judgmental approach within the supportive ambiance of the Balint experience that he or she creates is important here. This may lead to positive identification and role modeling. The Balint leader therefore may provide the appropriate atmosphere for looking at the case, giving the presenter the security and inspiration to look at his/her dilemma creatively, thus allowing for greater introspection and insight.

Leaders' discussions of Balint group activity and experiences may in itself be seen as a creative experience. In their discussions they are able to share their doubts and mistakes. They are open to listen and learn from one another, drawing in the diversity of human experience. In their intervention, creative leaders generate numbers and types of options for looking at the case, considering various strategies for effective intervention.

Play and creativity in treatment have received increasing prominence over the years. Winnicott (1971) introduced the concept of intermediate space, an area in the psychotherapeutic process between external reality and internal fantasy, where play and creativity evolve. In Balint activity the group itself may become an area of play where the leaders create a safe and consistent environment for experimentation and creativity. This group space must be open, non threatening and supportive. It should enable the presenter and the group to reflect and develop through playing and experimenting, questioning often rigid internal structures (Ringel 2003).

### **A Balint Case Vignette**

In a Balint group Dr Rene Davis, presented the case of Sandy, a 19-year-old woman who had diabetes which began a year previously. Dr Davis worked hard to help Sandy control the illness, and over the year of their contact, Sandy was stabilized on a regular, modified sugar free diet, regular exercise and insulin injections.

Dr Davis reported to the group that a very special relationship had developed between them. Dr Davis listened very intently to the material about Sandy's dysfunctional family; her mother was a drug addict who abandoned her when she was three years old. Her father had difficulty in bringing her up alone which led to Sandy spending most of her childhood and adolescent years living in foster homes. She described herself here as someone without roots, lonely and often feeling depressed. Sandy now lived with her uncle and his wife whose three children had left home to study. She had an ambivalent relationship with her aunt whom she described as overbearing and intrusive, because she made excessive demands on her.

Dr Davis spoke about this patient's extraordinary effect on her. She told the group that she would invite Sandy on Wednesdays, as her last patient, making extra time for her. She

would think of Sandy often, wondering and worrying about her welfare. She asked the group to help her understand this special relationship with this patient, which she felt had become quite overwhelming for her.

The group leader allowed a lively discussion to take place in the Balint group. He decided that an open style at first was called for to allow for maximum discussion. At some stage in the discussion a group member asked Dr Davis if her possible over-involvement with Sandy could be due to her own difficult upbringing which she had revealed to the group previously. Dr Davis seemed to agree partially with this explanation.

The group leader then raised another issue for discussion. He asked the group whether they thought that it was legitimate for Dr Davis to give more time to one patient, at the expense of others. Here a heated discussion took place. Dr Davis admitted that she had guilt feelings about the excessive time she 'devoted to this case'. That may have been the reason why she presented the case to the group in the first place. She then insightfully understood that she may have even unconsciously wanted the group to reprimand her for her inappropriate professional behavior.

At this point the group leader turned to the group and said that he had noticed that Dr Davis had used the word 'devoted' previously. Here the group leader's aim was to spontaneously seek out and understand covert meanings of Dr Davis's use of language, words or symbols, in the search of understanding her better. He gently asked Dr Davis and the group what the word devotion could mean. This allowed the group to discuss both Dr Davis's (and their own) possible unreasonable needs to give perfect care and doctoring, to be equally dedicated to all of patients, at all times. They felt that Dr Davis may have been guided by her possible need to please and consequently had difficulties in setting limits. Here the group leader introduced the concept of demandingness, a feature of irrational cognitive thinking (Ellis, 1998).

The Balint leader then had another insight. He asked Dr Davis whether she saw the case perhaps related to her own family. Dr Davis gave a broad smile. She then told the group that she had thought of her own daughter and her relationship with her throughout the discussion. Her daughter was now ten years older than Sandy. She then recalled her long working hours in the clinic when her daughter was Sandy's age, her feelings of frustration at not being the perfect mother and perfect doctor, and the guilt she had felt. Dr Davis said that in her relationship with Sandy she was, however, able to make special time to listen, support, and encourage her. This was something she regretted not having done for her own daughter.

Dr Davis then had a further sudden insight in understanding the role of Sandy's aunt in her Balint narrative, for both Sandy and herself. The aunt had set limits on Sandy, having expectations from her. Dr Davis on the other hand

now had the privilege of just being there for Sandy, having allocated time for her, listening and caring. This allowed the group to see that Dr Davis's smile had expressed feelings of pleasure in treating emotions so familiar to them.

In this group, the leader used a wide range of interventions in which he fostered creativity by adopting a flexible, intuitive open and integrative perspective. He opposed a dogmatic adherence to specific psychotherapeutic ideologies. He was therefore not entrapped by pre-established theoretical frameworks but represented a more comprehensive, integrative approach allowing for active listening and original options for creative group interaction. This group communication enriched the presenter and the group alike.

### **Passion, creativity and Balint groups**

Passion can be looked at as an intense feeling expressed by the individual towards someone or something, which suggests purpose, striving and initiative. Passion provides a purpose to life, a direction, a striving or meaning to it. It can also be seen as strong enthusiasm towards a specific goal or person, and an intense feeling, sometimes seen as a barely controllable emotion. In the context of intimacy, passion may be seen as an emotional state that allows the crossing of boundaries of the self. It is the daring delivery of the self to a desired union with the other, in the face of possible risks and dangers. (Wolf 1988). It involves maintaining individuality in the midst of togetherness.

Passion in Balint activity can be seen in the enthusiasm doctors find in their profession and their work, and the importance they attach to Balint work specifically. Passion can be expressed by the intensity of the doctors' belief in the importance of relational medicine, while not solely relying on evidence-based medicine. Passion in Balint activity can be seen in the intensity in which the group facilitator listens to the presenter and other members of the group, and the ambience he/she creates within the group experience itself. Furthermore it involves the energy doctors put into their Balint activity and their commitment and sincere belief in their care for others. Doctors should be passionate in their attentiveness to listening and focusing on the presenter's story openly and sensitively, while being constantly aware also of their own personal narratives.

Passion is needed for effective creativity to take place and may be seen as interrelated in

many ways. Passion provides the purpose for creativity, the mobilizing strength, giving direction and meaning to it, including striving and initiative. It may therefore be seen as the enhancing and motivating force for creativity, the energy that helps the person fully to actualize his/her creative pursuits. Passionate leaders of Balint groups react with their enthusiasm, allowing the presenter to overcome the limitations of convention, challenging inappropriate cognitive structures for the sake of a more open cognitive style.

The unique attribute of empathic listening can be found in creative and passionate clinicians, involving paying careful attention and responding accurately and thoughtfully to every professional encounter. It involves articulating and expressing words, or alternatively being able to remain silent for a given moment, listening and reflecting about patients' manifest and latent stories (and ones own). Hutt (2006) stated 'Listening requires time'. Leaders of Balint groups should therefore be committed to find the time to listen and perceive the group's experiences.

Being passionate in our Balint work may energize and inspire leaders, and by so doing, prevent chronic stress and professional burnout. It empowers them, enabling creative talents to be used enthusiastically and effectively. As we strive to improve the consistency and professional nature of our Balint activity, it is important to continue to cultivate and encourage passion and creativity in our groups in order to embrace and accept novelty, imagination and originality in treating our patients, and caring for ourselves.

### **References**

- Balint, M. (1957). *The Doctor, his Patient and the Illness*. London: Pitman.
- Ellis A, Blau S (1998) *A guide to well-being using rational emotive therapy*. New Jersey: Citadel Press.
- Hutt, P (2006) Balint or bust. *BMJ Career Focus*, 332: 123-124.
- Kohut H (1971) *The analysis of the self*. New York: International Universities Press.
- Maoz, B; Rabinowitz, S; Herz, M&; Katz, H. (1992). *Doctors and their feelings*. New York: Praeger Books.
- Novack D H, Suchman A L, Clark W, Epstein R M, Najberg E, Kaplan C.(1997) Calibrating the physician: personal awareness and effective patient care. *JAMA*. 278:502-509.
- Pittman, P.L,Coman GJ (1998).The stress of metropolitan general practice. *Medical Journal of Australia*. 169,133-137.
- Rabin S (2006). Creativity and passion in psychotherapy. Submitted for publication.
- Rabinowitz S, Kushnir T&, Ribak J. (1994). The training of primary care community nurses using the Balint method. *Health and Social Care* 2. 60-63.
- Rabinowitz S, Kushnir T & Ribak J. (1996). Preventing burnout: Increasing professional self-efficacy in primary care nurses in a Balint group. *Association of the American Occupational Health Nursing Journal*. 44, 28-32.
- Salinsky J. (1984) Balint training: Does it help the patient or does it only make the doctor feel better? *Journal of the Balint Society*. 12, 26-29.
- Winnicott, D. W. (1971). *Playing and reality*. London, Routledge
- Wolf ES (1988). *Treating the self*. New York, Guilford Press.

# Late understandings on death and love

by Andre Matalon MD, general practitioner, Israel

ROSZIKA, a Hungarian woman, was 55 years old when I first met her. She was married and a mother of a 15-year-old daughter, and a 19-year-old son. I was then a 30-year-old recently graduated doctor, just beginning my specialization in Family Medicine. She held a doctorate in German literature, was a poet and translator, an extremely intelligent and interesting woman. Her brightness and charisma overshadowed her handicap – she had a severe chronic lung disease consequent on tuberculosis that she had suffered when she was a child in the concentration camps in Germany. Her breathing was all sound – loud, harsh, and frightening breath sounds, a result of her lung disease. Her health and life difficulties were many but she found comfort and support in her beautiful daughter. Anna was a tall, loving and helpful adolescent. Her beauty radiated, in marked contrast with the heavy, sombre, dark furniture and general atmosphere of their house. Her other son, I almost didn't see him. But at this time, Roszika's greater difficulty was not her health, but nursing her husband.

Most of our encounters took place at their house, when I was called to treat her husband Kurt, 20 years her senior, suffering from Alzheimer's disease. He had frequent cough from food aspirations, several episodes of fever and delirium, and urinary tract infections. He could not even walk alone. As a new doctor my first impressions were that through treating him I would become skilled at dealing with difficult symptoms, without the technologies that I had learned to rely upon during my medical training. Each time I had suggested it, the family refused to take him to hospital. The only time they complied was after he fell with an obvious fracture of the femur neck, and they just could not keep him standing up any more.

At the hospital, following their repeated efforts to get him on his feet, he received blood transfusions because of internal bleeding. Unfortunately after his fall, his cognitive functions further deteriorated, and the doctors decided not to operate on him since he would not be an appropriate candidate for rehabilitation. He was then confined to bed, as any movement would generate great pain. A few days later pressure sores developed and the family was informed of the doctors' wish to transfer him to a nursing home. After a family discussion they decided to take him home and nurse him by themselves. He became a living vegetable, without human perceptions, feelings, or recognition of others.

I was suddenly involved in a treatment that I was not prepared for – home hospitalization. The pressure sores were already very deep and large and in less than a month he would hardly eat any food, in his state of semi-

stupor. The family, with the agreement and blessing of my tutor, their long-standing personal family physician, accepted the inevitable and prepared for his death. He wished to die at home, in his own bed, and mentioned this frequently over the previous ten years. The family also decided not to feed him by a gastric tube.

The next ten days were the most difficult of my medical life, as my tutor had requested that I follow him up. At the end of my working day, I would come to their house, either to examine him or to talk to Roszika and Anna. Most of our discussions involved death and dying, especially the different philosophical approaches toward dying. I was directed by my tutor to read *On Death and Dying* by Kubler-Ross, an American psychiatrist who interviewed dying patients. Anna would escape from most of our common meetings, but at that time I lacked the understanding and maturity required to be aware of her suffering. I was overwhelmed by my own feelings. I remember well my fear and apprehension each time I had to go for the home visits. It was almost as if I myself was passing through all the stages written in the book. I would often come home depressed, sometimes angry at what I had experienced. But, Roszika was always there, talking to me, reassuring me that we were doing the right thing. She even went to her books and brought to me papers on different views and significance of death in the literature. She paid special attention to the Buddhist philosophy of 'good death', while dealing with and rejecting the accusations of some of her family members who felt that she was treating her husband cruelly.

I went to their house every day for ten days, each day thinking that this would my last visit, but it went on and on. His body was getting thinner and thinner, and his breathing became more and more shallow. Roszika and Anna changed places at his bedside every eight hours, washing and cleaning him up and preparing him for his last breath. I kept on thinking of their courage all the time. I failed to get them out of my mind, yet I had an inner feeling of calm, respect and being part of an important life lesson. I did not understand all its implications then. I also could not believe it would last so long. After ten painful days, Kurt died. I was, of course, there to be with them and signed all the formalities for the burial. I decided not to go to the funeral but again, I was there the same evening for the family gathering of the 'shivah', the Jewish ritual seven days of mourning during which people call on the family to comfort them. The ambience was cold and correct, but by my coming the atmosphere changed, and I could immediately feel their love and gratitude. Inside myself, I felt that it was me that should be sitting there – I had to mourn not only for my lost innocence in treating my first dying patient, but also for the re-discovery of my

own deep fear of dying.

Time went by and I lost contact with the family. I once recognized Anna at an art fair. She told me that she dropped out of formal education, made her life as an artist and went to live in a boat. She was even more beautiful than she was then, a young frightened adolescent. She also informed me that her mother was getting old and sick.

Suddenly, fifteen years later, Roszika came back into my life again. She got my telephone number and invited me for a house call. I was quite apprehensive at the beginning. All sorts of feelings from the past reawakened in me. Why was she calling me? It took no time for me to learn that she herself was now dying and wanted my help and assistance in her dying. She told me that she remembered my understanding and sensitivity when dealing with her husband's disease and dying. She had just been released from hospitalization for respiratory insufficiency and had been on mechanically assisted ventilation for almost one month after a common cold. She was aware that a simple upper respiratory infection would deteriorate her respiratory functions again. She was definitely in agony, breathing through an oxygen mask, talking with extreme breathlessness, and with the same loud and frightening sounds of breathing that I would never forget. She had also 'collected' more diseases. She now had a disabling tremor in her hands and was not able to write any more. She was also almost not able to read any more, because of her cataract in both eyes and her fear of going through an operation. Each little change in her body, each simple viral infection, each change in her medications would immediately cause an exacerbation of her lung disease and she would be hospitalized with respiratory insufficiency for mechanical ventilation. She showed extreme difficulty in going through three hospitalizations in the last six months. She was alone at home, with a nurse visiting her for two hours a day, to help her with personal hygiene. Life for her was no longer worth living, as she was not able to read and write and did not have her children at her side. Roszika was not to change her children's decision and life trajectory. Her son was now a cello classical music player at a German philharmonic orchestra and Anna lived 400 km from her. She asked me not to involve them in her condition and in her decision to end her life.

I was in an internal turmoil again. First of all I felt an understanding for Roszika's condition and existence. Secondly I felt a deep compassion for her. I remember the three hours sitting beside her, talking about her life narrative, her strength and determination to build a new life for herself after the Holocaust. She told me about her life with her husband, an older person, a 'father-like' figure who loved her very much, but whom she respected more than loved. Then she surprised me by revealing another story. Her real love was expressed in a long secret affair with a married

close friend. I was even more astonished when she disclosed his name – a distinguished politician from the community and a person whom I had known very well. In my mixed feelings my mind wondered between two thoughts – how was it possible for this man to have love with such sick woman? Was it possible that it was her fantasy about the affair? I felt almost like a confessional priest taking her last vows and wishes. I understood that it was her secret life story that she was depositing in my 'hands'. She was preparing for her departure.

Coupled with my deep listening and acceptance of her existential situation I also had angry feelings. She had called me to be her 'executioner', and I was in internal conflict and frightened. I could clearly feel my wish to flee. Fright, fight or flight? And, again, she was not asking me to take an active part in her death. She just asked me if any or all the drugs in her drawer were sufficient to kill her. She couldn't accept the possibility of a failed attempt. How could or should I answer these direct questions? Was it right to take away all drugs from her drawer? Was it necessary to hospitalize her, against her will, in a psychiatric hospital? But, she was not at all delusional or not even depressed. Was it right for me to involve her children, against her will?

