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ASOCIAȚIEI BALINT DIN ROMÂNIA
Data înființării: 25 iulie 1993

Michael BALINT: Psihanalist englez de origine maghiară

Grupul BALINT: Grup specific alcătuit din cei care se ocupă de bolnavi şi care se reunesc sub conducerea a unu sau doi lideri, având ca obiect de studiu relația medic-bolnav prin analiza transferului şi contra-transferului între subiecți.

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- grupuri Balint,
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- formarea şi supervizarea liderilor,
- colaborare la scară internațională.

Specificul Asociației: Apolitică, nereligioasă, inter-universitară, multi-disciplinară, de formație polivalentă.

Obiective: Formarea psihologică continuă a participanților. Încercarea de a îmbunătăți prin cuvânt calitatea relației terapeutice între medic şi bolnav şi a comunicării dintre membrii diferitelor categorii profesionale. Rol de "punte" între etnii, confesiuni, categorii sociale, regiuni, țări.

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Cotizația se achită până la **31 martie a.c.** Cvantumul ei se hotărăşte anual de către Biroul Asociației. În cazul când ambii soți dintr-o familie sunt membrii Asociației, unul din ei poate cere scutirea de la plata abonamentului la Buletinul Informativ, al cărui cost se stabileşte anual.

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Autorii sunt rugați să se conformeze regulilor de redactare a articolelor.

ANALIZA TRIUNGHULUI

Dr. Csilla Moldovan, Mădăraş-Ciuc

Pacienta mea are ochii înecați în lacrimi. E nefiresc de slabă. Gesturile ei nesigure, privirea fără astâmpăr, cuvintele stol de păsări risipite, ca şi gândurile căutând un țărm al înțelegerii. O cunoscusem cu ani în urmă, când persecutată de soacră, neînțelegânduse cu soțul avusese o tentativă de suicid. A urmat spitalul, apoi echilibrul, iubirea recâştigată, copii, normalitatea. Peste ani, viața se tulbură din nou. Soțul are o relație cu o femeie măritată, nu crede, nu poate să creadă, evidența o convinge însă.

Soacra părăseşte conul de umbră al văduviei, ca o regină repusă în drepturi, se răzbună. Soțul îşi lasă soția singură şi se mută în casa mamei. Devine alt om, violent şi agresiv față de soție, față de fiică. „Omoară-te acum, poate vei reuşi" – sunt cuvintele rostite de un bărbat care odinioară o iubise.

Triunghiul conjugal nu e o raritate. Stranie e doar umbra arhetipală proiectată asupra lui. Mama e un regizor care preferă umbra. Actorii secundari sunt manevrați cu abilitate. Faptele se desfăşoară după un scenariu imuabil. Secvențe de evenimente se repetă în timp: plăcere hedonică şi pulsiune de moarte, peste toate – curioasa legătură mamă-fiu, care copleşeşte trăirile.

Triunghiul e o formă geometrică cu trei laturi, între care se înghesuie oceanul.

Fantasmele sunt în cel mai strâns raport cu dorința, spune Freud. Lumea interioară a mamei este generatoare de fantasme. Aceste fantasme îşi au originea dintr-o relație de tip dual. Relația mamă „obiect primar" după Melanie Klein şi fiu. Balint vorbeşte despre un ataşament preoedipian față de mamă care este regresiv şi nu se produce în mod conştient. Tip de ataşament care în nici un caz nu se manifestă la nivel de limbaj, doar prin acțiuni de tip regresiv din perioada copilăriei timpurii. Mama îşi hrăneşte copilul care e în casa ei şi este în sfârşit din nou al ei.

Ataşamentul mamă copil are la această vârstă ceva arhaic şi primitiv, ceva care se produce la nivelul inconştientului. Protagoniştii relației ar fi incapabili să formuleze în cuvinte cea ce se întâmplă. Acest tip de ataşament presupune un proces de regresie care se regăseşte după Freud în structurile psihopatologice cele mai diverse.

Este vorba aici de o regresie temporală față de mamă. Bărbatul însurat devine din nou copilul mamei, îngrijit de ea, i se iartă „micile pozne" ca adulterul, care pentru mamă nu prezintă importanță atîta timp cât nu percepe amanta ca pe o potențială rivală. Rivala mamei rămâne soția reprezentant-reprezentare pentru care în mod evident ea prezintă o fixație. Nora este ținta proiecțiilor inconştiente. Aceste proiecții par să oscileze între fantasme parțial sau total conştientizate: i-a luat copilul, a devenit stăpâna casei: soacra fiind văduvă, ierarhia familială s-a schimbat. Mult timp a fost nevoită să refuleze aceste sentimente. Adulterul fiului, implicit decăderea din rol a soției, a permis reactivarea a cea ce a fost înscris. La nivel inconştient şi-a urât nora din primul moment. Fantasmele legate de sentimentele foarte reale ale soacrei-ura, tendința de anihilare a rivalei, agresivitatea, sunt dorințe puternice pe care în cadrul regresiei temporale le poate transfera fiului ei. Transferul găseşte un teren fertil pe un Eu involuat la stadiul de „copilul mamei mele", un Eu imatur măcinat de tensiuni şi sentimente ambivalente generate de situația de viață în care e implicat. Transferul duce la un comportament structural proiectat asupra soției în mod ostil. Ostilitate care se identifică parțial cu dorințele mamei. Tensiunea existențială este generată de contradicția dintre lumea interioară a bărbatului şi lumea exterioară. Limitele sunt foarte lejere dar tensiunea generează pulsiune. Agresivitatea poate fi considerată ca element corelativ al acestei pulsiuni. Îndemnul la suicid e o proiecție a fantasmei bărbatului de a-şi anihila soția.

Relația mamă-fiu nu prezintă nici un defect. Complexul Oedip e puternic negativ. Lumea trebuie împărțită în obiecte bune şi rele pentru ca bărbatul să îşi păstreze imaginea de sine intactă. La acest nivel apare clivajul ca mecanism de apărare descris de M. Klein. Mama este „obiectul bun" în consecință soția va fi identificată cu „obiectul rău". Soția este însă o realitate fizică dar şi o realitate psihică internă care va trebui să fie expulzată în exterior pentru ca imaginea de sine a bărbatului să nu se deteriorizeze. Această expulzare se face printr-un „acting out" (M. Balint) cu violență, îndemn la suicid, distrugere fizică. În acest tip de comportament găsim compulsie la repetiție şi rezistența subiectului de a se elibera de trecut-ori de câte ori a greşit s-a întors la stadiul de „copilul mamei" şi-a izolat emoțional soția fapt care a determinat şi prima ei tentativă de suicid. Faptul că în relația „obiect primar-obiect bun şi rău" a apărut „obiectul tranzițional" – amanta, nu schimbă cu nimic situația. Acceptând adulterul mama îşi stăpâneşte fiul

Imaginea mamei s-ar putea identifica cu arhetipul matern dominator descris de Jung sau cu imaginea de mamă falică al lui Freud.