Five years later I had the opportunity to think about it in retrospect, when I had the courage to bring Roszika to my Balint group. By the reflections of my colleagues I understood that she was not asking me which drug to take. She was intelligent enough to decide this for herself. She simply was not able to die with her secret. In her wish to close her life with a clean slate and a clean conscience, I was chosen to be her forger, the 'confessional' priest/ rabbi/ doctor, to whom she had to reveal her secret. And to me, it was clear that in her death, she was still in love. I still remember the sudden burst of tears and comfort that I got from my colleagues in this special session. I realized some very important aspects of our personal and medical life that were present in this story: the right to die, the free will to decide our own destiny, our right and privilege to participate in the most extreme situations of life, our role in guarding our dying patients' secrets, and being their ultimate conscience. All the doubts and dilemmas we have in our medical life were present in this story: what to do with our fears, courage, guilt, or shame. This story is also a mirror to each of us – it can happen to all of us. Will I be demented, will I lose all my humanity, will I suffer, will I be lonely at the end of life, will I have the internal strength to take decisions by myself or will there be somebody to listen to me? Is there 'a good death'?

Maybe my burst of tears was related to our ultimate, total love that we want in our lives, and to die lovingly, filled with compassion. Suddenly I had a further flash of insight and things became clear for me: I was crying for my life being lived in the shadow of my own endless need and search for love.

# Tolstoy's psychosomatic imagination in *Anna Karenina*

by Sotiris Zalidis, General Practitioner

Address given to the Balint Society on 6 December 2005

## Introduction

To meet the emotional challenges of general practice, doctors need to cultivate their emotional understanding, of themselves and of their patients (Zalidis 2001). Attending Balint groups is one of the ways of achieving this (Balint 1957). These can be thought of as workshops, in which doctors are slowly able to increase their emotional awareness by practising empathy exercises. That is to say, by putting themselves sometimes in the shoes of the presenting doctor and sometimes in those of the presented patient and imagining their feelings and their relationship.



Tolstoy's Katya on film.

John Salinsky has pointed out that another way of increasing our emotional awareness is by reading classic literature. In those great books we find an exploration and an understanding of the connection between emotions and behaviour (Salinsky 2002, 2003). *Anna Karenina* is of course one of those great books and I have written this paper in order to share with you something of what I have learnt from Tolstoy's empathic understanding of his characters (Tolstoy 1873).

Tolstoy's biographer, A. N. Wilson, says that one of the things that makes him such a memorable writer is his extraordinary capacity to be emotionally aware; his capacity to feel and describe any shades of intonation, look and expression (Wilson 1988). Tolstoy does not just describe the life events of his characters, leaving it up to us to imagine their feelings, but he names each emotion and describes the behaviour it causes and the changes on his characters' faces. He is very much face-aware. He not only describes the facial expressions, but also how the characters relate by responding to each other's facial signals and tone of voice.

Reading Tolstoy is exhilarating because I find words to think and speak about emotional experiences that are usually left unthought and unspoken, and for as long as I read the book at least, I feel emotionally intelligent. It is Tolstoy's high level of emotional awareness that allows him to put himself empathically in his characters' shoes and imagine with astonishing accuracy their feelings and their reactions to those feelings that often include illness. In the novel, when a character becomes ill a doctor is called to examine him and find out what is wrong. Because Tolstoy's doctors are not interested in their patients' feelings, they usually make the wrong diagnosis.

In the following summary I have highlighted the four medical consultations around which I have organized my paper. These emphasize the contrast between the limited understanding Tolstoy allows his doctors to have, and the extensive emotional understanding he shares with his readers.

## **Anna Karenina: summary**

This novel tells the story of Anna's adulterous love affair with Alexis Kirilich Vronsky that unfolds within the context of three interrelated marriages: the marriage between Anna and her husband Alexis Alexandrovich Karenin; the marriage between Anna's brother Stiva Oblonsky and Dolly, and the marriage between Dolly's sister Katya and Konstantin Levin. This is a novel of extraordinary complexity, but Tolstoy's technical brilliance enables him to pull off this most difficult feat of playing out several story lines in a seamless way.

Vronsky had been flirting with Katya whose mother hoped that he would propose to her. She thought he was socially a better match for her than Levin who had been in love with Katya all his life. When Levin proposed to Katya, she turned him down. He went back to his estate to recover from the humiliation of his rejection through immersion in the affairs of his estate and in particular the physical labour of mowing, an activity that he called 'work cure'. Katya felt guilty for hurting Levin's feelings but was confident that Vronsky would propose marriage to her at the next ball. At this ball however Vronsky ignored her and Katya in dismay watched him being entranced with Anna who reciprocated his feelings.

Katya became ill and began feeling tired all the time.

1. **She consulted a doctor who thought she had developed tuberculosis and recommended going abroad to a spa town for treatment.**

There she became cured of the humiliation she

experienced by Vronsky's betrayal, through understanding that you become calm, happy and beautiful when you forget yourself and love others. In the meantime Anna consummated her affair with Vronsky and became pregnant. Karenin denied his jealousy and therefore his shame resulting from Anna's betrayal. He did however feel miserable without knowing why.

**2. He consulted a doctor who thought he was at breaking point from the external demands of his job and advised him to avoid stress.**

Vronsky had been asking Anna to leave her husband but although she found living with him dull and emotionally unrewarding, she was afraid that a showdown would threaten her relationship to her son. Just before participating in a very important horse racing event, Vronsky, who was supposed to stay calm before the races, went to see her for good luck and she told him that she was pregnant. He felt so agitated by the news that at a crucial point in the race, he made a mistake and fell with the horse that broke its back and had to be destroyed. Anna was very upset to see him fall and realized that she could not live without him. So on the way home from the races she told her husband that she hated him and that she was in love with Vronsky. Karenin could not turn a blind eye any more. He did not know what to do.

**3. A doctor was called to assist in the delivery of Anna's second child who subsequently developed puerperal fever and nearly died.**

Karenin, moved by the nearness of death, decided to forgive her, grant her a divorce and allow her to take her son with her. Soon after that however Karenin came under the influence of religious friends who swayed him to punish her by not giving her a divorce and forbidding access to her son. Anna was torn between the love for her lover and the love for her son. She also suffered because she was shunned by her social circle. Vronsky could not understand her love for her son and she felt alone in her dilemma. However, she went to Italy with Vronsky to recuperate from her illness and avoid her friends.

In the meantime Katya and Levin met again, he proposed and she accepted him. They were deliriously happy and got married. Levin had to make the painful transition from being a bachelor who did as he pleased, to learning to consider his wife's feelings.

Fortunately they were both emotionally intelligent and loving people and were able to negotiate the jealousy that erupted frequently, and adapt to their wedded state. Soon after their marriage Konstantin's brother Nikolay became terminally ill with pulmonary tuberculosis and the couple went to meet him and provide terminal care.

**4. A doctor was called to see Katya who fell ill during this time. He diagnosed fatigue and worry and prescribed inner peace.**

She was in fact suffering from symptoms of early pregnancy.

In the meantime Anna developed blepharospasm as she tried to avoid seeing that she had become a social outcast and had no access to her son. She felt that the only thing that was left to her was Vronsky's love and became increasingly fearful that he might stop loving her. She entered a vicious circle. The more she became afraid he might stop loving her, the tighter she clung to him suffocating him. The more he felt smothered by her love, the more determined he became to defend his freedom. Anna was unable to accommodate Vronsky's bid for freedom and became tormented by jealousy. Her life became intolerable, and in a fit of vengeful rage she threw herself under a train and her body was dreadfully mutilated. Vronsky who was trying to control his despair by clenching his teeth and suffering excruciating facial pain, joined a military campaign against the Turks and went to fight and die.

### **First medical consultation**

#### *Katya's illness*

One day in the middle of the winter, the family doctor is called to do a home visit on Katya, who became ill suddenly. Katya was a very pretty, 18-year-old girl, the youngest daughter of an old, noble, educated and honourable family who lived in Moscow. Her illness started with a headache, immediately after a ball she had attended, and very soon, she began feeling tired all the time. She lost her appetite, began losing weight, felt irritable and lost all interest in social life. The family doctor treated her by prescribing cod liver oil and iron preparations but to no avail. Two months had passed, the winter was coming to an end and Katya was feeling no better.

The family doctor suspected that her illness had something to do with acute emotional stress, except that in those days it was referred to as a **'hidden moral or spiritual cause'**. He felt that the stress had predisposed Katya to the **beginning of a tubercular lesion** and recommended going to a Spa town in Germany, in the belief that a change of habits and removal from the conditions evoking memories could be beneficial.

Before taking such drastic action however, the family wanted a second opinion, and requested a consultation with a famous physician. The physician, who was practising the cutting edge medicine of his time, insisted in carrying out a thorough physical examination on the naked patient, dismissing her embarrassment as a relic of barbarism or an affront to him. After the examination, he conferred with the family doctor and said that although he could not be certain they were dealing with pulmonary tuberculosis because he found no clinical evidence of lung cavities, he shared the family doctor's suspicion that Katya was suffering from the **beginning of a tubercular lesion** because of her poor appetite and nervous excitation.

### The emotional setting of Katya's illness

Tolstoy does not give his doctors the emotional skills that would allow them to explore, understand and develop the right attitude to deal with Katya's feelings. However, he describes very accurately the emotional setting of Katya's illness allowing us to make sense of it. One day before the ball Katya, under the influence of her mother, who wanted not just a good but a brilliant match for her daughter, had rejected Levin's proposal of marriage and was feeling guilty.

Levin was a friend of her family. He was 32-years-old, stoutly built, broad shouldered and had a curly beard. He was not particularly attractive and was rather clumsy socially, but he had a very good character. He had known Katya since she was a child and loved her dearly. Katya loved him too, but she had fallen in love with Vronsky, who had been flirting with her in all the balls. He was one of the finest examples of the gilded youth of St. Petersburg; an imperial aide-de-camp, very well connected, terribly rich, and handsome, very calm and self-confident.

Katya had rejected Levin because she expected Vronsky to propose to her in that fateful ball. Unfortunately, Vronsky ignored her because he had fallen, head over heels, in love with Anna Karenina, whom he had met a few days previously at Moscow railway station. Katya was related to Anna in that her sister Dolly, was married to Stiva Oblonsky, Anna's brother. It was Stiva who had asked Anna to come to Moscow from St. Petersburg, where she lived with her husband and her 8-year-old son. He did so in order to help him become reconciled to his wife who was in the grip of humiliated rage since she discovered that he had betrayed her by having an affair with the children's French governess. It was Katya's turn to experience the pain of betrayal.

Tolstoy not only names the feeling that precipitated Katya's illness but describes in a scientifically accurate way how it was triggered. I quote: 'The most **painful** moment, happened at the ball when Katya expected Vronsky to invite her for a waltz but did not. When she glanced at him with surprise, he blushed and hastened to invite her to dance but had only put his arm around her slender waist and taken the first step, when the music suddenly stopped. Katya looked into his face, which was a short distance from hers, and long afterwards, for several years, that look, so full of love she gave him then **and to which he did not respond** cut her heart with **tormenting shame.**' Katya's shame was activated at the moment when she perceived in Vronsky's gaze a failure in the dynamic and fluid process of affective resonance, at the moment when she detected an impediment to the mutuality of positive affect, at the moment when Vronsky failed to reciprocate Katya's loving gaze.

The face has central importance in interpersonal relations, particularly during early life when facial gazing between mother and baby is the earliest form of communication and helps

primary identification. This sense of oneness is recaptured later in adolescence and adulthood whenever there is mutual surrender to visual merging. For human beings, the extended gazing into each other's eyes enhances the interpersonal bridge. By gazing in mutual enjoyment into one another's eyes we actually merge into one another, and however briefly we become one. An interpersonal bridge forms out of reciprocal interest and shared experiences of trust. Consistency and predictability are crucial to building an interpersonal bridge, whether with a child, a lover or a patient. Trusting must be matched by the significant other behaving in a trustworthy fashion (Nathanson 1992). According to Gershen Kaufman, betrayal is a powerful activator of shame because it destroys the interpersonal bridge and disrupts the sharing of positive affect (Kaufman 1993). Any barrier to continued shared positive affect will rupture the interpersonal bridge and precipitate shame.

### Painful and tormenting shame

Whenever we think of an emotion we need to consider the activating trigger, the physiological phase, the cognitive phase and finally the reaction to that emotion (Nathanson 1992). Although Tolstoy does not describe the physiological phase of Katya's shame, we can fill in the gaps. Katya would probably have felt something like a sudden painful shock or a jolt to her body, or a poorly defined churning in her gut. She must have blushed and experienced a sudden loss of tone in the muscles of the neck. This must have caused her head to droop and her eyes to become lowered, breaking contact with Vronsky's face. She must have felt confused and unable to think clearly. The physiological phase of shame that causes this cognitive shock is painful but rather brief. What happens next is the cognitive phase during which we are flooded with thoughts and memories of all past humiliating experiences, and we become aware that we have been 'hit' by an emotion. By and large, it is the history of our previous experiences of shame and the importance to us of these painful moments that will determine the duration and intensity of our embarrassment.

Leon Wurmser has created a highly condensed list of all the themes around which we experience shame (Wurmser 1994).

1. Matters of personal size, strength, ability and skill. (I am weak, incompetent, stupid.)
2. Dependence/Independence. (I am helpless.)
3. Competition. (I am a loser.)
4. Sense of self. (I am unique to the extent that I am defective.)
5. Personal attractiveness (I am ugly, deformed. The blush stains my features and makes me even more the target of contempt.)
6. Sexuality. (There is something wrong with my sexuality.)
7. Issues of seeing and being seen. (The urge to escape from the eyes before which we have been exposed.)

8. Wishes and fears about closeness. (A feeling that one is unlovable. A wish to be left alone for ever.)

Tolstoy gives us a glimpse of Katya's cognitive phase of shame when, after the doctor's visit, she reveals to her sister, her 'vile, disgusting and coarse thoughts'. I quote: "'Why, what kind of vile thoughts could you have?'" Dolly asked smiling. "The most, most vile and coarse – I can't tell you. It is not anguish or boredom, it's much worse. As if all that was good in me got hidden, and only what's most vile was left. Well, how can I tell you?" She went on, seeing the perplexity in her sister's eyes, "It seems to me that all my father thinks about, is that I have got to get married. Mama takes me to a ball: it seems to me she only takes me in order to get married quickly and be rid of me. I know it is not true but I can't drive these thoughts away. The so-called suitors I can't even look at. It seems as if they are taking my measurements. Before, it was simply a pleasure for me to go somewhere in a ball gown, I admired myself; now I feel ashamed, awkward."

### **Withdrawal reaction to shame**

#### *What was Katya's illness?*

Once shame has been activated we will either defend against it, or, if our self-esteem is good and we recognize the emotion, choose to accept it. If we accept it, we can use this particular moment of shame as an unexpected opportunity to learn from, to examine this impediment to positive affect and improve ourselves. However, because shame is such a painful experience, most of us will do anything to avoid it, or if it cannot be avoided, limit its toxicity. Any emotion is preferable to shame.

Donald Nathanson has organized the possible defensive strategies of reacting to shame into the four points of what he calls the compass of shame (Nathanson 1992). At the north point is the defensive strategy of Withdrawal, at the south point the one of Avoidance. At the west point is the defensive strategy: Attack self (being self-deprecating) and at the east: Attack other (being arrogant, contemptuous, turning the tables on others and shaming them). Each of these categories represents an entire system of affect management, a set of strategies by which an individual has learnt to handle shame affect. Most people from time to time use techniques and strategies of all four systems. Nevertheless to the extent that we can be said to have a personal style, we tend to favour one or another of these systems of defence. I think that Katya's illness, which lasted over two months, has to be understood as the result of choosing a withdrawal strategy of defence against shame, rather than the shame affect per se.

The duration and intensity of withdrawal may be quite variable. At one end of the spectrum there are gestures that last seconds, such as lowering the eyes and glancing down, putting a hand to our lips as if to prevent our mouth from

speaking unacceptable words, biting the lower lip. At the other end of the spectrum there are periods of depression during which the person becomes isolated like a hermit. Between them lie an infinite number of forms and types of withdrawal. Katya's withdrawal allowed her to be overwhelmed and at the same time offered her two advantages. It protected her from further humiliating incidents and allowed her enough time to reflect on everything that had flooded into her consciousness. It gave her time to recover her self-esteem so that she could emerge into the world of others stronger.

### **Therapy**

Shame makes us want to hide and exposure activates shame. When the physician insisted in examining Katya naked and dismissed her embarrassment, he unwittingly compounded her shame, and with his total lack of empathy destroyed any possibility of trust building up between them. Tolstoy gave the task of therapy to Dolly who had an empathic understanding of Katya's predicament as she had recently experienced the humiliation of betrayal at first hand. Dolly recognized and validated Katya's feelings and reassured her that shame is an experience that everybody has suffered and survived. The conversation initially mobilized Katya's humiliated rage that she vented on her sister by expressing contempt for going back to the unfaithful husband. She was about to break the interpersonal bridge by walking out of the room in a rage, but she saw Dolly crying and felt guilty for hurting her. She burst into tears too and embraced her sister, thereby restoring the interpersonal bridge. This is how Tolstoy puts it: 'As if tears were the necessary lubricant without which the machine of mutual communication could not work successfully, the two sisters after these tears, started talking not about what preoccupied them, but about unrelated things and yet they understood each other.' This conversation between the sisters restored the interpersonal bridge and marked the beginning of Katya's recovery.

Donald Nathanson has written that the withdrawal system of adaptation to shame is the easiest to treat in psychotherapy. To do so, it is important to be empathic and show that you feel and understand the other person's pain. It is important to talk about shame in a manner that makes the patient feel that she is not alone in feeling that way. It is important to understand that the patient cannot return to normal interaction without help.

The therapist must be willing to educate the patient about the definition of the shame experience and to acknowledge humiliated rage and the guilt that follows. It is important to drive home the concept that the basic feature of any period of shame is an innate affect, a brief, scripted physiological experience, common to all humans, which lasts a very short time. It is also important to emphasize that even though these

moments tend to feel endless, eventually they will pass. The very fact that patient and therapist continue to talk, continue to maintain some form of empathic link, counteracts one of the main elements of the shame experience, the breaking of the interpersonal bridge.

### **Healthy pride**

Katya had become disgusted with the attentions of eligible young men. They made her feel as if she were exhibiting her wares waiting for buyers. She was ready to start looking for new interests in life and found this opportunity in Soden, the German Spa town. There she made friends with Varenka, a young woman whose natural and unselfconscious way of relating to the sick Katya admired. Varenka had the capacity to call everything by its name and was able to reassure her that almost everybody has felt the humiliation of rejection and it is not very important. She too had been rejected by the man she loved but she had a much more philosophical response to it, and besides she had found that helping the sick was more important. For Katya however, an obstacle to helping the sick was the disgust she felt for all consumptive patients including Nikolay, her future brother in law, whom she met for the first time in Soden. She worked hard at mastering her disgust, by imitating Varenka in all her activities. She even imitated her way of walking, speaking and even blinking her eyes. Gradually she overcame the revulsion she felt in the presence of tuberculous patients and felt proud that she was fulfilling the duties of a sister of mercy particularly in relation to the family of the sick painter Petrov. This pride was another step towards Katya's recovery of her self-esteem. Donald Nathanson stresses that healthy pride is competence pleasure and that efficacy experiences, or anything that can give us a moment of pride, are capable of counteracting shame.

When Katya returned to Russia she was cured. She was not as carefree and gay as before, but she was at peace. Her Moscow griefs became memories.

### **Second medical consultation**

#### *Karenin's illness*

Alexei Alexandrovich Karenin, a man in his early fifties, was a government official who occupied one of the most important positions in the ministry. Every year at the beginning of summer he went abroad to a spa location to recuperate from the hardships of his job. However last year it seemed to him was the busiest in his life and the trip abroad did not help him feel better. He felt exhausted, became irritable and lost his appetite. He looked ill and his friends were concerned about his health. Lydia Ivanovna arranged for her doctor to call on him for a medical check up.

#### **The consultation**

The doctor arrived when Alexei Alexandrovich least expected him, one day in July when he was

about to go and watch the horse races. He questioned him very attentively about his condition, sounded his chest, tapped and palpated his liver. The doctor was very displeased with Alexei Alexandrovich. He found his liver considerably enlarged, his appetite insufficient and the waters of no effect. He prescribed as much physical exercise and as little mental strain as possible, and above all to avoid stress – something as impossible for Alexei Alexandrovich as not to breathe. He went off leaving Karenin with the unpleasant awareness that something was wrong with him and that it could not be put right. The doctor assumed that hard working Karenin was at breaking point from the external demands of his job. Tolstoy as usual, does not give him the skills to explore Karenin's internal causes of stress. He does however give us enough information to understand that Karenin is in denial.

#### **The emotional setting of Karenin's illness: Karenin's childhood**

Alexei Alexandrovich had grown up as an orphan. He had a brother. They did not remember their father; and their mother had died when Alexei Alexandrovich was ten.

Tolstoy was an orphan too. He lost his mother when he was barely two and he could never remember her face. When he was ten years old his father died. In creating Karenin, Tolstoy reverses the order of death of his own parents and this makes me wonder whether Karenin represents Tolstoy's negative identity, what he could have turned into, if he did not have the gift of his extraordinary emotional awareness and empathy, or if he did not have the very close affectionate relationship with Tante Toinette, a distant aunt who looked after him following his mother's death. It was from her and perhaps **only** from her that he had any display of physical affection when he was a young child, and it was from her that he learnt the spiritual delight of love (Wilson 1988).

Tolstoy allows us to imagine that Alexei Alexandrovich did not have the benefit of such close and loving relationship. The fortune was small. Their uncle Karenin, an important official and once a favourite of the late emperor, had brought them up. Having finished his school and university studies with medals, Alexei Alexandrovich, with his uncle's help, had set out at once upon a prominent career in the civil service, and since then had devoted himself exclusively to his service ambitions. Alexei Alexandrovich had never made any close friends. His brother had been the closest person to him, but he had served in the ministry of foreign affairs and had always lived abroad, where he died shortly after Alexei's marriage.

Alexei Alexandrovich had one weakness that contradicted his cold and reasonable character and no one except the people closest to him knew. He was unable to hear and see the tears of a child or a woman with indifference. The sight

of tears perplexed him and made him lose all ability to reason. His office manager and his secretary knew it and warned lady petitioners that they should not weep, if they did not want to ruin their chances. 'He'll get angry and won't listen to you', they said. And indeed, in such cases the inner disturbance produced in Alexei Alexandrovich by tears expressed itself in quick anger. 'I can do nothing, nothing, kindly get out', he usually shouted. By giving him this attitude to crying, Tolstoy allows me to imagine that Karenin is not totally insensitive but rather afraid. He is afraid of the shame that is triggered by the weakness implied in the display of crying and all tender feelings.

### **Karenin's marriage**

During his governorship, he was introduced to Anna, who was twenty years younger than he was, by her aunt, a rich provincial lady, who had brought her up. She put him in such a position that he had either to declare himself or to leave town. Alexei Alexandrovich had hesitated for a long time. There were then as many reasons for this step as against it, and there was no decisive reason that could make him abandon his rule: when in doubt, don't. But Anna's aunt insinuated through an acquaintance that he had already compromised the girl and that he was honour-bound to propose. He proposed and gave his fiancée and wife all the feeling he was capable of. The attachment he experienced for Anna excluded from his soul the last need for heartfelt relations with other people. And now, among all his acquaintances, there was no one who was close to him. Alexei Alexandrovich had many people whom he could invite for dinner, or discuss work with; but his relations with these people were formal. Of people living in Petersburg, one of the closest was his doctor. He was well disposed towards him, but they had long ago come to a tacit agreement that they were both buried in work and always in a hurry.

### **Lack of empathic understanding**

During the eight years of his marriage, Karenin had always taken Anna's fidelity for granted, and as long as she observed the rules of propriety he did not pay much attention to her feelings. Had he done so, he might have noticed that since Anna met Vronsky, she had begun to find his physical appearance repulsive and in particular his prominent ears and his habit of cracking his fingers. It is interesting that John Gottman calls the appearance of disgust or contempt in marriage interactions one of the four horsemen of apocalypse predicting marital breakdown or dissolution. (The other three are criticism, defensiveness and stonewalling.) (Gottman 1997).

When Anna started seeing Vronsky regularly at social meetings, her husband denied his jealousy for over a year. It was only when he noticed that the other guests at a party they had both attended found Anna's and Vronsky's

intimacy improper, that he too found it improper and decided to say so to his wife and warn her that her behaviour was giving rise to malicious gossip. When that evening he tried to have this conversation, Anna responded with a mocking attitude of perplexed incomprehension, essentially stonewalling him and refusing to deal with his feelings. Since this failure to have a conversation with Anna, inwardly their relations had changed completely even though things outwardly appeared the same.

Karenin was ashamed to feel jealous. He believed that jealousy was insulting and a man ought to have trust in his wife. Why he ought to have trust – that is complete assurance that his young wife would always love him – he never asked himself. For the first time in his life he began thinking about Anna's life, about what she thought and felt. For the first time he vividly pictured to himself her personal life, her thoughts and wishes. The thought that she could and should have her own private life seemed so frightening to him that he hastened to drive it away. To put himself in thought and feeling into another being was a mental act alien to Alexei Alexandrovich. He regarded this mental act as harmful and dangerous fantasizing. He repressed and denied his suspicions and jealousy and never talked to her about them again but he was somewhat colder towards her.

Although he was so intelligent and subtle in official business, he did not understand all the madness of such an attitude towards his wife. He did not understand it because it was too dreadful for him to recognize his real position and in his soul he closed, locked and sealed the drawer in which he kept his feelings for his wife and son. If anyone had had the right to ask Alexei Alexandrovich what he thought about his wife's behaviour, the mild placid Alexei would have made no reply but would have become very angry with the man who had asked him about it. He did not allow himself to think of it, nevertheless, in the depths of his soul, he knew that he was a deceived husband, and it made him deeply unhappy.

### **Avoidance of shame**

Jealousy may be said to occur when a person either fears losing, or has already lost an important relationship with another person to a rival. Jealousy may be experienced in a number of ways, but typically these are thought to include fear of loss, humiliation over betrayal, humiliated fury and insecurity or doubt (Parrott 1991).

Just as Katya responded to her shame with withdrawal, Karenin responded to his with denial. It is possible to imagine that with his mother's death so early in his life, Karenin was deprived of the close, affectionate, maternal relationship that was so vital for his healthy development. It is possible to imagine that in the absence of a loving maternal substitute he might have been brought up to believe that there was something defective in him that made him

unlovable. He avoided the shame of his unlovability by shifting attention to something that could evoke pride, such as distinguishing himself with hard work and winning medals at school and achieving status later in life through overwork and devotion to duty.

According to Donald Nathanson there are two styles of shame-avoidance related to a sense of being unlovable: the acquisition and display of trophies, and the pursuit of new levels of ability, competence and wealth. Although Anna could be seen as a trophy wife, who bolstered his self-esteem with her youth, her beauty, her aliveness, and her naturalness, Karenin, by being unable to accept that she may have a private inner life, treated her almost as an extension of himself. The threat of loss of such a relationship amounts to the threat of loss of self and can arouse shame. Karenin denies his shame and remains unaware of his jealousy. Helen Block Lewis has shown that although the assumption is often made that if there is no awareness there is no emotion, the truth is that important emotions occur outside the patient's awareness. According to Helen Block Lewis, shame is an inevitable human response to loss of love. Humiliated fury, which is the inevitable accompaniment of shame, angrily protests the loss while demanding restitution of the other's positive feelings. Fury is pushing to turn the tables and send the shame back where it came from. But being angry with, and wanting the love of the same person is inherently disorganizing. Humiliated fury will not do it; expressing such fury is likely to get the self into even more trouble with the other, especially if humiliated fury is felt by the other as inappropriate or blameworthy. It seems to me that Karenin had to blind himself to Anna's betrayal in order to protect himself from becoming aware of the humiliation that could reactivate the trauma of losing his parents.

#### **'Attack other' reaction to shame: humiliated rage**

When Anna told him after the races that she was Vronsky's mistress and that she hated him, Karenin felt briefly a cruel pain in his heart, probably a pang of shame. But left alone in the carriage, Alexei Alexandrovich, to his own surprise and joy, felt complete deliverance from the doubt and jealousy that had lately tormented him. But that feeling had been replaced by humiliated rage that created the wish to punish her. As usual he did not acknowledge this feeling, but in the depths of his soul he wished her to suffer for disturbing his peace and honour. Alexei Alexandrovich became convinced that there was only one solution. To keep her with him, concealing what had happened from society, and taking all possible measures to stop their affair. He deceived himself by thinking that with his decision he was not punishing her but that he was acting in conformity with religion. This religious sanction of his decision gave him full satisfaction and protection from guilt.

### **Third medical consultation**

#### *Anna's disease*

One winter's day at St. Petersburg, the doctor is called to Anna Karenina's home to assist in the birth of her second child. Soon after the birth of a healthy daughter she develops a high temperature, becomes delirious and confused and has episodes of unconsciousness. The doctor diagnoses puerperal fever, a contagious disease that in ninety cases out of a hundred ends in death. He treats her fever by applying crushed ice and her agitation by administering morphine. Alexei Kirilich Vronsky, the father of the baby, is by her bedside, but Anna feels that she cannot die in peace unless her husband forgives her and has a telegram sent to him in Moscow where he is on business, imploring him to return as soon as possible. Alexei Alexandrovich on the way home tries in vain to repress a wish that she dies.

#### **Puerperal fever**

Tolstoy was writing Anna Karenina in the years 1873 to 1877 and by that time the infectious nature of puerperal fever had been established. In fact we learn from Roy Porter that puerperal fever had been attributed to putrid matter introduced into the uterus by the midwife or doctor as early as the late 18th century by Alexander Gordon (1752-1799), a Scottish physician. However, it was Ignaz Semmelweis (1818-1865), a Hungarian physician, who in the middle of the 19th century proved beyond doubt the contagious nature of the disease. He reduced the mortality rate from 29% to 1% by insisting that the doctors washed their hands and their instruments in chlorinated water before every delivery. Despite this evidence however, the orthodox wisdom that puerperal fever was neither contagious nor, perish the thought, caused by doctors, lingered on (Porter 1997). Tolstoy knew that infection is caused when an infective agent meets a vulnerable host. Contact with the doctor's contaminated instruments or hands would have supplied the streptococcus, but what could have contributed to an increase in Anna's vulnerability?

#### **The emotional context of Anna's disease: giving up – given up complex**

In considering this question, George Engel's research on the giving up – given up complex, is relevant here. This complex is a psychological state that he found to precede the onset of physical illness in about 70% to 80% of cases (Engel 1968). Perhaps the most characteristic feature of this complex is a sense of psychological impotence, a feeling that for shorter or longer periods of time one is unable to cope with changes in the environment, a situation where the psychological or social devices utilized in the past seem no longer effective or available. In place of the smooth, almost effortless integration of behaviour and the sense of mastery of the environment that mark effective functioning, there is a disruption, a pause, an

interruption, while the mind seems to search in vain for a solution. And for that period of impasse there is a profound alteration in how one sees one's environment.

From interviews with thousands of patients who described their life setting and their feelings before the start of their illness, Engel identified five characteristics of the giving up – given up complex.

1. The giving-up affects of hopelessness and helplessness.
2. A depressed image of oneself.
3. A loss of gratification from relationship or roles in life.
4. A disruption of the sense of continuity between past, present and future.
5. A reactivation of memories of earlier periods of giving up.

Tolstoy provides a masterful account of Anna's affect state preceding her disease that includes all the elements of the giving up – given up complex. Anna, a woman in her early thirties, had been married for eight years, to Alexei Alexandrovich, a man twenty years her senior. His cold and ironic attitude did not appeal to her passionate nature and she could not love him. Although she compensated for the absence of love in her marriage by doting on her son and enjoying her social life, she yearned for love. When Vronsky declared his passionate love for her, nearly two years before the baby was born, Anna reciprocated his love after a brief struggle with her conscience. At first everybody thought that their affair was a momentary passion that would go away, as society liaisons do, leaving no traces in the life of either one of them, except some pleasant or unpleasant memories.