Soția care a pierdut siguranța afectivă-iubirea soțului-dar şi siguranța materială punându-i-se în vedere izgonirea din propriul cămin, a rezonat la evenimente printr-un puternic complex de inferioritate. Emoțional ea se află încă într-un stadiu de ambivalență afectivă față de soț, la nivelul gândirii logice îl respinge însă. Pentru ea transformarea obiectului bun în obiect ostil este generatoare de angoasă. Copleşită de sentimente de vinovăție pentru că nu a recunoscut din timp modificarea afectivă a soțului, recurge la introspecție şi adoptă o poziție depresivă oscilând încă între sentimentul de iubire şi ură. Prezintă simptomele nevrozei de abandon-etiologie preoedipiană după Freud. Simte o acută nevoie de iubire căci numai iubirea oferă siguranță. Prototipul regăsirii siguranței pierdute este fuzionarea cu persoana iubită (G.Gueux). Ori în situația ei acest lucru pare imposibil. Imaginea de sine este puternic afectată. Această femeie caută să lupte împotriva golirii afective printr-o disperată încercare de umplere al vidului interior. E momentul în care suferințele psihice se somatizează. Boala apare ca un refugiu din fața suferinței, un răspuns la frustrare şi abandon dar şi o răzbunare, parcă ar spune „m-ați distrus iar eu vă pedepsec îmbolnăvindu-mă". Pacienta mea este victima degradării unui sistem relațional, victimizată de lipsa iubirii, de ură şi dispreț. Ca orice victimă ea aşteaptă să i se spună – exişti, nu eşti singură, contezi pentru alții. Momentan existența ei este dominată de vidul din interior. E o goliciune care trebuie umplută cu cuvinte, compasiune chiar şi cu analize şi prescripții medicale. Momentan punctul forte al existenței este boala. Indiferent dacă diagnosticul acoperă sau nu realitatea, boala constituie un pretext pentru a deveni din nou importantă. Printr-o ciudată alchimie a contrariilor ceea ce ar trebui să distrugă, alină. Prin boală imaginea de sine câştigă un echilibru relativ.

Triunghiul este o figură geometrică cu trei laturi dar între aceste trei laturi se înghesuie oceanul.

Triunghiul cuprinde o mulțime de lucruri, o soție înşelată, o soacră figură arhetipală, o relație medic-bolnav-boală dificilă. Între laturile lui încap Freud, M.Klein, Jung, psihanaliza cu teoriile ei şi fără îndoială şi cutremurătoarea, umila suferință omenească.

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KATHYM IMAGINATIVE PSYCHOTHERAPY (KIP) – PART I: A DESCRIPTION OF THE METHODOLOGY*

dr. Irén Acsai, Budapest

Summary: *The purpose of the study is to provide a brief insight and to introduce a thematic case study into a psychotherapeutic method less used in the Anglo-Saxon language area, which was first introduced by H. Leuner in 1955 as a scientifically established method among the different psychotherapeutic methods.*

The first part of the study sets forth a short description of the methodology of KIP. The next (2nd) parts the case study of a patient, who was successfully treated for her panic syndrome with an imaginative technique based on emotional basis.

Key-words: *Psychoanalysis, Relaxation, Changed State of Mind, Symbols, Leuner-pictures, Katathym Imaginative Psychotherapy*

Introduction

Katathym Imaginative Psychotherapy /KIP/ is an imaginative psychotherapeutic process based on psycho dynamically based imaginative psychotherapy. In English it is known as Guided Affective Imagery. Images are the product of the faculty of *imagination.*

The international organization of KIP is the Internationelle Gesellschaft für Katathymes Bilderleben /IGKB/ based in Vienna, Austria.

Theoretical basis and historic development

Freud used imaginative techniques (1882-1888) and listed examples of "the outstandingly successful performances of the therapy. His first publications about such imaginations were in a case study on the treatment of Anna O. who in a spontaneous hypnotic state "unravelled a private theatre, which became an important part of the therapeutic process and finally led to the discovery of the "cathartic method". (1)

The psychoanalyst Siberer tried to study the threshold experience between awakenings and falling asleep, generating daytime dreamlike "hallucinations", which he called rudimentary dreams and saw in this pre-conscious and unconscious emotional stress and that these were mood based. He called these phenomena auto-symbolism. (2, 3.)

C. G. Jung /1916/ used among his tools the "active recalling of internal pictures", which he called active imagination (imagery). (4)

E. Kretschmer /1922/ also observed spontaneous imaginative phenomena and tried to use the Freudian dream symbols and dream work, thus establishing the "film reel thinking". (5)

I.H. Schultz /1932/ further developing the method of Autogenic Training, worked out a systematic imagination method, the highest level of autogenic training. (6)

The French Desoille published a method in 1945, which could be called "attended daytime dream", since this technique differs from techniques so far, that the therapist follows the imagination directly. (7) Its difference to KIP is still substantial in that he called the method more as a symbolic behavioural training in which deep emotional aspects were rarely given any importance.

Hanscarl Leuner started a major series of studies in 1948 with healthy and neurotic patients. During the process of this he discovered a series of surprising phenomena, since he found evidence between dreams and the primary processes published by Freud. Concurrently it became evident for him that the regular daily dream sessions resulted unexpected therapeutic efficiency with neurotic patients. (8)

He published his experiences in a comprehensive study in 1955 and introduced his method as a katathym visual experience, a clinical psychotherapeutic method. (8, 9.)

In 1970 he published his book „Einführung in die Psychotherapie mit dem Tagtraum. Katathymes Bilderleben. Ein Seminar" at Thieme Publishers. (10)

The textbook on the Katathym Visual Experience was published in 1985 by the Hans Huber Publishers under the title „Das Lehrbuch des Katathymen Bilderlebens".

Studies published in English in the USA: Leuner, H. (11, 12, 13.)

Mental imagery techniques may play a useful role „in establishing rapport with the patient, to assess his problems and potentialities, and to actively involve him in the therapeutic process."

The patient symbolically represents his meaningful experience. Evoking these images establishes rapport with the patient by entering into the client's unique frame of reference.

Images can be used for assessment, as well. A psychotherapist might ask the client to imagine or draw a tree to assess the client's sense of self.

Imagery can also actively involve a patient in therapy because he must interact with the image. He may be called upon to give the image a voice, draw it, dialog with it, and transform it in his imagination. All of this makes the image compelling and meaningful to the patient.

The task in psychotherapy is for the patient and the therapist to assign meanings to these images, to relate the process to the possibility of new awareness, and hopefully change."

The essentials of the KIP psychotherapeutic method

1. Theoretical basics in psychoanalysis
2. The use of imagination
3. During the course of imagination structuring (basic level), confrontation (intermediate level) and integration (advanced level) on the symbol and with the symbol.
4. Discussion of the experiences of the imagination, the pictorial content, embedding into the conscious and processing.

Indications for the use of KIP

1./ Short psychotherapy 25-30 hours: ie. crisis interventions, current conflicts, anxiety, current neurosis, reactive depression etc.

2./ Medium and long-term psychotherapy: from 30 hours to years: classical neurotic disorders: psychosomatic problems, narcissist disorders, addictive disorders, psychogenic psychosis, etc.

It can be used as both a short and long therapeutic method without restrictions on age. It is successfully used with children, adolescents and adults.

Individual, pair, family and family therapy techniques have also been developed.

Contraindications: Acute psychotic states, prepsychotic states, severe organic brain syndrome with a reduction of performance and deterioration, the most serious form of hysteric character syndromes.

Relative contraindication /reserved for specialists/

Chronic psychosis, psychosis maintained with medical treatment, the most serious forms of compulsion and hysteric structured deference.