However, soon their passion proved to be all-consuming and even though they tried to conceal it by lying to their friends and deceiving their relatives, everybody noticed and started gossiping about it. Anna and Vronsky began to feel frustrated by the restrictions imposed on their relationship and by the need to observe propriety. They longed to be able to enjoy their love freely. Vronsky had been asking her to tell her husband the truth so that she could ask for a divorce and leave him. Anna however, was very reluctant to do so because such a solution would damage her relationship to her son and her standing in society. Anna managed to avoid thinking of the consequences of their love affair for about a year, until she became pregnant. Then, as the pregnancy progressed, she realized that it would not be possible to pretend that nothing had changed and she felt more and more under pressure to do something. This situation came to a head immediately after the races, during which she became distressed when Alexei Vronsky fell with his horse and she thought he was hurt. When Karenin objected that her behaviour was not becoming, she told him in an agitated state that she hated him and that she was Vronsky's mistress. Although in the heat of her agitation she felt that this was the right thing to do and that her

situation at last would be clarified, the next day she realized the hopelessness of her situation.

### Hopelessness

Engel describes hopelessness as the feeling of the person who blames herself for her failure or inability to cope, and has no expectation that any change in the environment is possible or will help. Responsible for her own fate, she feels that help, even if offered, will be of no avail.

Anna suddenly realized that she was terrified of disgrace which she had not even thought of before. She felt that the position she enjoyed in society, which seemed so insignificant to her until the races, was precious to her and that she would not be able to exchange it for the shameful position of a woman who has abandoned her husband and her son and joined her lover; that try as she might she could not be stronger than she was.

She felt guilty towards her husband and anticipated his punishing her by trying to take her son away, something unthinkable. Anna felt hopeless about preventing a change in her relationship to her son. When she thought of her son, and his future attitude towards the mother who had abandoned his father, she felt so frightened at what she had done that she did not reason but tried to calm down by deceiving herself with false arguments so that everything would remain as before, and she could forget the terrible question of what would happen to her son. She was getting ready to take her son and go away, when Karenin's letter arrived making her an offer. He would allow her to stay in his home and continue living with her son, provided she did not see her lover again. He left it up to her to imagine what would happen if she disobeyed.

Reading the letter, Anna in despair realized that she would not be able to get out of her former situation however false and dishonest it was. She knew that everything would stay as it had been and would even be far worse than it had been. She would never experience the freedom of love, but would forever remain a criminal wife under threat of exposure every moment, deceiving her husband for the sake of a disgraceful affair with another, an independent man with whom she could not live life as one. She knew that this was how it would be, and it was so terrible that she could not even imagine how it would end. She did not know whom to turn to for help and felt helpless.

### Helplessness

Engel describes helplessness as the feeling of the person who blames the failures of the environment for her impotence and at the same time looks to it to provide a solution.

In her state of mind Anna imagined that Vronsky did not love her and that he was beginning to feel burdened by her. He did not suspect how torn she felt between her love for her son and her love for him, and therefore she felt alone in her dilemma, could not ask for his help

and she hated him for that. Even the thought of seeking solace from religion in her situation was as foreign to her as seeking help from her husband. She knew beforehand that the help of religion was possible only on condition that she renounced everything that made her life meaningful.

Tolstoy, by creating Anna maternally deprived, adds the final element of the giving up - given up complex: a reactivation of earlier memories of giving up. He allows us to imagine that as she is considering the impossible choice between losing the love of her son or the love of Vronsky, she experiences a reactivation of feelings aroused by her own motherlessness. Abandonment of a child by her mother, at one level is experienced by the child as a betrayal. It creates doubt about one's lovability and arouses helplessness that is a form of shame. It brings in its wake the violent protest of humiliated rage.

The tragedy of Anna is that she submits to the compulsion to repeat the trauma of motherlessness. She does so by inflicting it on her son whom she abandons in her own search for unconditional love. She is overwhelmed by the toxic mix of guilt, fear of abandonment and shame. In a state of humiliated rage she kills herself in a violent way and turns the tables by abandoning everybody. Vengeance is mine!

#### **Increasing susceptibility to disease**

Engel proposed that during the giving up - given up state, the total biologic economy of the organism may be altered in such a way that its capability to deal with certain potentially pathogenic processes is reduced, permitting disease to develop. However, the predisposition to the organic disease must already exist; otherwise the person may be psychologically distressed but she will not become ill. Thus, this psychobiologic condition contributes to the emergence of the disease; it does not cause it, nor is it a necessary or sufficient condition for disease development. Engel pointed out that there was ample evidence in modern neurophysiology and neuroendocrinology and neuroimmunology to show that it is precisely when the central nervous system is failing in its task of processing information that emergency biologic defence systems are invoked. Such failure results when the organism is overloaded by environmental information, or when no program or response to the information is available, or, in psychological terms, when information cannot be handled promptly and effectively by mental mechanisms alone. Under such circumstances the organism does not have a relevant behaviour with which to respond. At this point the limbic structures of the forebrain and midbrain forming an elaborate neural circuit with the hypothalamus in the centre, respond by mobilizing emergency systems to prepare the body to deal with or avoid damage. Engel conceptualized the biological component of the complex as conservation - withdrawal, a biological defence system that has survival value

unless prolonged; it is associated with a predominance of parasympathetic activity and anabolic functions in contrast with the fight-or-flight response, which involves the sympathetic nervous system and catabolic functions that was part of all previous psychosomatic theories. Once the giving up - given up complex develops, it was thought to initiate autonomic, endocrinologic and immunologic processes which lower the body's resistance and allow the emergence of disease.

#### **Fourth medical consultation**

*Nikolay's death and Katya's pregnancy.*

*Katya's symptoms*

Katya and Kostya Levin finally got married at about the same time as Anna was giving birth to her baby. They were rather surprised to discover that although they were happy together and in love, they could still argue and feel jealous of each other at times. Three months after their wedding, Levin received a letter from Marya Nikolaevna, his brother's woman, informing him that Nikolay was dying in a hotel room at a provincial town. Levin decided to go at once and be with his brother during his last days and Katya declared her intention to go with him. Levin's immediate reaction was to refuse. He assumed that the main reason she wanted to go with him was to avoid being bored on her own. Besides, he wanted to be free from responsibility to his wife so that he could concentrate on his brother's needs. Also he was afraid that her honour would be compromised by staying under the same roof with his brother's woman, who was a slut.

As soon as Katya heard his reasons she became offended and angry that he was ascribing mean motives to her. She burst into tears and protested vehemently. 'It has nothing to do with my fear of being on my own', she declared, 'I feel it is my duty to be with my husband when my husband is in distress.' When Levin realized that he could not put her off, he decided grudgingly that they would go together the next day.

Nikolay's terminal illness lasted ten days. On the tenth day Katya fell ill. She had a headache, vomited and could not leave her bed all morning. The doctor was called who as soon as he found out what Katya was involved in, assumed that her illness was caused by fatigue and worry, and prescribed inner peace! However, after dinner, Katya got up and went to tend the sick man as usual. Later that night Nikolay died. As Katya's "illness" persisted, she soon suspected that she was suffering from symptoms of early pregnancy and the doctor was able to confirm her suspicions.

#### **The fear of disgust**

Tolstoy as usual does not give the doctor the emotional skills to explore whether Katya was equal to the task she had undertaken. Instead he makes him assume that Katya was overwhelmed by negative feelings. If he had the capacity however, to evaluate Katya's frame of mind he would have discovered that even though she felt

exhausted both morally and physically, she had in her the excitement and quickness of judgment that appears in men before a battle, one of those dangerous and decisive times in life, when once and for all a man shows his worth and that his whole past has not been in vain but has been in preparation for those moments. Tolstoy leaves us in no doubt about which one of the two was better equipped to deal with the emotional labour they had undertaken.

As soon as they arrived at the provincial capital, they booked a room in the same seedy hotel Nikolay was staying, and Levin went on his own to his brother's room to see him. He had in no way expected what he saw and felt there. He had expected to experience pity, at losing his beloved brother, and abstract horror in the face of death, in other words, the same feelings that he had experienced when Nikolay had come to visit him in his estate a year earlier, only to a greater degree. And he had been preparing himself for that. But he found something else entirely.

When Tolstoy writes of abstract horror, he means mental horror, disembodied horror, horror without somatic involvement. Silvan Tomkins has emphasized that horror is a composite emotion consisting of fear and disgust, and that disgust is probably the most visceral of all emotions, creating a sense of nausea with all the unpleasant autonomic effects that go with it (Tomkins 1963). It was this somatic response that was activated by what Levin saw and smelt.

He saw a small, dirty room, with bespattered painted panels on the walls. He smelt an atmosphere pervaded with a stifling smell of excrement. And then on a bed moved away from the wall, he saw a blanket covered body. One arm of this body lay on top of the blanket and an enormous, rake like hand was in some incomprehensible way attached to this bone thin long arm. The head lay sideways on the pillow. Levin could see the sweaty, thin hair on the temples and the taut, as if transparent, forehead. He could not believe that this terrible body was his brother Nikolay. But when he came nearer and saw the face, doubt was no longer possible. Despite the terrible change in the face, Levin had only to look into those living eyes raised to him as he entered, notice the slight movement of the mouth under the matted moustache, to realize the terrible truth, that this dead body was his living brother.

Levin smelt the terrible stench, saw the filth, the disorder and the painful posture, heard the groaning and felt that it was impossible to be of help. It did not even occur to him to look into the details of the sick man's state. It did not occur to him to think of how his body lay there, bent awkwardly under the blanket. It did not occur to him that his limbs could be laid out more comfortably. It did not occur to him to do something, if not to improve things, at least to make them less bad. A chill went down his spine when he began to think of these details. He was certain beyond doubt that nothing could be done

to prolong his brother's life or alleviate his suffering. But the sick man sensed that his brother considered all help impossible, and was annoyed by it. And that made it even harder for Levin. If Levin had been alone with his brother, he would have looked at him with horror and would have waited with still greater horror until he died, unable to do anything else. Levin felt quite sick and could not wait for an excuse to go out of the room and get rid of the painful feelings, at least for a moment. During a gap in the conversation, and profiting from a moment of silence, Levin stood up and said he would go and bring his wife. When he was in the corridor he stopped. He had said he would bring his wife, but now aware of the feeling he had experienced, he decided on the contrary to try and persuade her not to go and see the sick man because he assumed that she would suffer in the same way as he did, and wanted to spare her this suffering.

### **Mastery of disgust**

Most of the time we make the assumption that in similar circumstances we all feel the same, and that a named emotion is the exact duplicate of our own. This is an adaptive assumption that confirms our common humanity and allows us to imagine other people's feelings. However, this is not always the case.

Levin assumed that Katya would feel the same way as he did, but Katya, thought, felt and acted quite differently. At the sight of the sick man she felt pity for him. And pity in her woman's soul produced none of the horrors and squeamishness it did in her husband, but a need to act, to find all the details of his condition and help with them.

She was interested to find out about Nikolay's condition and when Levin asked her to come in, she entered his room walking with a light tread. She kept glancing at her husband and showed a brave and compassionate face. She gently closed the door behind her and with inaudible steps approached quickly the sick man's bed. She placed herself so that he would not have to turn his head, and took his enormous, skeletal hand in her own and pressed it. She began talking to him with that unoffending and sympathetic animation peculiar only to women.

'We met at the Spa town in Germany but did not become acquainted', she said, 'You never thought I'd be your sister.'

'Would you have recognized me?' He said lighting up with a smile as she came in.

'Yes, I would. You were so right to let us know! There wasn't a day when Kostya didn't remember you and worry about you.'

Katya did not have the slightest doubt that she had to help him, and so she got to work at once. Those same details, the mere thought of which horrified her husband, at once attracted her attention. She sent for the doctor, sent to the pharmacy, ordered Marya Nikolaevna and the maid who had come with her to sweep, dust, and scrub. She washed and rinsed something herself.

She gave orders with such gentle insistence that it was impossible for anybody to walk away from her. Levin at first disapproved of it all. He thought that Nikolay might become angry. But though he seemed indifferent he did not get angry but only embarrassed.

Katya gave orders to have Nikolay's underwear changed. When he protested she understood that he found it embarrassing and unpleasant to be naked in front of her and so she averted her gaze and said: 'I am not looking I am not looking.' Unlike the doctor who examined her when she was ill, Katya did not ignore and dismiss the sick man's shame at his nakedness and helplessness. Instead, she acknowledged his embarrassment and respected his modesty.

At this point Levin walked in and Katya sent him to find a small vial.

When he returned with the vial, he found the sick man lying down and everything around him completely changed. The heavy smell was replaced by the smell of vinegar and scent. No dust could be seen anywhere. Vials and a carafe stood neatly on the table where the necessary linen lay folded. The sick man himself, washed and combed lay on clean sheets, on high propped pillows. He looked at Katya, not taking his eyes off her, with a new expression of hope. The doctor Katya sent for arrived and took out a little tube and listened to the patient's chest. He shook his head, wrote a prescription, and explained with particular thoroughness first, how to take the medicine, then what diet to observe. He advised eggs, raw or slightly boiled, and seltzer water with fresh milk at a certain temperature. When the doctor left, the sick man said something to his brother; but Levin heard only the last words, 'your Katya', and by the look he gave her, Levin understood that he was praising her. He beckoned to Katya to come over.

'I am much better already', he said. 'With you I'd have recovered long ago. How nice!' He took her hand and drew it towards his lips, but fearing it would be unpleasant for her, changed his mind, let go and only stroked it. Katya took his hand in both of hers and pressed it.

'Now turn me on my left side and go to bed,' he said.

No one made out what he said, only Katya understood him. She understood because her thought constantly followed what he needed.

Nikolay died the tenth day after their arrival.

### **The challenge of disgust**

Tolstoy's brilliant depiction of Katya's maturation from a teenager who is easily overwhelmed by her feelings to an adult who can modulate them, illustrates a very important point for everybody who wants to become a doctor, a nurse or a therapist: that in order to become effective health care workers we have to learn to modulate and deal in an adaptive way with the negative emotions aroused in us by disease and suffering.

Disgust is one of the basic emotions, and Paul Ekman describes it as a feeling of aversion that can be aroused by offensive tastes, smells, sights, sounds or even thoughts of repulsive objects (Ekman 2003). Disgust can also be evoked by the actions and appearance of people, even ideas. People can be offensive in their appearance; to look at them may be distasteful. Some people experience disgust when seeing a deformed, crippled, or an ugly person. An injured person with an exposed wound may be disgusting. The sight of blood or the witnessing of surgery makes some people disgusted. Certain human actions are also disgusting; you may be revolted by what a person does. A person who mistreats or tortures a dog or a cat for instance, may be an object of disgust. A person who indulges in what others consider sexual perversion may be disgusting. A philosophy, or way of treating people that is considered debasing, can make those who regard it that way feel disgusted. Paul Ekman in his research, found that it is the morally repugnant which is the most disgusting rather than the disgust aroused by bodily products. An important function of disgust has been to remove us from what is revolting and thereby provide a benefit in reducing contagion.

However, there is a problem when it comes to caring for the diseased and the injured, when the sight of their blood or the deformation of their body brings forth disgust rather than concern. Paul Ekman, in the early days of his research on emotional expression across cultures, found that films of people who were suffering, produced disgust expressions in the majority of the college students he studied in Japan. These films showed the cutting of flesh with a lot of blood as part of an operation, or a man with a third degree burn standing, while burnt skin was stripped off his body. There was a minority group (about 20%) however, who displayed very different reactions to the sight of another person's suffering during the films. Instead of showing disgust, they reacted with sadness and pain as if they were identifying with the victims. He concludes that we are designed to be revolted by the sight of the insides of another person's body especially if there is blood. However, the disgust reaction is suspended when it is not a stranger but an intimate, a relative, our kin, who bleeds. Then we are motivated to reduce the suffering rather than get away from it.

One can imagine how revulsion at the physical signs of suffering or disease might have had a benefit in reducing contagion, but it comes at the cost of reducing our capacity for empathy and compassion which are essential for the caring professions. In Paul Ekman's experience, Buddhists view both empathy and compassion as human capacities that do not need to be learnt but do need to be cultivated if they are to come to the fore. He takes that to mean that if we are to regard all human beings as our kin, to suspend disgust at the bloody signs of suffering and the impairments of disease, we need to work at it, for nature did

not make it easy for us to do so.