Planning the therapy

Diagnostic phase: the first contact – in terms of the first deep emotional interview (complaints, feeling of suffering, symptoms, actual living circumstances etc.)

Therapeutic agreement: the precise definition of the therapeutic objective, definition of criteria, the projected length of the therapy (short, medium or long term), the length of therapeutic sessions, the method of conclusion etc.

Deep emotional anamnesis taking.

Diagnostics: Personality culture, self-development, self-protecting mechanism, deferring mechanism, etc. Establishment of the first diagnosis.

Setting and mutual acceptance of a **therapeutic objective**.

Drafting of the plan.

The precise documentation of the therapy is extremely important.

Dialogue is important, as it can be documented either in a written or a taped form, as the changes in the pictures and symbols of the patient's inner world and the healing processes can be manifested with its help.

The potential dangers of KIP

It is important to call the attention to the fact that although this psychotherapeutic method seems easy to manage, it is still suggested to be used by methodically trained therapist.

The unconscious effects, emotions, instinctive reactions, needs and conflicts manifested in the imaginations of the patient may cause anxiety and provide a burden on the personality of the patient. Thus therapists have to continuously control the quantity of burden, the take into account what the endurance and maturity of the patient – and the transfer of anger appearing in the imaginations.

The visual-affective-emotional character of the imaginations of the patient also have/could have a strong inductive impact and are capable of stirring up unconscious affects, needs etc. For this reason the own control, knowledge of problems and their management by the therapist is especially important, just as well as the control not transfer negative emotions.

Thus from a methodology point of view the basic, intermediate and the high level forms of Katathym Imaginative Psychotherapy can be distinguished.

The KIP psychotherapeutic training contains deep emotional, psychopathologic and method specific knowledge with its developed training system.

Interpretation of symbols in therapy

Symbols – appear like calling signs when the unconscious is addressed, questions about a problem re raised. Imaginations reflect deep emotional and provide a projection surface to reflect internal feelings, experiences and emotions. The symbolic technique helps to bring to surface concealed or yet unknown unconscious, pre-conscious content. Symbols are always a compound, visual abstraction, with similar analogous thinking structure meanings like "it as if" or "it is like".

The Leuner-therapy includes all forms of the interpretation of deep emotional symbols both on the levels of the individual, archaic and collective unconscious. In this sense all symbols have multiple meanings. The essence of the therapy is to lift the archaic and collective meanings for the patient to the individual level and based upon the maturity to allow the patient to interpret them on the level of reality. In interpreting the symbol, looking at the patient and shortly after the appearance of the picture, the dialogue with the therapist can lead the patient to conclusions on the contents of the picture. The spontaneous willingness to interpret the katathym pictures helps to unravel the individual meaning of the symbol.

The Katathym pictures

The expression katathym – as written by E. Bölcs (14) – refers to symbolic projections of experience and the emotionally lived, symbolic projections of the unconscious. The visual experience is induced with a therapeutic objective, emphasizing the visual character of the world of experiences of the daytime dream, in which the significant part of the therapeutic process is conducted. Imagination stands for the work conducted on imaginative content, work conducted on the premier levels of emotional processes, which is close to work on the unconscious. Imagination means regression into the early periods of visual thinking. The visual aspect with its symbolic character plays a meditative role, between the deep unconscious vibes, desires, emotions, instincts, their development, conflicts and the conscious experience.

The visual experience lifts unconscious content into the conscious. These symbolic, pre-conscious contents can either become conscious through experience or discussion of the visual or can be further enriched in the conscious with associative memories of emotions. Therapy with imagination, means work carried out with symbols, on symbols thus work going on in the unconscious. This allows for a replenishment of earlier emotional deficits, a delayed development of the personality, allowing the possibility to discuss a conflict in a visual manner /first level of therapy/ thus meaning work carried out in the unconscious.

Thus the therapeutic process occurs on two levels. The first level is that of imagination, induced by the therapist, leading the patient during the whole visual experience with a dialogue. In their evolution katathym imaginations are plastic, colourful and three-dimensional. The patient can in the world induced by imagination move and act freely in a "quasi real" space. The situations induced by imagination shortly become real and can only partially be influenced by will. **This is what differentiates katathym scenes from simple pictures of fantasy.**

When developing the imagination it is important at first that we involve all sensory modalities into the sphere of experience. The therapist uses structured questions related to optical, tactile, acoustic and olfactory impressions, just as much as concentrating on physical needs and the impressions on physical reactions. By this, instead of the previously construed ideas, a well structured fantasy world develops, which is in line with the projections of the unconscious.

The therapist has at disposal a repertoire of so-called standard symbols in order to make the wide range of the content of day-time dreams into a comprehensive sphere of experiences. These serve as crystallisation points for the development of the individual contents projected by the patient. Symbols are provided in accordance with the therapeutic plan gradually (basic, intermediate, advanced level). The type of the motivation, the therapeutic attitude, the style and technique of intervention are all related to the level at which the therapy is at. The method with which the pre- and post-therapy discussion is conducted also varies according to this.

In KIP the second phase of the therapeutic process, the discussion aimed at investigating psychological depths with its events of mainly a secondary nature constitute the secondary analysis of the patient. (14)

The basic level of KIP

The standard symbols of KIP are linked to the early (pre-oedipal) experiences and allow manifesting them. The katathym pictures of a healthy person are natural, colourful and three-dimensional, and can be described by all sensory modalities. The deeper the trouble in the early phase of development, the more fundamental irregularities appears during the course of the imagination. The more anti-natural the pictures, the problems there are which could lead to bizarre forms of imagination. The incongruence between the emotional participation and the picture content, the lack of sensory experience are also important factors in psychological disorders.

The basic level technique provides an opportunity to rebuild missing structures, to replenish emotional deficiencies with gradual practice. The process requires long and systematic work of building, which allows the missing maturation of the personality. The basic technique has special importance in treating early disorders (self-structure deficit, narcistic disorders, psychosomatic disorders, borderline-structures).

In "Fulfilment of archaic needs" (10) in therapy is the method by which the self-function is strengthened (regression in the service of the ego). In KIP regressions can be manageable in a "controlled regression" and lead back to the early phase of development.

The behaviour of the therapist: emphatic, supportive, unconditional (but not motherly without conditions), accepting even if the imagination carries negative affects.

The principles of the therapy are: "feed and nourish", "forgive", "let the other open up", "stimulate", "allow growth" and to "allow". These principles protect the patient from his/her own fear and anxiety.

The standard symbols of the basic level: flowers, field, creek, mountain, house, forest line.

The flower symbol

This symbol is all the more special because it is used as the very first one, as a diagnostic symbols at the start of the therapy. The form of the flower, its details reflect early personality characteristics, with reference to other skills /imprinting, environment/ as well as self-evaluation, requirements and the relationship with oneself.

The type of the flower, the experience with it and the emotional resonance to it all provide data on the personality of the patient.

Imaginations always reflect on the current status of the psyche, the current emotional state, current experiences, which all appear in the picture.

The field symbols

This allows for wide ranging questions and discussion, rooted in different foundations.

The field in the case of non-neurotic people reflects a status of calm, peace, balance, free of conflicts and rivalry, and as can be expected world orally centred on the mother. The field symbols reflects the mood of the patient. This appears most evidently in the weather. The season of the year – can provide reference to a deeper, more lasting basic mood, like autumn to depressive sadness, spring to optimist expectations and summer to a satisfactory fulfilment. The field as a symbols can also be used as the background for spontaneous or pre-arranged meetings.

The creek symbols

It symbolises the maturing and the emotional development of the personality. Visiting the creek means the return to the origins (oral link to the mother relationship). Following the flow of the creek is a symbolic manifestation of the psychological-emotional development, the uninterrupted unfolding of emotional dynamics or psychic energies. Water on the one hand is in connection with the symbol of the unconscious, on the other hand as an element it has since old ages been linked with the power of life. Water by all means has magic effects: it gives life, refreshes, can be healing, if we drink it, cleanses us inside-out if we bathe in it. In the Christian culture "consecrated water" has as a sacral element become an indispensable part of or lives- and death.

The mountain symbols

The symbols for performance, ambitions, requirements, and rivalries determined in the internal psyche etc., the symbols of the father's world but to a certain extent also the reflection of the inductions from the father. This symbols is used in two forms:

1. Looking at a mountain from afar.
2. Climbing a mountain, looking around from the summit, finally the road leading down.

Fantasies, task solving, evolution of a career, the struggle with challenges of life or the achievement of objectives are all related to climbing a mountain. Looking around from the top of a mountain can also be construed as being an intellectual exercise to study one's own spiritual and emotional status, but can also be the subjective assessment of a current external situation of life, which need not necessarily coincide with the objective situation.

Symbols of the intermediate level

The intermediate level of KIP

The intermediate level is mainly in their mainly conflict-oriented and allows the assessment of the Oedipal-phase and the later phases of development along with their problems.

The behaviour of the therapist

meanwhile has learned to navigate in his/her katathym world and in the dynamics of the imaginative process has learned to depict in a symbolic his/her conflict in away that the therapist can understand – is stopped here by the therapist, to allow confrontation with these conflicting symbols.

The intervention techniques of the therapist: associative process in the management of imagination, the changing work of the patient on a conflict ridden symbol, (operation carried out on the symbol, the generation of creative problem solving and action attempts.

During the course of the therapy the patient reacts differently to symbols that are hostile ore create anxiety, thus the therapist has to find the attitude best suited to the individual. It is always important to find the best measure, at which anxiety is still bearable for the patient and by this it is possible to find other ways and opportunities in emotional digestion of events. This is where the principle of enrichment and nourishment meet, just as the methods of reconciliation and a gentle touch.

For example we can feed a wild beast, calm it and talk to it. The essence of this process is the neutralization and change aggressive, hostile or anxiety filled subjects.

During the symbol confrontation hostile and anxiety filled (many times archaic and disassociated) symbol forms are processed.

It is important that the projective space for play of the patient is widened and that every expansive impulse is made possible.

Symbols related to the personality and experiencing it

A tree: carries aspects of a flower, but seizes the developed personality.

An animal: reflects the aspects of the dynamics of the instinct in the personality.

Self-ideal: the same-gender person imagined with the same name shows self-realization along the lines of the ideal and the superior ego.

Symbols putting the relational aspect at the centre

Three trees: description of the mother, father, child triad.

Pack of animals: a dynamic representation of the family structure and relational experiences.

For further descriptions of the symbols see: Leuner, H. (10, 11.)

Mechanisms showing the aspects of instinctual dynamics

Lion or a wild beast: relation to aggression.

Rose bush /or men/, hitchhiking, or fruit tree /for women/ depict the internal relationship to sexuality.

Further standard symbols of the intermediate level: actual conflict, person in conflict, continuation of a night time dream.

Apart from standard symbols on the intermediate level every symbol or metaphor is suitable for visualization of what the patient considers to be a problem or what is selected by the therapist. Pictures can be depicted again and again from time to time, which shows how the given conflict changes in internal content and what changes it brings about in the life-style and the personality of the patient.

The high level of KIP

It means the deepening of the archaic dimensions of the personality of the intermediate level. In essence it does not differ from the intermediate technique but the selection of symbols is different, the processing of symbolic content is deeper and more integration oriented. The post-processing phases are more intensive, there is more room for associations than in the intermediate technique.

The standard symbols of the high level technique

The cave: The feeling of "being surrounded" in all aspects invokes the experience of the ancient cave all the way to the pre-natal experiences.

Marsh: Connects to the hostile, anxiety invoking anal and sexual component of instincts.

Volcano: Activates archaic components of instinct, which appear symbolically and allow transformation.

Codex (old book): Shows unconscious higher content stored deeply.

Family photo-album with developed and undeveloped photos: experiences which carry the family myth and the family stories.

In order to get better acquainted with pair, family and group therapies, and gain deeper knowledge of the Katathym Imaginative Psychotherapy we propose the reading of the textbook written by Leuner, H. (10) and the relevant literature.

Conclusion

Katathym Imaginative Psychotherapy is a therapeutic method based on deep emotional basics. The patient in the relaxed phase (based on a predefined symbol) imagines katathym visual experiences by living them as an experience, which is followed continuously by talking with the therapist. The behaviour of the therapist is one that accompanies the patient with continuous dialogue. The behaviour of the therapist is always accompanying, suited to the given level of the therapy – and only very rarely, cautiously and to the necessary extent is interpretative. During the therapeutic process de patient will to smaller or larger extent have "aha" and cathartic experiences. Therapeutic experiences show that the katathym pictures can heal in themselves, which is further strengthened by the secondary processing with the interpretation of the level of rationality and self interpretation, thus helping the healing. The Katathym Imaginative Psychotherapy provides perhaps the highest protection in the healing process both for the patient and the therapist.

The discussion of the theory behind the method was prepared on the basis of a study published by Erik Bölcs[1].

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REFERATE

INTERNATIONAL "BALINT" AWARD 2006

1st year medical student, Lala I. Adrian
"Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania
Coordinating prof.: Prof. Dr. Ioan Bardu Iamandescu, Head of Department of Medical Psychology

Being a first year medical student doesn't give you a large opportunity to interact with patients. Having that in mind and trying to find a way to correct it I've enrolled in the Emergency and ResuscitationMedical Ambulance system as a volunteer in hope that this will help me make a good idea of what medical practice is all about and also to help me create a vision of what my future patients could be going throughbefore arriving at the hospital.

After receiving the Basic Life Support diploma I had the chance to work with some very good doctors and take part in the solving of medical cases of all sort, many of them being experiences from which I've learned things that will probably guide me through my future career in taking of people's physical and psychical health.

During a night route, at 1:20 AM we received the chart of a 17 year old boy suspected of a drug overdose. I've been to overdose cases before but the doctor I was working with that night went over the things we should be doing upon arrival at the patient's house. The age of the patient and the fact that his fatherwas the one who called the ambulance was at first thought of as a strange thing, most of our overdose patient being over 20 and in a distinctly bad social situation.

Arriving at the house – a 2 room flat at the 2nd floor of a fairly good neighborhood we were greeted by the patient's extremely frightened mother that quickly guided us to one of the rooms where the 17 year old was sitting on a chair facing the wall in front of him, glaring at it with an absent, almost ghostly look.I have to say that I was more impressed by this child's look than I was of patients in much more horrible situations, thinking about it later I arrived at the conclusion that it was because of his age and the fact that, as I was to find out, he was very scared and without hope. It was my first-encounter with a seemingly conscious patient that was not responding to any questions or other means of interaction.