Levin was paralyzed by his disgust at the sight and smell of Nikolay's diseased and deformed body and could be of no use to him. Katya however, had mastered the disgust she used to feel in the presence of all tuberculous patients. She achieved this during her brief stay in the German Spa town of Soden where she met Varenka, a young woman whose natural and unaffected way of talking with patients, she admired. By identifying with Varenka's qualities and practising her skill of providing friendly understanding and compassion, she gradually made it her own.

### References

- Balint, M. (1957) *The doctor his patient and the illness*. Pitman Medical. London
- Ekman, P. 2003. *Emotions revealed. Understanding faces and feelings*. Weidenfeld and Nicolson. London.
- Engel, G. L. 1968. A life setting conducive to illness: the giving up – given up complex. *Annals of Internal Medicine* 69: 293 – 300.
- Gottman, J. 1997. *Why marriages succeed or fail. And how you can make yours last*. Bloomsbury Publishing. London.
- Kaufman, G. 1993. *The psychology of shame. Theory and treatment of shame based syndromes*. Routledge. London.
- Nathanson, D. L. 1992. *Shame and Pride. Affect Sex and the birth of the Self*. Norton. New York. London.
- Porter, R. 1997. *The greatest benefit to mankind. A medical history of humanity from antiquity to the present*. Harper Collins. London.
- Parrott, G. 1991. The emotional experiences of envy and jealousy. In *The psychology of Jealousy and Envy*. Peter Salovey editor. The Guilford Press. New York. London.
- Salinsky, J. 2002. *Medicine and literature. The doctor's companion to the classics*. Radcliffe Medical Press. Oxford.
- Salinsky, J. 2003. *Medicine and literature. The doctor's companion to the classics. Vol 2*. Radcliffe Medical Press. Oxford.
- Tolstoy, L. 1873. *Anna Karenina*. Translated by Richard Pevear and Larissa Volokhonsky. Penguin classics 2003
- Tomkins, S. S. 1963. *Affect Imagery and Consciousness. Vol. 2. The Negative Affects* Springer Publishing Company. Inc. New York. Tavistock Publications. London.
- Wilson, A. N. 1988. *Tolstoy. A biography*. W.W Norton and Company. New York. London.
- Wurmser, L. 1994. *The Mask of Shame*. Jason Aronson INC. Northvale, New Jersey, London.
- Zalidis, S. 2001. *A general practitioner, his patients and their feelings. Exploring the emotions behind physical symptoms*. Free Association Books. London.
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# Franz Kafka joins the Balint Society

by John Salinsky

(An explanation of a presentation to the Balint Society on 25 October 2005)

This article is the paper I might have presented to the Balint Society if I hadn't decided to make it an interactive experience instead. You can't read a print version of an interactive experience. You had to be there. But for those who weren't – and for those who were but remain a little mystified – this will serve as an explanation.

During my early days as a family doctor over 30 years ago I kept coming across a quotation from a story by Kafka called *A Country Doctor*.<sup>1</sup> The quotation was:

*To write prescriptions is easy but to come to an understanding with people is hard.*

It was used by Marshall Marinker as the epigraph to a famous Balint book about Repeat Prescriptions<sup>2</sup> but it kept cropping up in lectures and articles. This was in the 1970s when general practice re-invented itself as a speciality in its own right. Far from being inferior to the hospital specialists, we GPs felt that we could provide a personal service to patients that no other doctor could offer. And Kafka's words seemed to encapsulate everything we stood for. Our mission was – and is – not just to scribble on the pad but to connect with our patients as human beings. And of course, for those of us in the Balint world Kafka's words had an even greater significance. In those days, everyone I spoke to seemed to know the quotation but, strangely, no one had read the story. Years later, when I finally read it myself, I was blown away by its power and its strange dreamlike quality. Not only was it a wonderful piece of writing, but the author seemed to have such an intimate knowledge of what it felt like to be a doctor. Had he ever studied medicine? I didn't think so. And being by Kafka the story must have all sorts of other meaning as well that I might not have figured out. When I telephoned an old friend who is an English professor, he told me that it wasn't really about doctors at all. But I was not entirely convinced.

I became obsessed with *A Country Doctor* and decided to write an essay about it for the journal *Education in Primary Care* with whose editor I had a certain influence. This led to a kind of rebirth of my interest in literature, which had always competed with my ambition to be a doctor when I was at school. I went on to write a series of articles for the journal about different literary classics. The idea was to introduce or re-introduce my fellow doctors to the pleasures of reading great works of fiction. I felt sure that we could all learn more about our patients as people from reading Kafka and Tolstoy and Dickens than from any number of lectures on psychology. As a result of these articles, I was invited to do seminars on Medicine and Literature for medical

students and GP registrars as well as mature doctors. I wondered how I should structure these sessions. I wanted them to be interactive and I wanted the students to have read something literary before we started. Kafka's story leapt to mind as the ideal vehicle. It was short – only six pages – and it was about a doctor. My class could easily read it the night before the seminar and then we could discuss it. It was one of these interactive seminars which I eventually presented (or perhaps performed would be a better word) at the Balint Society meeting on 25 October 2005. At this point, I should tell you something about the story. Or maybe refresh your memories if you who already know it.

The story begins in the first person. The country doctor is speaking:

*I was in great perplexity; I had to start on an urgent journey; a seriously ill patient was waiting for me in a village ten miles off; a thick blizzard of snow filled all the spaces between him and me. I had a gig, a light gig with big wheels, exactly right for our country roads; muffled in furs, my bag of instruments in my hand, I was in the courtyard all ready for the journey; but there was no horse to be had, no horse.*

We learn that the doctor's horse has died in the night and he has been unable to borrow one in spite of the efforts of his servant girl Rose. Then the story takes a magical or dreamlike turn. Out of an old pigsty emerge two splendid horses and a groom who seems to be in charge of them. Problem solved? Yes and no. The groom turns out to be a demonic character who is intent on raping poor little Rose. The doctor finds himself being carried away in the gig by the furiously galloping horses and unable to protect Rose from the groom. As in a dream, the gig arrives at the patient's village almost instantaneously and the doctor has to concentrate on his work, despite the agonies of his private life.

*'You're coming with me', I said to the groom, 'or I won't go, urgent as my journey is. I'm not thinking of paying for it by handing the girl over to you.' 'Gee up!' he said; clapped his hands; the gig whirled off like a log in a stream; I could just hear the door of my house splitting and bursting as the groom charged at it and then I was deafened and blinded by a storming rush that steadily buffeted all my senses. But this only for a moment, since, as if my patient's farmyard had opened out just before my courtyard gate, I was already there; the horses had come quietly to a standstill; the blizzard had stopped; moonlight all around; my patient's parents hurried out of the house, his sister behind them; I was almost*

*lifted out of the gig.*

The patient is a young man who, at first sight appears to have taken to his bed out of sheer indolence. The doctor is furious that he has been dragged out on a totally unnecessary house call in the middle of the night. He grumbles about the way everyone abuses his professional position and his good nature.

*My horse was dead, and not a single person in the village would lend me another. I had to get my team out of the pigsty; if they hadn't chanced to be horses, I would have to travel with swine. That was how it was. And I nodded to the family. They knew nothing about it and had they known, would not have believed it. To write prescriptions is easy but to come to an understanding with people is hard. Well, this should be the end of my visit. I had once again been called out needlessly...*

Plenty of resonance for present day doctors there. But the family don't accept his perfunctory diagnosis. The sister waves a blood soaked towel in his face. Even the two horses who have managed to poke their heads through the windows (a wonderful comic visual touch) seem to be urging the doctor to take another look. When he does so he discovers that the boy has a terrible wound in his side from which he will surely die. *Poor boy, you were past helping; I had discovered your great wound; this blossom in your side was destroying you...* Will you save me? pleads the boy. But the doctor just goes on grumbling to himself about how people expect him to do the impossible. Suddenly the family and the village elders jump on him, strip all his clothes off and put him in bed naked with the patient while a school choir assembles outside and sings a little folk song.

Rather disgracefully, the doctor now tries to reassure the young man that all will be well so that he can make his escape. Hastily he gathers up his fur coat and equipment and – still naked – leaps through the window onto the back of one of the horses. The journey back is painfully slow and the doctor laments the ruin of his life and his practice – all because of one wrong decision.

So that's the story. It's brilliant, exciting, disturbing, baffling. You must certainly go away and read it. But what is it about? It certainly seems to me to have a message for doctors, and you can easily imagine the old doctor relating his bizarre story to a village Balint group somewhere in the Bohemian countryside, if only such a group had existed. But there are, of course, all sorts of other things going on in the story as well. You might discover in it something about conflicting personal and vocational needs, responsibility, sexuality, artistic vocation, even religion. East European Jewish folklore is in there too. There's an angry relationship between an older man and a youth that might remind you of the young Kafka and his father and even evoke Freud and the

Oedipus complex. Or you might prefer just to admire and enjoy the quality of the writing.

As I prepared for my first Medicine and Literature seminar, I was thinking about all this. And also wondering: how am I going to use this story in a ninety-minute session with a bunch of doctors? This is what I did.

To start with, I told them about my interest in the story just as I have told you. When they had all read the story again, I divided them into three sub-groups. I asked the first group to discuss the story as a piece of literature: to look at the structure, the style and the underlying themes. I asked them to think about how Kafka achieved his effects as well as what he might be trying to say. The second group were asked to look at what the story had to say to doctors in particular. I wanted them to find things like the doctor's irritation about being called out for something 'trivial'; the attitude of the patient's family; his discovery of the true diagnosis only after a second, closer look (something that has happened to all of us doctors). And finally his unwillingness to tell the patient the truth about a fatal illness. The third group were provided with some biographies of Kafka and asked to find out as much as they could about the author's life. I had correctly assumed that they knew virtually nothing about Kafka's personal history. After half an hour, I brought all the groups together again and asked them to share their findings. This seemed to work quite well as the discoveries of each group shed light on the questions raised in the other two.

Now you may ask why I thought it was important for them to know about Kafka as a person. I am aware that post-modern literary theory teaches that only the text is important and the author's life is irrelevant. Nevertheless, literary biographies remain very popular and with some one like Kafka it is virtually impossible to resist being curious about what sort of person he was and the life he lived. In any case, I am sure you will agree that doctors should always be interested in people's lives. Especially family doctors. We always encourage our young GPs to be curious about the patient's personal history as well as his pathology. If the symptoms and signs of the patient's illness are like a text to be studied and interpreted, then his or her life story is the biography that may reveal important truths about how the text was written and what it means.

But my early groups were not too happy with the written biographies. It was difficult to speed-read the material and come up with a coherent story to present in half an hour. So, one day I decided that I would be Kafka myself. That is, I would impersonate him and let the biography group interview me, as if they were asking a patient about his life story. I prepared for this role by steeping myself in Kafka biographies and letters. I decided not to try and disguise myself with a wig or try to become taller or thinner. My Jewish looks would have to be enough.

In the event my first appearance as Kafka

was gratifyingly successful. Some members of the group seemed almost to believe that I was Kafka, risen from the dead. They were quite abashed when I reprimanded them for not addressing me as 'Dr Kafka'. My doctorate was not in medicine I explained, but in law. As usual, they had little or no previous knowledge of Kafka and approached him without prejudice. They were surprised to discover that I wrote in German, that I was Jewish. I told them that I had lived mainly in Prague from 1883 to 1924 and died of tuberculosis. I encouraged them to ask factual questions about my parents, childhood, education and friends. I told them all about my troubled relationship with my father. When they daringly asked if had been married I teased them by telling them no, but I had been engaged three times, twice to the same girl. This led to some discussion about my conflict between wanting to marry and have a family and needing to live alone to concentrate on my writing. I had never studied medicine but through my own illnesses, I had plenty of contact with doctors. And I had a favourite uncle (Siegfried) who was himself a country doctor and I used to stay with him in the holidays. Aha! So, that must be where the story started.

About some things, I had to be ambivalent or even evasive. There are of course many questions about Kafka to which even I did not know the answer. Did I really want all my unpublished works to be burned when I died? Well, yes and no. I was also slippery and evasive about the meaning of my works. I would say: many different interpretations have been suggested: some think my work is political; others view it as psychoanalytic, existential, religious, philosophical. Or indeed, autobiographical. But, I told them, I leave all that sort of thing to the scholars. I tried to get over to them that as a person I was not always full of gloom

and self-hatred. I enjoyed a good laugh and was regarded by my friends in Prague as a fun person to be with. When the interview group joined the other two groups, they were bursting to share their information with those who had studied the text but not had the privilege of meeting Kafka in person. They were able to talk about Kafka's life with some authority and it seemed to open up a deeper appreciation of the story for everyone.

I have now used this format with students, GP trainees and teachers and in medical humanities courses for doctors and other health workers. And, in the high point of my career as a Kafka impersonator, I have performed at the Balint Society, which is where we came in. The technique seems to work equally well with other Kafka stories such as *The Metamorphosis*, or *A Hunger Artist*, or even *The Trial*. My only slight concern is that I might wake up one morning from troubled dreams and find that I have turned into an anxious, over-introspective, tubercular Czech writer... To avoid this disaster, I am considering extending my roles to include other famous novelists. I am thinking of Tolstoy, Charles Dickens, James Joyce or Ernest Hemingway. I don't think I could do Jane Austen, but someone else might. I certainly recommend the method to anyone who would like to use it for teaching medical humanities. I am grateful to the Balint Society for their enthusiastic co-operation in the Kafka evening. And I apologise once again for deceiving Tessa Dresser and Arnold Kalina who both came along hoping for a proper lecture.

### References

1. Kafka Franz (1919) *Ein Landarzt*. English translation (*A Country Doctor*) by Willa and Edwin Muir (1948) in *The Complete Short Stories of Franz Kafka* (1999) Vintage Books.
2. Balint M, Hunt N, Joyce M, Marinker M and Woodcock J (1970) *Treatment or Diagnosis: a study of repeat prescriptions in general practice*. London: Tavistock Publications.

# *Hable Con Ella:* The Talking Cure, from Freud to Almodóvar

by Andrea Sabbadini, psychoanalyst

Address given to The Balint Society 21 February 2006

*Talk to Her [Hable con Ella]* (Spain 2002)  
**Direction and screenplay** Pedro Almodóvar  
**Production** El Deseo  
**Distribution** Pathé

Psychoanalysis was born, circa 1895, with the publication of the *Studies on Hysteria*. The central case history in that book is that of Joseph Breuer's famous patient Fräulein Anna O. At that time, the common form of treatment for hysterical patients like her was hypnotherapy; but, in Anna O's case, and on her own request, Breuer replaced hypnosis with what will later be known as the method of free associations. As Anna O's traumatic memories started to emerge, such recollections had the effect to make her hysterical symptoms disappear. She wittily described this cathartic process as 'chimney-sweeping' and as a 'talking cure' – a quite accurate definition that has remained attached to our profession ever since.

Talking about oneself – about one's thoughts, feelings, memories, dreams, fantasies, fears and desires – may well be therapeutic then, but only on condition that it occurs in the presence of a listening other. Indeed, rather than as the 'talking cure', it would be more accurate to refer to psychoanalysis as the 'talking and listening cure'.

I remember some years ago one of my patients noticing a 'For Sale' sign outside the house where I had my consulting room. At first she had panicked at the idea that I might be selling up, move abroad and abandon her; but then, as she realized that the sign did not refer to my house but to the one next door (which, being in a terrace, was identical to mine), she expressed the fantasy of buying it herself, furnishing its top floor where I had my consulting room exactly like my own and then lying there every day by herself for fifty minutes on the couch, at the precise time of her sessions, to say all the same things she would have told me. At that point she realized that such solitary form of self-analysis would have been impossible. Talking would have been meaningless to her unless I was there to listen to her words.

The *quality* of the analyst's listening is, of course, of crucial importance. Freud recommends it should take place in a state of 'evenly suspended attention' that would be the counterpart to the patient's free associations, and

Theodor Reik suggests it should be done with what he calls 'the third ear', the one tuned into the same wavelength as the analysand's unconscious communication.