In the same room were the patient's father - age 52, his mother - age 46 and for a short while his19 year old sister. The doctor told me to give the patient a regular checkup, consisting of blood pressure, blood sugar level and body exam for needle marks, bruises, eye responses, etc. During this time she was talking to the father. All the exams came out very good, a sign that the boy was in good physical health, we even encouraged the family that he had a good muscle tone and he is a very healthy child from this point of view. What seemed strange at that moment was the father's reaction which became very anxious and starting arguing with the doctor telling her that he knows better because he is a police officer and had a very good experience with drug consumers and addicts. When asked what gave him the suspicion that his son was one of these people he told us of a strange paint-thinner smell that he felt in the last 3 months, at this momentwas the child's first response, looking up to his father in a very hate-filled way. It was becoming more andmore obvious to the doctor and I that we weren't dealing with the usual medical case of drug abuse but with a complicated family situation that was hardly in our grasp.

A very strange but revealing moment was the next one when I asked the mother to give me her son's identity card so I could fill in some information on the chart; she asked the son where he kept it but gotno answer in return so she went in his room to look for it. After about 30 seconds the father reached for the phone and called the police precinct he was working at. The mother came in with the card and asked himwhat he was doing and he answered aggressively "I was calling the police station to see why he's identity card id missing, in what kind of trouble he is in." It was then known to us that the family was in a crisis andwas searching for help in every corner they could find, either by calling the ambulance at 2AM for a fake reason and by calling the police for no reason at all. It was a very confusing moment because I didn't knowwhere my attention should be projected, on the father or on the son, because both attitudes seemed abnormal to me. I even thought that we should abandon the case because of the horrible chart mismatch, I felt an urgent need to get out of that atmosphere, I was a little bit frightened by the situation but on the other hand I thought I was very lucky to have an experienced doctor beside me.

After that the father went on to tell us stories about his youth and how he would obey his parentsand not cause them any trouble, how he became a police officer just like his father and made him proud and how even now, at that age he had a better relationship with his father then he has with his son. The problem started to seam to me like any other generation conflict between father and son, only I had never seen one that has degenerated so bad that the son would be in the state that we found him in. We asked him if heever tried to communicate with his son and ask him about his problems in order to understand his points of view but, again, we were struck by refusal and even ignorance on his behalf.

Using the excuse that we had to start writing a chart the doctor, which happened to also be a licensed psychologist, pulled me away and told me that we were probably dealing with an induced schizophrenia of the child and that she also spotted some problems on the father's side. When I asked her if it was of our duty to help these people she told me something which I hope to never forget: "medicine is never a matter of duty, but of competence and good will", furthermore she told me that there was something "very strange about the boy" and that I should go with him alone in the other room and try to find out what the actual problems are, if I could, she suspected that because of my close age he would open up to me. During thistime the patient's mother

was growing more and more anxious and was looking at the father and asking him whether their boy was ok, whether he was going to be fine, and if it was an overdose or not. Hearing this, the doctor reassured them that it wasn't even the case of an overdose, but this statement didn't really seem to help them much since the father had already confirmed her fears before we could say anything about it.

Finding myself alone with the patient in the other room I noticed that he finally started to have some normal behavior such as looking around, blinking, he even looked straight at me. Meeting his sight I took the chance to connect with him and asked him questions that looked more like questions a friend wouldask, rather than a doctor. I asked him why he thought his parents suspected him of drug consumption and I was very surprised by the fact that the young man that 5 minutes earlier was just sitting in a chair lookingpoint-blank at the wall in front of him, not even blinking was talking to me as any normal person would. He told me that "this" was going on for over 6 months, that his father was constantly "harassing" him and that he just wouldn't accept any arguments that he brought in his defense, therefore he had chosen to completely ignore him and everybody else in his family. I asked him about his relationship with his sister and he told me that because of the fact that his father was forcing her to spy on him he had to "give her up to", adding that she has "her own problems to take care of" since she was in her graduate year and had to prepare for her exams. He also told me that the only person that he is sorry for is his mother but that he couldn't getclose to her either because she was under the father's strict authority. It was very hard for me to ask him whether he was actually taking drugs or not, but when I did I got an answer which I probably should have expected: receiving my question with a smile he told me that "it would have probably been better" if he did,but he doesn't. I asked him what did he mean by that and he told me that he could never take drugs, especially paint thinner - what he was accused of, because he knows "what those things can do to you", and thatin a burst of laughter he said that even if he wanted to he didn't have the money to do it anyway. I then asked him if he had any explanation for the smell that seamed to be the root of all these problems and he toldme that he had started smoking almost a year before and had arguments about that, afterwards his father had started accusing him of more serious things that he "honestly did not do". He even started to confess that he ran away from home for 2 days a couple of months before because of the strict severity that he "was forced to endure" there. When I asked him about his school results he looked satisfied and said that was notone of his problems, that he is trying to keep up under the circumstances and that he can't wait to finish high school and gain his independence. Realizing that I had made some progress in communicating with him I tried to be sensitive to all his needs in order to maintain his morale, but it was hard for me at this point to help suggest any decision or strong advice because the situation was very delicate and complicated. It seemed rather weird to me that he would open up so quickly and sincerely, I had no explanation for that but I was glad it was happening because comparing his situation when we entered the house with the one he was experiencing then there was an obvious evolution for the better.

At that point I was very confused; I couldn't understand how a person could go so quickly from astate in which we suspected him of schizophrenia to one that was fairly normal for a child of his age. I asked him if he ever tried to cooperate with his father in finding a solution to their arguments but he replied that it doesn't matter, that he plans to leave this home for good the moment he turns 18; also after telling me this he smiled and said that he couldn't wait for that moment to come. My confusion got even more intensewhen I realized that I was about to fall into the trap of considering that there was nothing wrong with the person in front of me, and that I was beginning to forget my role there

During the conversation I often thought that I was very lucky not to have the problems I was being told, which made me even more reluctant to try to give him any advice because I was considering myselfnot to be the right person to do so. Although being consumed by them, it wasn't very hard to hide those feelings from the patient.

Returning to the first room to talk to the doctor I found that she was expecting me and looked like she had something important to say to me. She told me that she had talked to the father and that the biggest problem was there, not with the son, responded by telling her what I had found out in the other room. It seams that the father and son hadn't spoken a word to one another in 6 months and that the situation was critical. The doctor explained to the father that there was no problem with his son, that she was almost sure that he didn't even consume drugs, let alone be addicted or suffer an overdose, at which point the father hit the ground with his foot saying "no, I know better, he is an addict and I want you to help me put him into a rehabilitation center". Knowing that I had an experience with patients that had undergone drug rehab and hoping that there was a small chance that the father would respond to that, the doctor asked me to explain to him what treatment in that sort of place implies, as she went to give the child a final exam.

I began by assuring the father that I had a good experience in working with addicts and rehab centers because I was part of an association that activated in the field of post-addiction maintenance of ex drugconsumers but I didn't want to confront him directly with my conclusion that his son was not one of those cases, and so I started to tell him stories that I thought will get his attention and maybe change his perception. I could not get a single doubt into him that he was wrong, after about 30 minutes of explaining what rehabilitation is all about, all I got from him in response was a "well, that was a nice story, kid, but you don'tknow anything about my problems, that one (referring to his son) needs help and I'm going to make sure he gets it". Hearing this I was disappointed and I'm ashamed to say that for a moment I felt like I wanted him to feel for himself what his son was going through. It was the first moment that night that I was scared, I don't know if it was because I didn't know what to do anymore or because I was imagining what the 17 year old in the other room was about to undergo after we were to leave their house.

It was exactly that fear that made me think even harder about the possibilities I could find to helpthis man, with which there was clearly something wrong, to make him understand the fact that he was mistaking to have such radical attitudes towards his son. I then did something that goes beyond the competences and the attributes of an emergency service volunteer - I asked the father to come with me in one of thoserehab centers he was talking about and see what kind of patients he could find there. At first he was reluctant to do so, but I strongly suggested that from my objective point of view he was doing nothing right in hisattempt to help his son. At that point he seemed to have the first doubt that he could be wrong in addressing the problems and I was very happy to find out that he had accepted my invitation. When the doctor came out of the child's room he looked at me and confirmed my feelings that our patient was actually healthy in every way, that the only thing wrong with him is a slight bad attitude and nothing more. She pulled me away for a couple of seconds and said to me "he is as normal as a child can be when the father is not in the room". I told the doctor about my intent to take the parents to see a rehab center and she looked angry at meand told me that I wasn't allowed to do so, but then she gave it another thought and said "but then again itmight help them realize some things".

The doctor then said out loud that he has proposed to their son to see a psychologist but he refused by telling her that there was nothing wrong with him and that he didn't need to talk to one. The parents looked surprised to one another, probably disturbed by the fact that their son was speaking about his problems with a stranger and refused to talk to them at all. The doctor then continued to address the father saying that she hopes he learned something from what I've told him and that she thinks the visit that was going to happen the next day will help him understand both his son's problem - that of having a father that is wrongfully accusing you of taking drugs, but also the fact that he should think twice before making some decisions. The doctor made it indirectly clear that she thought that the primary guilt for the situation is the father's. After that talk I was told that the patient requested me to talk to him again and I went back to his roomwhile the doctor had a conversation with the both parents together. Later I found out that in that conversation the parents refused the doctor's suggestion to undergo some family therapy with a professional doctor by the excuse that they feel this sort of thing are better of being sorted out in the family.

As I entered he said "hello" and apologized for the problems he had caused me and the doctor, he made it specifically clear that he is not apologizing for the ones he is causing his parents. I told him it wasok and a talk concerning seeing a psychologist started. He told me that he didn't want to see one because he didn't think he had any problems, an even if he did he couldn't trust a psychologist to give him advice oranswers concerning them. I explained that he didn't even need to have "problems" to see such a person, and that it will do him good to talk about what he was experiencing even if he didn't consider those things tobe his problem. I suggested the school psychologist if they had one and also wrote him the name and telephone number of one that I knew had experience with this sort of cases. After that I went on to open a shortdiscussion about colleges thinking that it might do him well to have some plans for the future to look forward to, he seemed disappointed about that perspective but then again he said he has enough time to think things through. I told him I would be more than happy to help him understand that his decisions needed to bethought out very deep before having been made, but that it was best that he sorted these things out with a specialized person. He then told me that he was glad it was me and that doctor that came and not someone else. I explained that it was impossible for him to receive all the help he needed during our visit, and emphasized the fact that the best thing he could do is take the advice I had just given him. After our conversationI could sense that he just might take into consideration seeing that therapist and I felt proud that I may have convinced him to do so when the doctor said she couldn't.

After completing our chart for the young patient, a chart that said "no diagnose could be set". Weleft the house. Both me and the doctor looked at one-another and though how good it was to be away fromthe tension that surrounded us in that house. She said that I handled myself good and that if I analyzed thesituation a bit I had many things to learn from it, I'm glad to say that she was right.

The 2nd day I went on to meet the parents at a local hospital but only the father showed up for themeeting, I asked him how did things go after we left and was glad to hear an answer starting with "my sonsaid". He said his son told him that he is not taking any drugs and that he is inclined to believe him, but that he wants to go ahead with visiting the ward as promised. As we entered I explained that there was no reason for him not to believe or trust in whatever advice I or the doctor had given him and that that kind of situation can't be completely solved by the ambulance or the police, for that matter. The nigh before I was given some very good pointers of what I should be discussing with him during our visit. I was careful in showing him some very shocking patients and he was noticeably impressed by the suffering he was seeing. Hismost powerful reaction was upon the sight of a 16 year old patient while having a crisis. After the visit I had the first normal conversation with him, one in which I really felt like he was listening to my arguments. It made me feel really good that he was actually opening up to the possibility that he was the one making amistake and not his son, and for the first time I felt there was some hope of a healthy ending to this case. The problem with working on an ambulance is that you never know the actual ending of a certain situation, especially one of this sort, but this aspect strangely inspires me to always give my best since it might be theonly chance that I could have to help people that desperately need to be helped.

Being intrigued by this situation and driven by deep thoughts and strong emotion derived from that case I went on to study things that would help me better understand what it was all about and how could I have given them more

efficient advice or assistance. The next day all I could think about were possible scenarios of what happened before and after our visit at the patient's house, I thought long and hard about theattitudes of every member of that family and I tried to create an empathy maze to help me systemize the information I had to work with. It was very strange to me to realize that out of 6 cases I had to work on that night, 2 of them being a matter of life and death, my mind was only on this one - a case that was more psychological then medical. Reflecting on the facts I came to the conclusion that I had to carefully take into consideration every piece of information I could remember.

I took this case into a Balint group at the University and after going through it many perspectivesopened up and I had a larger picture of the circumstances concerning it. Being asked questions about the case made me look more closely at some of the details I had missed during the experience; also I found out that the situation would had been empathically overwhelming to most of the participants at the group. Thatmade me get passed my fears of not doing so well so I could reflect on things from a calm and objective point of view.

The first thing that I came to realize was that everyone in that family had a certain problem. The father was confronting the idea that his authority was undermined and that his view of himself as a young child was not at all what he was dealing with in his son. After thinking it through I came to the conclusion that the discomfort I felt when talking to him was a matter of my condition of a student. Since before I had witnessed his refusal to listen to even the doctor's advice I was very discouraged in trying to explain him myview of the situation, especially when this wasn't the case of a medical act but a pure nonmedical advice. Ihad to get passed my feelings and take care of the problem in the most objective way possible; if that manwas to take any facts into consideration they would have to be seen and acknowledged by himself and not supplied by someone else. Having that in mind I went on and gave him the opportunity to do so but by thatI actually went over the line of medical and even psychological assistance. It was very clear to me that since I and the doctor had so little time to deal with these people and given the fact that they strongly refused any help from a specialized person all the advice and support we would give them had to be serious and we needed to make sure that it would be taken into account after we left.