Let me add here a few more general considerations. Firstly, in the psychoanalytic couple it is not only the patient who does all the talking and the analyst all the listening, but their roles can be reversed. Insight and therapeutic progress may occur when the patient listens, and then responds verbally or emotionally, to the analyst's interpretations and constructions. Secondly, the analysand who talks with the analyst, and is listened to by him, is not the only one to benefit from such an interaction: also the analyst is. In other words, being in the position of the listener to someone else's talking can itself be therapeutic. Thirdly, as we know from personal experience, it is in all relationships, and not just in the context of psychoanalytic encounters, that talking and listening can be helpful: between partners, in families, among friends, in the classroom, or at the workplace.

And, perhaps, also at the bedside of a patient in a coma.

Pedro Almodóvar, the Spanish screenwriter and director of *Talk to Her [Hable con Ella]* (2002), is a sophisticated observer of hysterical and other psychologically disturbed women, many of the characters in his previous films (such as *Women on the Verge of a Nervous Breakdown* 1988) comically displaying such neurotic features. With *Talk to Her* he confirms his progression to a less idiosyncratic, yet still highly original and more mature style of film-making, already noticeable in his previous two works, *Live Flesh* (1997) and *All About My Mother* (1999). Departing from many of his earlier films, characterised by flamboyantly kitsch and outrageously punk and camp comedy, he uses here a mostly restrained melodramatic language to represent a series of multiple parallel stories, characters and themes, in a fascinating play of mirrors.

Two men, young nurse Benigno (Javier Cámara) and forty-something journalist Marco (Dario Grandinetti), love two women who lie in a state of coma in the same clinic. It was in similar fashions that both these women were nearly killed: Lydia (Rosario Flores), described in the screenplay as 'brave, almost suicidal' was hit by a charging bull in a *corrida*, Alicia (Leonor Watling) was hit by a charging vehicle in a road accident. Indeed their respective activities, bullfighting and dancing, have plenty in common. Their lives are reconstructed for us through a series of flashbacks, and constantly interpreted in

the light of the 'material' that emerges as the film narrative develops, challenging our assumptions and forcing us to reconsider our initial constructions.

The film title, *Talk to Her*, sounds like a piece of advice, almost an injunction. It may be interesting to notice that the Spanish original *Hable con Ella* means 'talk **with** her'. Its inaccurate translation, *Talk to Her*, for the English version, misses the dimension of mutuality. In either case, however, the title refers to the different attitudes that the two male protagonists, for reasons of character and personal history, have towards the two women. Benigno talks incessantly to his comatose patient Alicia, though in fact he is convinced he is talking *with* her, and that she can hear him, enjoy his stories and even see what he shows her.



**Benigno talking to Alicia**

The less talkative, but more prone to tears, Marco, on the other hand, finds it almost impossible to address his words to Lydia, feeling certain, especially after his conversation with doctor Vega, that patients in a coma are unreachable to our words.

'We don't know if vegetative life is really life... Alicia is practically dead! She can't feel anything for anybody, not for you, not for me, not even for herself!'. Marco tells Benigno, as the latter tries in vain to convince him of being less 'secretive' with her (*hermetico* in the original Spanish).



**Benigno and Marco, with Alicia and Lydia**

We may notice that before her accident Marco was talking, but not listening, to Lydia: in the car on the way to her fatal bullfight, she insists they should talk. As Marco says they have already been in conversation for an hour, Lydia points out that it was him doing all the talking while she had not had a chance to get a word in edgeways.

Monologue or dialogue? This question, relevant to the psychoanalytic situation, is also central to Almodóvar's film. Not just because the subject of *Talk to Her* concerns the depth of communication that is (or that we believe is) possible with another individual in a state of coma, but also because the film – as indeed any other artistic creation – draws us into an intellectual and emotional engagement, a sort of 'conversation', with itself. In other words, *Talk to Her* talks to us. Such one-way dialogues, or perhaps two-way monologues, with art products can be enormously rewarding. This is why, after all, we go to concerts, read books, visit art galleries, watch movies. It is remarkable how Almodóvar invites his audience of *Talk to Her* (us, that is) to join in and share the enjoyment of his audiences **within** *Talk to Her*, as the film not only is a show in itself, but also offers us a number of other spectacular performances within it: Pina Bausch's moving ballet choreographies, containing the film like two book-ends, on the Lope de Vega stage; a dramatic *corrida* in the bullring of Brihuega; the screening of a delightfully funny silent movie at the Cinematheque; Caetano Veloso's seductive interpretation of a traditional Spanish melody; and what is, among such performances, perhaps the most theatrical of them all, a wedding in the church of Our Lady of Aracoeli.

Benigno, desperately and pathologically enamoured of Alicia, often left on his own all night to look after her beautiful comatose body, will end up making love to (rather than *with*) her, as a result of which she will become pregnant, with inevitably tragic consequences. Here and elsewhere (for example in his masterpiece, *All About My Mother* 1999) Almodóvar is a master in challenging some of our conventional moral preconceptions, offering us his own original offbeat view of life and relationships, of sexuality and friendship. In particular he draws the spectators of his films into reconsidering their assumptions about what is normal and what perverse – or, in other words, into thinking about what we can, or cannot, justify in the name of 'love'.

After watching *Talk to Her* many of us may no longer so easily dismiss Benigno as a psychopath and his behaviour towards Alicia as a case of necrophilic rape deserving our contempt and the harshest of punishments. We are invited, instead, to understand such an act, disturbing and abusive as it is, in all its complexity, drawing us personally into it in the process. 'What are we to do, men and women alike', asks Lichtenstein in a recent psychoanalytically-informed review of the film, 'with the erotic fascination generated by

extreme helplessness, and especially by a helpless woman?' (2005, p. 905). Almodóvar revealed that one of the sources that inspired him to write this screenplay was the intriguing story of a ward in a Romanian morgue who brought back to life the only-apparently dead body of an attractive young woman by making love to her. While the girl's own family was extremely grateful to him, public justice had him put into prison.

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The moment one dies, in that instant of profoundly silent transition, one stops being a person and becomes a body. This sudden transformation leaves those who find themselves near the dead (and who are still persons) in a state of awesome confusion, faced as they are with something intangible, emotionally charged with a sense of mysterious finality.

There are other situations, though, where death is not so absolute, or certain, and which therefore evoke different responses. I am thinking, for instance, about the tragic condition of the relatives and friends of those thirty-thousand *desaparecidos* kidnapped during the Argentinean military dictatorship between 1976 and 1983. They had reasons to believe that their dear ones had been tortured and murdered but, deprived as they were of reliable information, went on for months or years hoping they could still be alive. Left in a state of a most painful uncertainty, they could not even have the comfort of mourning their losses.

The situation that concerns us here in relation to *Talk to Her* is that of people who, following an accident or an illness, fall into that state of deep and prolonged unconsciousness which we call coma. 'Her brain is dead', says Dr Vega about Lydia, 'she's got no ideas or feelings'. Yet these patients are somehow still alive insofar as their vital physiological functions are operating – no longer 'persons', maybe, but also not yet 'just bodies'. Of course, much as a few *desaparecidos* did return home, doctors' prognoses could sometimes be wrong, and some such comatose patients, like for instance Alicia in the film, do miraculously come back to life: 'I believe in miracles!', says Benigno to his incredulous colleague Rosa.

A recent article in *the Guardian* reported the following story:

A man who began speaking again after two years in a coma says that he had heard and understood everything going on around him. Salvatore Crisafulli, 38, has had great difficulty in speaking since recovering, but asked if he could remember the past two years, he replied "yes" and wept. In true Italian style, his mother told reporters that his first word had been "*Mamma*" (Hooper 2005, p. 15).

A condition similar to coma is the one of those individuals suffering from *Encephalitis Lethargica*. These patients woke up after many

years of deep sleep thanks to a newly discovered drug (L-DOPA), as described by psychoneurologist Oliver Sacks in his book *Awakenings*:

The terror of suffering, sickness and death', he writes there, 'of losing ourselves and losing the world are the most elemental and intense we know; and so too are our dreams of recovery and rebirth, of being wonderfully restored to ourselves and the world (1973, p. 202).

At one level Almodóvar's powerful film could be read as a conventional narrative of unrequited love, set however in the most unconventional of circumstances. At another level, it could be seen as an in-depth exploration of the conflict, represented by the contrasting attitudes of the two male protagonists, between hope and hopelessness; the ancient Romans used to say *Spes ultima dea* ('Hope is the ultimate goddess'), meaning that human beings have a tendency to hold on to hope even when reason – or, in the case concerning us here, medical science – suggests that a specific situation is, to all intents and purposes, hopeless. At yet another level, the film is a compassionate description of the beautiful, if desperate, friendship which grows between them from such a tension, even more than as a result of homoerotic attraction or of the coincidence of finding themselves in similar situations.

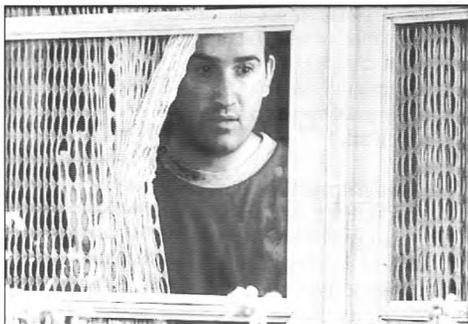
I would like to suggest that Benigno's life is conditioned by his regressive hope to re-unite with his primary object, by his fantasy of returning into his mother's womb. Before looking after his beloved patient Alicia, Benigno had cared for his ill mother for fifteen years, until her death. Anna O herself, it may be remembered, had developed her hysterical symptoms at the time of nursing her terminally-ill father. Both are instances, it could be argued, of failed resolutions of Oedipal attachments.

This regressive need is related to another central theme in the film, that of multiple losses and replacements. Benigno has lost his mother and replaced her with Alicia; Lydia has lost her lover El Niño and replaced him with Marco, before replacing him again with El Niño; and Marco, having recovered from the loss of his girlfriend Angela and having replaced her with Lydia, after she dies will perhaps replace her with the resuscitated Alicia.

As a touch of his playful genius for paradox, Almodóvar has Benigno – the man who believes in talking – become an enthusiastic spectator (as Alicia had been herself) of *silent* movies. As he watches the seven-minute *Amante menguante*, Benigno identifies with the shrunk Alfredo, its protagonist, who climbs, or rather dives, inside the body of his sleepy girlfriend Amparo. 'That door', writes Almodóvar in the screenplay, 'source of life and pleasure, the first door, will also be the last'. This scene in the

movie-within-the-movie, and its accompanying regressive fantasy, are then enacted in Benigno's sexual penetration of, and merging with, his comatose patient Alicia – the centrepiece event of *Talk to Her* which Almodóvar, however, sensitively withholds from his spectators' voyeuristic curiosity. We only find out about it as a *fait-accomplí* when Marco himself is informed of Alicia's pregnancy over the telephone. Benigno is arrested and then, having been told that the son he had conceived in such an exceptional way and with whom he identifies has died, and having been deceived into believing that Alicia herself will never awake back to life again, makes the final regressive and identificatory step of killing himself – that is of dying like them.

Throughout the film we can also remark a clear, if only implicit, reference to the Christian narrative of death, resurrection and salvation – a variation on the vast theme of 'rescue fantasies' which I have elsewhere illustrated with the Greek myth of Orpheus and Eurydice (Sabbadini 2003). Benigno – who talked to Alicia with the same fervour of the faithful praying to mostly silent gods – is ready to sacrifice himself on the cross of his own suffering for his mother and then for Alicia; and indeed his final sacrifice, taking him first to jail and then to a lethal overdose, is what makes her resurrect from (near) death. As Marco says on Benigno's grave (talking to his dead male friend as he had never been able to do to his half-dead girlfriend): 'Alicia is alive. You woke her up': a variation on the theme of the fairy-tale of *Sleeping Beauty*.



Benigno at the window

By then, Marco has already moved into Benigno's flat, where, like him four years earlier, he spends time at the window observing Alicia in the dance academy.

The relationship Marco may develop with her would be but the organic continuation of his already advanced identification with Benigno. Their actual meeting, in the same theatre of the film's first sequences, and the caption *Marco y Alicia* that goes with it, suggest this will be the beginning of Almodóvar's next movie.

Almodóvar's next movie, however, as we now know, was *Bad Education* (2004), which has nothing to do with Marco and Alicia's vicissitudes. Anyone familiar with the Spanish director's sense of humour could have predicted that a sequel to *Talk to Her* was unlikely. Instead – just as Almodóvar remembers doing himself as a child when he was retelling and changing for his sisters, much to their enjoyment, the films they had watched together – it will be up to us to use his open finale and our own creative imagination to invent a new narrative. This may be as generous a post-modern gift to us from Almodóvar as the beautiful stories he has offered us with *Talk to Her*.

### References

- Almodovar, P. (2001). *Hable con ella*. Italian Translation: *Parla con lei*. Torino Einaudi, 2003.
- Breuer, J. & Freud, S. (1893-95). *Studies on Hysteria*. In *Standard Edition*, Vol. II. London: Hogarth Press, 1955.
- Hooper, J. (2005). I could hear everything, says man after two years in coma. *The Guardian*, 6 October.
- Lichtenstein, D. (2005). Hable con ella [Talk to her]. *International Journal of Psychoanalysis*, 86(3): 905-914.
- Sabbadini, A. (2003). 'Not something destroyed but something that is still alive': *Amores Perros* at the intersection of rescue fantasies. *The International Journal of Psychoanalysis*, 84(3): 755-764.
- Sacks, O. (1973). *Awakenings*. London: Picador, 1982.

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# The whole truth

by Dr Mike Sheldon, director of The Whole-Person Trust

(Summary of a talk given to the Balint Society on 11 April 2006)

## Who am I?

- Academic GP
- Now a portfolio career
- Training in counselling
- Interest in whole-person medicine
- [www.wholepersonhealth.co.uk](http://www.wholepersonhealth.co.uk)
- Set up a whole-person assessment clinic
- Exploring ways of integrating a whole-person approach into primary care.

## How did I get here?

- Heart Surgeon to GP
  - Research interests
  - Senior lecturer at Nottingham
  - Severe RTA – re-evaluation of life
  - YWAM – counselling training
  - Back to Barts and the London
  - GP in Bethnal Green
  - Now on the Isle of Dogs
- 
- As an academic GP I obtained a broad view of different practices
  - I recognised the value of continuity of care, family medicine and the person-centred approach.
  - Early 1980s – little understanding of the whole person
  - Set up the Whole Person Health Trust as a charity
  - Ploughed my own furrow

## Everyone intends to be a good doctor – but what to include?

- Clinical competence
- Up to date
- Available
- Caring
- Patient centred
- “Holistic” or Whole-Person

## The world before Michael Balint

- Centred on specialists, little value placed in generalists in the community
- Scientific humanism model of man with medical science of prime importance
- Consultations doctor centred
- Little understanding of the doctor/patient relationship

## Bio-medical model of medicine

- Biological basis of body
- Mind is dependent on brain activity
- No dualism
- Physical not metaphysical
- Disease categories based on pathology
- Laboratory results take precedence
- Therapy usually physically based
- Physician’s responsibility

## The world after Balint (and others)

- Increasing importance of generalists in the community
- Understanding of the different ways consultations can be used
- Patient-centred approach
- Doctor as healer
- Deeper analysis of health interactions

## From OBM to EBM

- Opinion Based Medicine  
As we begin medicine our practice is informed by other’s opinions -
- Teachers
- Text book authors
- Journal educational articles
- Clinical role models
- And later by our own clinical experience and research evidence

## EBM (Evidence Based Medicine)

- EBM is the integration of –
- Best research evidence
- Experience of experts
- Our own clinical experience
- Patient’s values and circumstances

## A post-modern “wholistic” model of Medicine

- Patient’s experience of illness
- Importance of understanding health
- Patient choices
- Co-operation rather than paternalism
- Doctor as advocate and support
- Team work

## Post-modern medical movements

- Social science and psychology
- Patient-centred approach
- Narrative medicine
- Salutogenesis
- Complexity theory
- Alternative and Complementary therapies
- Self-help groups

## “OLD” philosophy

Natural (physical)  
Superior animal  
Quantitative, statistical analysis  
Objective observation  
Placing the person within an event  
Logic and facts

## Integrated health care

The whole-person approach seeks to integrate the best from the bio-medical approach with social science, psychology and other appropriate models of humanity, including spirituality.

**Illness = disease + person**

### **What is a whole-person?**

A person may be observed through three windows, which reflect different aspects of their lives

- Physical
- Psychological
- Spiritual

### **Whole-person Clinic**

- Patient centred assessment
- Integrated assessment
- Time
- Three windows into the person
- Somatic
- Psychological
- Spiritual

### **Clinic Methods**

An integrated assessment

- Physical window
  - Listening in a relaxed manner to the patient's story
  - Build up a trusting relationship
  - Concentrate on the medical aspects
  - Picking up on verbal and non-verbal clues to explore further
  - Exploring their health beliefs
  - Allow the patient to set the agenda and pace

Taking a herstory

GP and the patient

### **Counselling Assessment in whole-person care**

#### **Counselling**

- **Two basic tools**
- Life-lines
- Significant people/support networks

#### **Additional questionnaires and counselling tools**

- **Broad theoretical base with knowledge of**
- A number of models of counselling (Person centred, TA, Gestalt, REBT)
- Personality developmental models

#### **Basic approach to assessment**

- Simple tools of counselling
- Broad knowledge base
  - Medical
  - Counselling
  - Spiritual

- Life experience

#### **Spiritual Assessment**

- About the human spirit and not just religious experience
- Varies according to known beliefs of the person
- Assessment and not therapy at this stage
- Start with explanation of what the spirit is and does

7 stage model of the human spirit

- 1 Self-image
- 2 Relationships with others
- 3 Relating to the world
- 4 Moral and ethical practice
- 5 Purpose and meaning in life
- 6 Belief and faith
- 7 Religious experience and practice

Integrated assessment

- Three therapists come together and with the patient also contributing complete a full assessment of all health problems.
- Then an action plan is produced with the patient.

- **We stress the importance of the patient understanding their problems.**

#### **Telling the story**

Telling their story increases a person's understanding of their health.

- Importance of language – verbal, non-verbal and emotional.
- The more times the story is told the nearer it can come to the truth.
- The story is told within the context of a trusting relationship

Telling their story

- **Three therapists**
- **Windows into their lives**
  - Physical
  - Psychological
  - Spiritual
- Take time to listen and feel
- Allow the patient to reflect
- Combine the external hearing and the internal experiencing viewpoints.

#### **Patient discovers the truth**

- Knowledge leads to understanding which allows wisdom to be used.
- Truth sets free, empowers patient to make health care decisions which will be more effective

#### **How to get the whole story**

- Reflective writing
- Multiple short consultations
- Long consultation
- Pass the buck to someone else

My experience of long consultations

- I allow 90 minutes, and most patients are beginning to come to the end around 60 minutes.
- However it is at that stage that the "real" issues surface.
- Usually no-one has previously heard the patient's story (including themselves).
- Someone has to take time with the patient – and I consider that the GP is the best person to do this.
- Then later let them have therapy as appropriate with counsellors etc.

**Value of the long consultation**

- So are long consultations “a foreign body” in general practice?
  - Do multiple short consultations provide any clues as to the “real” health problems?
  - Who is best placed to make an assessment of the patient’s whole health problems?
  - Are there alternative ways of making assessments (computers, assistants, questionnaires etc)?
- 

**Problem issues to discuss:**

- Is the long consultation the best or the only way to hear the patient’s story?
- Where does the time come from if a GP is to do this?
- Is a whole-person assessment of real value?

# Walking the talk

Richard Addison reviews the Balint Society's latest Research Publication

*Talking about my patient: the Balint approach in GP education, Occasional Paper 87.* Royal College of General Practitioners, April 2006. Pinder R, McKee A, Sackin P, Salinsky J, Samuel O, Suckling H.

In this era of increasing pressure on physicians for greater productivity, there is great danger for physicians to forget the therapeutic benefits of the physician-patient relationship. Some training programs utilize Balint groups to help physicians in training learn about this. Some utilize other small group processes. The Occasional Paper, *Talking about my patient: the Balint approach in GP education*, addresses the question of whether Balint work has something special to offer physicians in training. The principal researcher, Ruth Pinder, observed and analyzed seven case studies (five were from a Balint group and two were from a non-Balint group) in an effort to determine what stood out as different, effective or helpful for the education of physicians in training. She looked at the limitations as well as the possibilities of small group work for helping physicians-in-training grapple with and better understand the emotional complexity of the physician-patient relationship. She did this by observing each group's discussions of cases and later interviewing the group members. She then analyzed the collected data into themes. Questions arose as the research continued and were further discussed in a group that included the other members of the research committee. *Talking about my patient* is the report of that research. The findings are presented by laying out the framework of the study, the small group training, the context of each group, and a description of each case and its implications for learning.

*Talking about my patient* stands out as noteworthy and illuminating for several reasons. First, the researchers appropriately used an interpretive ethnographic method to study their research questions. Though they originally set out to develop an instrument to measure the difference between Balint and non-Balint groups, they soon realized that this was not possible. They understood that to carry out a meaningful study that takes into account the complexity of group process, an ethnographic method of inquiry was necessary. Not many researchers have the wherewithal to undertake and complete such a rigorous research plan. The researchers of *Talking about my patient* truly walk the talk by carrying out such an intensive research project.

As stated before, seven patient cases are presented in detail. Though a more developed narrative for each case presentation might have

been more helpful, by the end of the seventh case report, the reader begins to get a better understanding of the small group process being looked at. Through close observation and interaction with the groups in action as well as consultation with outside experts familiar with and reflective about small group process, the researchers unearthed significant and salient themes. These themes included, but were not limited to, the context of the groups, the possibilities of new ways of thinking about patients, the stories that were not presented, the effect of cultural similarities and differences, caring for self and others, and openness to self and others. They discuss these themes in depth as well as how each theme appears in the small group process. The researchers recognized the inevitability of one's own prejudice in any research undertaken and the necessity of outside experts to check on the analysis and interpretation of their findings. Our understanding of human interaction would be better off with interpretive studies as thorough as this one.

The researchers also noted that one of the strengths of Balint work is an appreciation of complexity. The groups themselves helped physicians juggle the complexity in their patients' lives, in their own existence, and in their relationships with patients. At the same time, the researchers recognized that it was impossible to spell out what Balint groups offered in a list of concrete characteristics. They also realized it was not possible to isolate the effects of the group process alone among all the experiences of the physicians before, during, and after the group. Nonetheless, the researchers still crystallized many areas for further thought and investigation. The themes mentioned above are all themes that are alive for small group process. For instance, the theme of learning about self is one the authors discuss quite eloquently when they refer to deep learning opportunities as 'those that seek to penetrate obscurity rather than focus on predefined tasks' (p. 24). They recognize that there may be implications of such deep learning opportunities in years to come: 'It is clear that the small-group work discussed here is an ongoing process, not an end-product. Like all deep learning opportunities it is uncertain of outcome: a lifetime destination rather than a set of clearly prescribed steps along the way' (p. 24). As Balint leaders, we must recognize that the physicians in our small groups may not be able to conceptualize what they are learning, or the value of that learning at the time of the learning, nor is it essential or desirable that they do so. Thus *Talking about my patient* raises the complex and not easily answered question for further study: how does this type of small group work affect physicians as they advance in their career?

Third, the question of the distinction in

value and effectiveness of Balint vs. non-Balint group permeated the research study and the paper. The researchers found similarities as well as differences in the Balint and non-Balint groups and so were unable to clearly spell out the qualitative differences resulting from the two types of groups. (One interpretation of this unclear differentiation is that the Balint group was flexible enough not to fall back on traditional Balint doctrine in a dogmatic and imposing fashion without consideration of the participants' needs, personalities, culture, and context.) Nevertheless, they raise important and essential questions for further dialogue and discussion: What are the advantages of a Balint group over a non-Balint group? Is there a difference between what Balint groups say they do and what they are observed doing? What is the effect on the group of the personality of the leaders? How flexible can Balint groups be and still be called Balint groups? And what type of small group process is best given the current changes in medical practice, the culture of the group itself, and the often conflicting aims of the leaders and members? These are all important, alive questions in an ongoing conversation. In one of the appendices to the paper, one of the authors, an experienced physician training organizer, grapples further with some of these questions.

In conclusion, *Talking about my patient* is an illuminating, meaningful interpretive ethnography that addresses complex and

important questions about the effectiveness, value and significance of small group processes in physician education. Without a small group process that encourages self-reflection, allows for conscious and unconscious emotional experience, and reinforces the importance of an empathic physician-patient relationship, physicians are far more likely to experience burnout and dissatisfaction in their work and have problematic relationships with patients. Small group work, such as Balint groups, over time, can lead to greater satisfaction for physicians and their patients alike. *Talking about my patient* is a thoughtful and thought-provoking paper that brings the small group process into the foreground of research inquiry. It is clearly worth reading.

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#### References

1. Pinder R, McKee A, Sackin P, Salinsky J, Samuel O, Suckling H. Talking about my patient: the Balint approach in GP education. Occasional Paper 87; 2006 April.
2. Addison RB. An antidote to physician burnout: The Balint group as a hermeneutic clearing for the possibility of finding meaning in medicine. In: Salinsky J, editor. Proceedings of the Eleventh International Balint Congress; 1998; Exeter College, Oxford, England: Limited Edition Press, Southport, England; 1998. p. 191-9.

## Book Review

*Suburban Shaman* by Cecil Helman, Hammersmith Press London 2006. 194 pp. Paperback. £ 9.99

Dr Helman is at present professor of medical anthropology at Brunel University. He is also senior lecturer in the department of primary care and population sciences at Royal Free and University College medical school, London UK. In 2002 after working as a clinician for 27 years, he retired from clinical practice because he wanted to concentrate on writing and teaching other doctors and medical students.

As an object, the book is an attractive small paperback easy to handle and pleasant to look at with a bright cover decorated with a colourful pattern. In it Dr Helman gives a personal account of the influences that shaped his professional development. He was born into a medical family in South Africa, where he studied medicine during apartheid. Then he emigrated to London where he worked as a General practitioner and eventually pursued an academic career in social anthropology.

The material is arranged in twenty four short chapters that make the book easy to read and these are divided in three parts entitled: 'Setting out', 'The family doctor' and 'States of the art' roughly corresponding to the phases of his career.

Anthropology has given Dr Helman the opportunity to learn in some detail about several forms of traditional healing found in the world and then to compare them and contrast them with our own system of health care. In doing so he discovered that at least some aspects of the work of a family doctor have a resemblance to those of a traditional healer or Shaman, hence the title of the book. These are sometimes referred to as the art of medicine or bedside skills and include traditional values such as continuity of care, understanding the patient's belief systems, being comfortable with uncertainty, being able to listen in a particular way, trying to feel what it must be like to be the patient, understanding the story teller as well as the story.

He is afraid that these values are in danger of being forgotten by today's rushed, over specialised "techno-doctors" who rely extensively on sophisticated diagnostic equipment and focus their attention on diseased organs rather than ill persons. He is quick to point out that the book is not a rejection of scientific medicine nor of medical specialization. He is aware that both contributed to medicine's great triumphs in the cure and prevention of disease. However, he believes that they are not sufficient. He believes that focusing only on a tiny part of the body, and seeing people in the impersonal setting of a clinic or hospital ward, far removed from their familial home or family context denies patients a vital ingredient of healing. Something

else is needed. This something is a more holistic view of illness that focuses primarily on a person and not just on their diseased organ; an approach that understands human nature and aims to offer the patient a relationship of compassion and care, some explanation of what has gone wrong and why, and a sense of order or meaning imposed on the apparent chaos of their personal suffering; an approach that helps the patient make sense of their suffering and to cope.

The value of traditional practitioners, or Shamans as they are also known, lies in their holistic approach. They view man in his totality within a wide ecological spectrum. One thing that we can learn from them is the way they see health as a balance, as a state of equilibrium not only within a person's body and psyche but also in the person's relationships with the other people around them, with the natural environment and with the world of their gods and ancestral spirits. Dr Helman believes that family medicine – at least in Britain – is perhaps the last bastion of old style medical holism. Despite the avalanche of reforms that are pushing general practice towards a disease-oriented approach, it still holds the personal, the subjective and the social to be important – especially the patients' own narratives of their illnesses, as well as their family history.

It is a pity that Balint groups were not among Dr Helman's formative experiences because they are one of the few methods available for promoting the holistic attitude that we all value. The importance of this approach was signalled in April 2006 when the Royal College of General Practitioners published Occasional Paper 87 entitled *Talking about my patient: the Balint approach in GP education*. The publication describes recent research into the work of Balint groups informed by anthropological inquiry.

According to Dr Helman, family practice in Britain is a rushed and unglamorous life and the effects of its heavy workload can be grinding and corrosive. When he complained to a Navajo friend in New Mexico that back in London he often got angry, depressed, frustrated, tired and exhausted after seeing so many patients in a day, his friend nodded sympathetically and told him that this is the fate of healers. Her grandfather was a traditional healer and he too came back emotionally drained from doing his healing ceremonies some of which took days to perform. But that he and his family dealt with this in a very different way. Each time he returned, her grandmother would take over the healing role performing special rituals and songs for him so that the wounded healer would now become healed in his turn.

Last June, at the first International Psychosomatic Conference organized by Russian doctors at St. Petersburg, Vladimir Vinokur, a Balint doctor and professor of psychosomatic medicine there, reminded me that Balint doctors

all over the world see themselves sometimes as members of a big family. When I read Dr Helman's account of his conversation with his Navajo friend I wondered whether he was describing a kind of proto-Balint experience. It is after all well known that one of the functions of Balint groups is to nourish group members and help them renew the strength they need to cope

with their everyday work.

In summary I think that this is a well-written and interesting book, worth reading. It defends and celebrates the traditional values of medicine in general and family practice in particular.

**Sotiris Zalidis**

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# Secretary's Report 2005-2006

## Oxford Weekend

The Society's largest event took place from September 16th to 18th 2005 at Exeter College. 46 people attended and made up five working groups through the weekend.

Six attendees were from the Icelandic Vocational Training Scheme, brought along by friend Dr Katrin Fjeldsted. There were four medical students from a graduate entry programme in the Midlands. The keynote address, 'Back to the Consultation', was given by Dr John Salinsky, with film clips to illustrate difficult patients as portrayed in Hollywood movies. As well as providing group experience for participants the groups were able to give leadership opportunities to new or less experienced leaders. In discussion at the AGM of the Society at the end of the weekend it was decided to offer a leadership training day on the day before the next Oxford conference in 2006

## Lecture Series

The 2005-6 series at the RCGP was heavily biased towards the use of the arts in medicine, a current interest of many of our members, and also of the medical academic community. The papers are mostly published in this journal and we began with Dr John Salinsky on October 25th with a session on Kafka. It was an interactive seminar, which most people enjoyed, with groups looking at different aspects of one short story *A Country Doctor*. Dr Sotiris Zalidis gave a formal paper on December 6th about psychosomatic symptoms described in Tolstoy's *Anna Karenina*. For both of these we circulated some information so participants came armed with some knowledge of the subject. The first meeting of 2006 was on the 21st February, when Dr Andrea Sabbadini led us through Pedro Almadóvar's film *Talk to Her*, with illustrations from the film on DVD. Dr Sabbadini is a psychoanalyst and helps organise the ICA's Sunday series on film and psychoanalysis. The 21st March brought Dr Gillie Bolton, back by popular request, for an example of her work on reflective writing. She got the participants writing spontaneously about their work and life within the space of an hour! The last session, unfortunately poorly attended, was given by Dr Mike Sheldon, on April 11th, a GP who runs a charity in Tower Hamlets,

providing holistic assessments for difficult patients referred from GPs. The particular interest is in the consideration of the clients' spiritual beliefs/needs as part of what we and they may need to consider.

## Chester Weekend

The sixth annual Chester weekend took place on June 16th-18th 2006, actually not in Chester, but organised by Dr Caroline Palmer again. Due to capacity problems at the previous venue we were treated to a beautiful conference centre at Whalley Abbey, further north in Lancashire. It is a country house built into the abbey ruins, beside the River Calder. The eleven participants found it a great place to work, bond and explore their problem patients. More people can be accommodated here so let's try to get two groups next year!! In 2007 there will also be another Balint weekend in the north of England, organised by our many members in the Newcastle area. This will take place from 20-22nd April, 2007 at Longhirst Hall.