The 2nd day, I think, was very important on many aspects. Firstly the father had no confidence ineither myself or the doctor I was assisting so taking the time to meet him and explain our point of view came as a proof of our good intentions which in the end he appreciated. Creating a good relationship with him was crucial if he was to take any of the advice we had given him, since there would be no other chance to support that advice with the perception that it came form competent and good willing people. Further more I was determined to make him realize how wrong he was in accusing his son without proof, I can't say ifthe feeling I experienced was the need for a success or the fear of failure but it determined me to express myself strongly concerning this aspect and I think that even this determination of mine had an important partto play in the father's final reaction. During the visit I insisted on explaining to him every part of treating adrug addict, with all the painful details and the psychical implication in the process, and I was always putting his son in the role of the patient. I could see for sure that it had a strong effect on him and was glad thatI could finally get that. Walking out of the ward with him I explained that the doctor that had been at theirhouse the night before was both a very good physician and a psychologist. He was actually glad to hear this and said to me that he thought that situation could have been the only possible one which implied him orhis son actually seeing a psychologist.

In my dealing with the young patient I was fortunate to find one that could open up and share hisproblems with me, although confused at first by his contradictory attitude towards me in comparison withhis family I tried to always remember that I am there to take care of his medical problems and not anything else. At first that was very confusing since I could find nothing wrong with him, he seemed like any ordinary boy. Even now I can't explain why I couldn't objectively take into consideration the fact that he was playing a double role that was hardly the case of someone who didn't need help. Regarding whether I was the right person to offer him the help he needed the problem still stands, but considering the fact that I was the only one that seemed to communicate with him I could say that I did my part well. In our conversations Ifelt very sorry for him and even sorrier for the fact that I couldn't really do something to help him on the spot. When dealing with other types of patients there are usually step-by-step rules you must follow in a crisis situation or at least one ordinary thing you can do to reassure him, but in such a case I found myself disoriented and confused in an empathic dead end situation. My first instinct was to encourage him to have an opened relationship with his sister but that failed since after telling me his situation I could understand the fact that there was an obvious hostility between them, one that was maintained and supported by the family scenario. When he told me about his concern for his sister's exams I realized that in fact I wasn't dealing with a person totally indifferent to the needs of the people that surrounded him as I thought so and tried to actaccordingly. I was thinking that any advice I gave him at that time should be a lasting one since it had to help him get over a phase that was not going to end shortly. The emotional build-up I was experiencing was getting overwhelming and it was getting harder and harder to be objective due to the complicated situation and my lack of experience in psychology. The worst thing I had to confront was considering the person in front of me a friend in need of help instead of a patient; that made me overlook some of the basic principles that I had learned and followed at every case I had assisted except for this one. Being sorry for a patient, asI realized, in most cases does nothing but to distance you from the objective point of view and puts you in a situation where you're likely not to make the best decision you could make.

In the 45 minutes, as I approximated to be the total time I had spent with the boy, I came to find out many aspects of

his life and often I confessed that I wouldn't had known what to do in his place. The feeling of uselessness I had was very disturbing but it kept me thinking about that should be done. It wasn't the first time I had felt this but it was strange because all the other times were in the cases of patients that had a life threatening emergency that had gone bad, which was hardly the situation here. The fact that upon leaving the room he told me that he was glad I and the doctor had come made me feel a lot better. I was glad that because of my position as a medical student and my age that was close to the patient's, I actually played an important part in helping him realize that he could find support if he looked for it.

This episode was educative on how there could be situations when a certain patient may need assistance not from a doctor but from someone that seems to have an objective point of view, a person to whom the patient can react to and share his problems with. On this account it should be taken into consideration the involvement of medical students in cases regarding young patients that will not respond well to theirdoctor. I've learned that a patient's compliance to a medic's advice or treatment is directly influenced by his personal opinion of the person that is offering it and even more intensely by the way it is offered. When the father was advised to see a family therapist he immediately refused and accused me of trying to pass the responsibility, but when I offered to personally help him understand my point by sacrificing my own timehe was bound to believe that I am really trying to help him and that I have no hidden reason for doing so.

Furthermore, the noticeably good doctor-student relationship at the case location was very well appreciated as the father confided the 2nd day when he said that he wished he could collaborate with his son as well as he saw us collaborate that night. I was swift to tell him that it required efforts on both parts and he seemed to draw a useful conclusion from that.

I was and am still amazed by the complexity of the term "medical help" since, as I found out, youcan never draw a line between the physical and the psychical care you have to assure a patient. In order tohave a good doctor-patient or student-patient relationship one must firstly take care of the patient's emotional needs or at least try to assure him that they are taken into consideration, otherwise he could be struck by unwanted reactions on the patient's behalf, as I was by the father's indifference to my attempts of broadening his views. The dual aspect of the physician is beginning to be more and more a need than a choice. My student-patient relationship that night was deeply influenced by the excellent communication between me and the doctor. It was very important for me to know that there was an experienced person there that could help me in the difficulties I had in approaching the patients, and I have to say that without the doctor's valuable input I don't think we could have made any progress in dealing with that family's problems. What Ihave come to conclude from this aspect will be of great importance in my future making of decisions concerning the way I communicate with patients.

Firstly, the case I have presented is not a common one and unlikely to come about in the practiceof the majority of medical students but I have to emphasize the fact that because of its strong empathical requests it is a marker for the importance of the doctor/student's desire and capability to acknowledge and understand every aspect of his patient's sufferings, either pathological or not, before proceeding to offer the actual medical care.

Also, it should be taken into account that some situations that on first view seem not to have anything in common with the usual medical act should be approached with great care because, untreated, theymay derive into even more complicated ones, this widens the area of the level of competence any doctoror student that is working under the pressure of the emergency medical act should have.

In addition, the involvement of medical students in the earlier mentioned cases should be closely observed by a competent doctor and should invariably be doubled by a close doctor-student collaborationwhich comes not only in the student's aid but also in the patient's. This is especially true for situations like the one I presented when the time of interaction with the patient is short. Showing a good relationship and collaboration between parts should be considered of vital importance by any medical team in the act of treating a patient.

In closing, must mention the importance in the fact that any medical student or doctor is aware of the possible conditions that have driven a person to show up as a patient and how those conditions are acting as factors of influence in the patient's receptiveness to advise, treatment compliance and feed-back. Thetherapist must be aware of every aspect of a patient's emotional state; this, in some cases, implies the co-working of a part that has the best chance of receiving the necessary information and a part that is specialized in treating the illness or preventing it. The refusal to work in these conditions due to possessiveness over an area of expertise or lack of confidence between parts should be avoided by consideration of the patient's well being.

My condition of a first year medical student may have been a decisive factor in some of the conclusions I could draw from the encounter I presented in this essay, but I have the faith that if faulty, these conclusions will be further corrected during future practice. In my presentation I tried to lay out the facts as correctly and completely as I remembered them; my personal opinions and subjective entries were marked asbeing so, with the hope of succeeding to expose these aspects as well as they could be exposed.

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THE ORIGINS OF ADDICTION: EVIDENCE FROM THE ADVERSE CHILDHOOD EXPERIENCES STUDY*

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"In my beginning is my end."
T.S. Eliot, "Four Quartets" 1

ABSTRACT: A population-based analysis of over 17,000 middle-class American adults undergoing comprehensive, biopsychosocial medical evaluation indicates that three common categories of addiction are strongly related in a proportionate manner to several specific categories of adverse experiences during childhood. This, coupled with related information, suggests that the basic cause of addiction is predominantly experience-dependent during childhood and not substance-dependent. This challenge to the usual concept of the cause of addictions has significant implications for medical practice and for treatment programs.