## Group Leaders Workshop

The Group Leaders workshop met three times this year. There were presentations of groups run in Darwin, Australia and from the Newcastle area. One session ran as a group, allowing presentation of either a patient or a difficult group situation. The next Group Leaders' workshop date at the Tavistock is on December 5th 2006.

## Annual Dinner

The Annual Dinner took place again in the Garden Room of the Royal Society of Medicine, on the 27th of June. 24 people dined, including two guests from the Danish Balint Society, and were addressed dramatically by Dr John Salinsky. He gave us a modern NHS version of what might happen in the story *Metamorphosis* if Gregor's wife phoned his GP somewhere in Yorkshire.

I look forward to the Oxford weekend from September 15th-17th with the theme of 'Continuity', and also to the next International Balint Conference in Lisbon, from 1-5 September 2007.

David Watt

# The International Balint Federation

Heather Suckling

## Membership:

The British Balint Society is one of 18 national Balint Societies that fulfil the criteria of membership of the International Balint Federation.

All members of the British Balint Society are welcome to attend the international meetings. These are advertised on the website [www.balintinternational.com](http://www.balintinternational.com) and most of them are conducted in English.

## Events 2005-2006:

• **International Balint Congress, Stockholm 24th-27th August 2005:**

The Swedish Psychological Society hosted a very successful congress in August 2005. There were Balint groups with a truly international membership, many erudite and useful papers and an excellent social programme. A report of the congress appears elsewhere in this journal.

• **Miercurea Ciuc, Transylvania, Romania, 22nd-25th September 2005:**

The Romanian Balint Society invited us to an international meeting on "The Balintian Approach to Psychosomatic Disorders" in September 2005. Andrew Dicker and Heather Suckling attended and were made very welcome.

• **Brussels March 10th-12th 2006:**

The Belgian Balint Society hosted the spring meeting of the Council of the International Balint Federation. Our Belgian hosts arranged a wonderful tour of Brussels that was greatly enjoyed in spite of the bitterly cold wind and snow! We feasted on delicious Belgian food and were able to see the newly restored and illuminated Atomium by moonlight, a magical experience.

The main item of discussion at the business meeting concerned preparations for the 15th International Balint Congress to be held in Lisbon in September 2007.

The Council was delighted to hear that the Educational Network of the Royal College of General Practitioners had responded positively to a request from John Salinsky to include Balint groups in the curriculum for the training of general practitioners. This will aid the efforts of the IBF in its endeavours to press for Balint groups to be included in all European GP training schemes through the European Academy of Teachers in General Practice (EURACT). Heather Suckling is a member of EURACT and would be delighted to hear of other British members. Anyone involved in the teaching of GPs or medical students is eligible to join and if you are interested please contact me, by email [heathers@doctors.org.uk](mailto:heathers@doctors.org.uk)

• **Dubrovnik, Croatia 6th-11th June 2006:**

The Croatian Balint Society held another wonderful meeting in Dubrovnik, the Muradif Kulenovic School of Balint where the theme was "Doctor-patient relationships and the Ageing Process".

## Future events:

• **Bethlehem, Pennsylvania USA, 12th-16th October 2006: (Balint Leaders' Workshop)**

The American Balint Society will host the Autumn Balint Leaders' Training Intensive in Bethlehem, Pennsylvania. These weekend courses are invaluable for leaders. If you are interested, please contact Jeffrey.Sternlieb@lvh.com

• **Maa'gan near the Sea of Galilee (Tiberias), Israel 16th-18th November 2006: (Balint Workshop)**

The autumn Council meeting was planned to take place in Israel, but at the time of writing, there is doubt about the venue because of the conflict in the area. The Israeli Balint Society intends to hold a workshop during these dates in any case and extends a warm invitation to you all. For further information please contact Professor Benyamin Maoz [bmaoz@zahav.net.il](mailto:bmaoz@zahav.net.il)

• **Santa Rosa, California, USA, 15th-18th March 2007 (Balint Leaders' Workshop)**

The American Balint Society will host the Spring Balint Leaders' Training Intensive in Santa Rosa California. Please contact Ritch Addison [Addison@itsa.ucsf.edu](mailto:Addison@itsa.ucsf.edu)

• **Dubrovnik, Croatia 4th-8th June 2007 (dates to be confirmed):**

The Croatian Balint Society will host the annual Muradif Kulenovic School of Balint in Dubrovnik.

For further information please contact Sanja Blazekovic-Milakovic [sanja10@net.hr](mailto:sanja10@net.hr)

• **Lisbon, Portugal, 15th International Balint Congress September 1st-5th 2007:**

Please book early for this event! All members of the Balint Society will be notified as soon as registration opens in the autumn. The call for papers has already been sent out; these should be submitted in full before 31st December 2006. For further details please contact Jorge Brandao [Jorge.hipotalam@netcabo.pt](mailto:Jorge.hipotalam@netcabo.pt)

Please see the website [www.balintinternational.com](http://www.balintinternational.com) for a full list of activities.

## 14th International Balint Congress in Stockholm, 2005

The 14th International Balint Congress took place in Stockholm, Sweden, from 24-27 August 2005. Over 120 delegates from 18 countries took part and it was a very enjoyable occasion. The Swedish Association of Medical Psychology were excellent hosts and our material, social and cultural needs were well taken care of. We began with a welcome party in Stockholm's magnificent City Hall (where the Nobel Prize winners are also entertained to dinner each year). On the second evening we had a boat tour round the City's main waterways with wonderful views of the city's graceful public buildings.. The Congress Dinner and Dance was held in the unique Junibacken museum, dedicated to the storybook world of the great children's writer Astrid Lindgren. She was the creator of Pippi Longstocking and many other characters whom we felt we should get to know better. It was especially good to meet old friends and make new ones; and to talk about our work with colleagues who share our feelings about the importance of empathy-based medicine.

During the scientific sessions we listened to and discussed each other's papers and took part in Balint groups with an international flavour. These Congresses now stretch back more than 3 decades and in the last few years there has been a sense of continuity and forward momentum, with each conference taking up the work from the previous one. The theme of the Stockholm Congress was 'Balint work in times of change and crisis in the health care system'. In the many excellent papers we heard both a celebration of our achievements and a concern about whether Balint work can survive and prosper in the current health care climate.

We heard from a number of different countries about groups for students who were full of enthusiasm for a person centred approach to medicine; other speakers described how a Balint group can protect mature doctors from overwork, cynicism and professional despair. We learned a good deal about how group leaders were being trained and supported. Balint famously talked

about 'research-cum-training' and there were also many reports of research activities. Some groups were trying to evaluate the effects of participation in a particular group while others were trying to find ways to evaluate the overall outcome of Balint training and to see what difference it makes. The difficulties of applying the classical scientific method in the arena of human feelings was apparent and there was more emphasis on qualitative research methods than in previous years. However, although this approach can tell us more about what really goes on in a Balint group it may not convince the medical education authorities that Balint deserves a central place in the curriculum. Some people felt that we had to talk to them in their own (positivist) language in order to get through to them. On the other hand we might be able to interest them in learning our language! Those who are in charge of our healthcare systems seem to be reacting to recurrent crises by showing less interest in maintaining the personal and continuous care which we (and our patients) value so deeply. We need to gain the attention of the politicians and encourage them to invest in Balint. We need to move with the times but at the same time, in our anxiety to 'market' Balint groups we must not lose touch with our own core values, which have their roots in the discoveries of psychoanalysis.

I hope that this brief account will give you some impression of the content and flavour of the 14th International Congress. The papers and discussions were lively and challenging. People listened to each other. They sometimes disagreed but the whole conference was permeated by a wonderful spirit of friendliness and good-humoured co-operation. And so we return to our work in our own countries feeling refreshed, invigorated and already looking forward to the 15th Congress which will be in Lisbon, Portugal, in September 2007. I do hope you will join us!

**John Salinsky**

# Report on Whalley Abbey Weekend Workshop, June 2006.

(or Keeping the Boat Afloat!)

by Caroline Palmer

At midsummer 2006, a group of 11 doctors travelled from far and wide to deepest rural Lancashire to meet in the ancient and peaceful abbey house amidst the ruins of Whalley Abbey. It was a lovely venue, deeply relaxing and beautiful, but I felt some trepidation as this was a new venue for the Balint Society, the workshop was running a month later than previously, several people had cancelled at the last minute, and some had contacted me to say that they had family crises of one sort or another and might not be able to come, so it all felt a bit wobbly.

As the group began, I began to relax and remembered that giving a needy doctor time and attention had always been helpful in the past and was likely to be again too. The group did operate a bit like a 'Roll on Roll off' ferry, with late arrivals and early departures, but the boat kept afloat despite this, with goodwill and camaraderie amongst the passengers and expert handling of the vessel by the captain and his mate (John Salinsky and Zoe Kenyon!).

The group navigated many different obstacles and weathers in the doctor-patient relationship over the weekend. The first two cases had the presenting GPs feeling drowned, overwhelmed and inundated by neediness, and patients feeling too close, but the group ably responded by helping us accept the longer-term challenge and reminded us of the hope of change in the end. Balint work could be both a lifeline and a buoyancy aid, and indeed I noticed natural laughter in the group to help counter-balance the sadness and as a nervous escape.

The group then encountered situations in which the patient seemed too distant and evasive, a bit like a slippery fish or a mirage on the water, which caused frustration and embarrassment to the GP. Other situations were described in which the patient blocked communication, either by projecting their needs or disabling the doctor and relegating them to a secretarial role, so that they felt in the doldrums, rudderless and deprived of the helm.

In the Saturday evening session the group encountered stormy seas with the GP recounting

a consultation by an angry man with angry arthritic joints, in which the doctor had felt frightened and disabled by his anger. The group helped the GP see that their sense of impotence in the situation might reflect the patient's impotence on several levels. After the storm came a melancholy, bittersweet calm, as a doctor talked of his sadness at the likely death of a favourite patient during his forthcoming sabbatical and his regret about the situation. It was heart-warming at this juncture to hear of a patient that was so likable, having heard of a lot of complicated and damaged individuals until then.

On the last morning there was a theme of insecurity, not only about diagnoses but also about handing fragile and special patients over to the care of your team, and another case in which boundaries felt insecure, and in which as a result the GP felt scrutinised, disabled, confused and set up to fail either way. The group was able to affirm the validity of the doctors' feelings, as well as their competence to handle these difficult situations as well as any doctor could, and the group seemed to agree that these uncharted waters are the most treacherous of all!

I'd been nervous that with the comings and goings of group members during the weekend that there might not be an adequate sense of safety, that somehow we needed strictly sanctified time in a secure group, but Balint work is so powerful that it overcame these minor difficulties. In fact the group reflected the way that in general practice, transfigurative 'flashes' of shared insight can occur in a busy surgery with interruptions, emergencies, phone calls etc.

So despite the comings and goings, the crew worked extraordinarily well, the skippers did a good job of keeping us on course and focused with their Balint telescope on the doctor-patient relationship, the boat stayed afloat, and did a grand job delivering the members to terra firma and safe havens.

We all agreed that it was a great weekend and a fantastic venue, so all are invited to join the group next year on June 15th to 17th 2007!

# BALINT

Occasional  
Paper

## Talking About My Patient: The Balint Approach in GP Education

Ruth Pinder, Anne McKee, Paul Sackin, John Salinsky, Oliver Samuel, Heather Suckling

Can Balint groups that focus on the doctor-patient relationship still offer vocational training schemes (VTS) – something that they can ill-afford to be without? Or has the Balint influence been fully subsumed into the culture of general practice education?



This Occasional Paper explores how Michael Balint's work in the 1950s and 1960s influences general practice education today.

At a time when much work in vocational training reflects the current fashion for competency and skill-based approaches – based on what can be demonstrated and tested – is something valuable being neglected or lost?

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This interpretive study examines what happens when a Balint group takes place in VTS training, how it is variously read and understood by practitioners, and with what likely benefits and consequences.

**The research questions at the heart of this investigation are:**

- What does a Balint approach to small-group work in VTS provide?
- Given the likely complexity of the learning process, how is effectiveness to be gauged? What does effectiveness mean in this context?
- What wider lessons does an intensive analysis of a Balint approach in one VTS group have for course organisers and other educators who wish to put it to work?

**ISBN: 0850843030**

# 15th International Balint Congress

Lisbon 2007

September 1st - 5th 2007

FIRST ANNOUNCEMENT

## *Medicine, Evidence and Emotions – 50 years on...*

... the first English edition of *The Doctor, His Patient and The Illness* was published in 1957!

Its publication and worldwide circulation, uncovered many beautiful and new ideas about the doctor-patient relationship. Its concepts and ideas spread and became embedded in the theory and practice of medicine.

How are we today?

What is the future for Balint work?

## **The Congress will take place at Faculdade de Ciências Médicas – Campo de Santana**

It is an historic building, for many years dedicated to the teaching of Medicine, located on the top of one of the seven hills of Lisbon. From there, it is possible to enjoy nice views of the old city castle and the river Tejo. It is surrounded by some other historic institutions dedicated to health care and research

**The programme** will start with Registration on the **afternoon of Saturday, the 1st of September**, followed by a Welcome Reception in the evening.

From Sunday 2nd until the afternoon of Wednesday the 5th of September, there will be plenary sessions, parallel lectures in smaller lecture halls and Balint group work each evening. Throughout the programme there will be plenty of opportunity for discussion.

**Language:** The main language will be English but there will be some sessions and group work in Portuguese

**The fee** will be approximately 400 Euros. This will include the Congress book, lunches, coffee breaks, the welcome and farewell parties and the city tour.

Individual applications for reduction of fees will be possible and handled by the organising committee in co-operation with the IBF board.

**Accommodation:** Hotel rooms of good, luxurious, not luxurious and standard qualities will be available in the neighbourhood. We will negotiate as good a price as possible.

**Social Programme:** Lisbon is a beautiful city located on the right bank of the river Tejo, close to where it runs into the ocean. There will be many opportunities for sightseeing.

September is a good month for visiting Lisbon, as many of its inhabitants and working people are away on holiday and the weather will be not excessively warm.

**Papers:** The call for papers will go out with this notice; **the full text should be sent by the 31st of December 2006.**

We will make a further official announcement in the autumn of 2006 and information and registration will be available on the web-site of the International Balint Federation.

The organising committee of the Congress is constituted by:

Antónia Lavinha,  
João Sequeira Carlos,  
Jorge Brandão,  
Josefina Marau,  
Rizério Salgado,  
Teresa Laginha,

General Practitioner  
General Practitioner  
General Practitioner  
General Practitioner  
General Practitioner  
General Practitioner

## The Balint Society Essay Prize 2007

The Council of the Balint Society awards a prize of £500 each year for the best essay on the Balint Group and the Doctor-patient relationship.

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

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

Length of essay is not critical.

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

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

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

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

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

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

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by 1st May 2007 and sent to: Dr David Watt,  
Tollgate Health Centre,  
220 Tollgate Road,  
London E6 5JS.

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## International Balint Award for Students

Medical students are invited to submit a paper based on their personal experience of relationships with patients and include critical reflection. Prizes totalling SFR 5,000 will be awarded to the best essays. Papers in English, French, Italian and German will be accepted.

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.
2. Reflection. A description of how the student actually experienced the relationship either individually or as part of a medical team. This could reflect multiple relations between students and staff of various specialties and the 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 or she 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.

Submissions of up to 15 pages should be sent by e-mail as a word attachment to:

Geschäftsstelle der Stiftung Ascona (email [stiftung-ascona@web.de](mailto:stiftung-ascona@web.de))

Or: Geschäftsstelle der Deutschen Balintgesellschaft (e-mail: [Geschaeftsstelle@balintgesellschaft.de](mailto:Geschaeftsstelle@balintgesellschaft.de))

They should be received before 30 April 2007

You will find more information on the International Website: [www.balintinternational.com](http://www.balintinternational.com)

**The Balint Society**  
(Founded 1969)  
**Council 2006/2007**

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Tessa Dresser  
Andrew Dicker  
Caroline Palmer  
Sotiris Zalidis  
David Price

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## Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr John Salinsky by email: [JVSalinsky@aol.com](mailto:JVSalinsky@aol.com) as a word file.

We welcome research papers, personal reflections, case studies, book reviews and reports of Balint events and ongoing groups.

### References

References may be in the Harvard or Vancouver style. 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.

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