Purpose: My intent is to challenge the usual concept of addiction with new evidence from a population-based clinical study of over 17,000 adult, middle-class Americans. The usual concept of addiction essentially states that the compulsive use of 'addictive' substances is in some way caused by properties intrinsic to their molecular structure. This view confuses mechanism with cause. Because any accepted explanation of addiction has social, medical, therapeutic, and legal implications, the way one understands addiction is important. Confusing mechanism with basic cause quickly leads one down a path that is misleading. Here, new data is presented to stimulate rethinking the basis of addiction.

Background: The information I present comes from the Adverse Childhood Experiences (ACE) Study.2 The ACE Study deals with the basic causes underlying the 10 most common causes of death in America; addiction is only one of several outcomes studied.

In the mid-1980s, physicians in Kaiser Permanente's Department of Preventive Medicine in San Diego discovered that patients successfully losing weight in the Weight Program were the most likely to drop out. This unexpected observation led to our discovery that overeating and obesity were often being used unconsciously as protective solutions to unrecognized problems dating back to childhood.3, 4 Counterintuitively, obesity provided hidden benefits: it often was sexually, physically, or emotionally protective.

Our discovery that public health problems like obesity could also be personal solutions, and our finding an unexpectedly high prevalence of adverse childhood experiences in our middle class adult population, led to collaboration with the Centers for Disease Control (CDC) to document their prevalence and to study the implications of these unexpected clinical observations. I am deeply indebted to my colleague, Robert F. Anda MD, who skillfully designed the Adverse Childhood Experiences (ACE) Study in an epidemiologically sound manner, and whose group at CDC analyzed several hundred thousand pages of patient data to produce the data we have published.

Many of our obese patients had previously been heavy drinkers, heavy smokers, or users of illicit drugs. Of what relevance are these observations; do they imply some unspecified innate tendency to addiction? Is addiction genetic, as some have proposed for alcoholism? Is addiction a biomedical disease, a personality disorder, or something different? Are diseases and personality disorders separable, or are they ultimately related? What does one make of the dramatic recent findings in neurobiology that seem to promise a neurochemical explanation for addiction? Why does only a small percent of persons exposed to addictive substances become compulsive users?

Although the problem of narcotic addiction has led to extensive legislative attempts at eradication, its prevalence has not abated over the past century. However, the distribution pattern of narcotic use within the population has radically changed, attracting significant political attention and governmental action.5 The inability to control addiction by these major, well-intended governmental efforts has drawn thoughtful and challenging commentary from a number of different viewpoints.6,7

In our detailed study of over 17,000 middle-class American adults of diverse ethnicity, we found that the compulsive use of nicotine, alcohol, and injected street drugs increases proportionally in a strong, graded, dose-response manner that closely parallels the intensity of adverse life experiences during childhood. This of course supports old psychoanalytic views and is at odds with current concepts, including those of biological psychiatry, drug-treatment programs, and drug-eradication programs. Our findings are disturbing to some because they imply that the basic causes of addiction lie within us and the way we treat each other, not in drug dealers or dangerous chemicals. They suggest that billions of dollars have been spent verywhere except where the answer is to be found.

Study design:

Kaiser Permanente (KP) is the largest prepaid, non-profit, healthcare delivery system in the United States; there are 500,000 KP members in San Diego, approximately 30% of the greater metropolitan population. We invited 26,000 consecutive adults voluntarily seeking

comprehensive medical evaluation in the Department of Preventive Medicine to help us understand how events in childhood might later affect health status in adult life. Seventy percent agreed, understanding the information obtained was anonymous and would not become part of their medical records. Our cohort population was 80% white including Hispanic, 10% black, and 10% Asian. Their average age was 57 years; 74% had been to college, 44% had graduated college; 49.5% were men. In any four-year period, 81% of all adult Kaiser Health Plan members seek such medical evaluation; there is no reason to believe that selection bias is a significant factor in the Study. The Study was carried out in two waves, to allow mid point correction if necessary. Further details of Study design are described in our initial ublication.2

The ACE Study compares adverse childhood experiences against adult health status, on average a half-century later. The experiences studied were eight categories of diverse childhood experience commonly observed in the Weight Program.

The prevalence of each category is stated in parentheses. The categories are:

- recurrent and severe physical abuse (11%)
- recurrent and severe emotional abuse (11%)
- contact sexual abuse (22%)

growing up in a household with:

- an alcoholic or drug-user (25%)
- a member being imprisoned (3%)
- a mentally ill, chronically depressed, or institutionalized member (19%)
- the mother being treated violently (12%)
- both biological parents not being present (22%)

The scoring system is simple: exposure during childhood or adolescence to any category of ACE was scored as one point. Multiple exposures within a category were not scored: one alcoholic within a household counted the same as an alcoholic and a drug user; if anything, this tends to understate our findings. The ACE Score therefore can range from 0 to 8. Less than half of this middle-class population had an ACE Score of 0; one in fourteen had an ACE Score of 4 or more.

In retrospect, an initial design flaw was not scoring subtle issues like low-level neglect and lack of interest in a child who is otherwise the recipient of adequate physical care. This omission will not affect the interpretation of our First Wave findings, and may explain the presence of some unexpected outcomes in persons having ACE Score zero.

Emotional neglect was studied in the Second Wave.

The ACE Study contains a prospective arm: the starting cohort is being followed forward in time to match adverse childhood experiences against current doctor office visits, emergency department visits, pharmacy costs, hospitalizations, and death. Publication of these analyses soon will begin.

Findings:

Our overall findings, presented extensively in the American literature, demonstrate that:

- Adverse childhood experiences are surprisingly common, although typically concealed and unrecognized.
- ACEs still have a profound effect 50 years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness.
- Adverse childhood experiences are the main determinant of the health and social well-being of the nation.

Our overall findings challenge conventional views, some of which are clearly defensive. They also provide opportunities for new approaches to some of our most difficult public health problems. Findings from the ACE Study provide insights into changes that are needed in pediatrics and adult medicine, which expectedly will have a significant impact on the cost and effectiveness of medical care.

Our intent here is to present our findings only as they relate to the problem of addiction, using nicotine, alcohol, and injected illicit drugs as examples of substances that are commonly viewed as 'addicting'. If we know why things happen and how, then we may have a new basis for prevention.

Smoking:

Smoking tobacco has come under heavy opposition in the United States, particularly in southern California where the ACE Study was carried out. Whereas at one time most men and many women smoked, only a minority does so now; it is illegal to smoke in office buildings, public transportation, restaurants, bars, and in most areas of hotels.

When we studied current smokers, we found that smoking had a strong, graded relationship to adverse childhood experiences. Figure 1 illustrates this clearly. The p value for this and all other data displays is .001 or better.

This stepwise 250% increase in the likelihood of an ACE Score 6 child being a current smoker, compared to an ACE Score 0 child, is generally not known.8 This simple observation has profound implications that illustrate the psychoactive benefits of nicotine9; this information has largely been lost in the public health onslaught against smoking, but is important in understanding the intractable nature of smoking in many people.10, 11, 12, 13

ACE Score vs. Smoking024681012141618200123456 or morACE Score % Presently Smoking

When we match the prevalence of adult chronic bronchitis and emphysema against ACEs, we again see a strong dose-response relationship. We thereby proceed from the relationship of adverse childhood experiences to a health-risk behavior to their relationship with an organic disease. In other words, Figure 2 illustrates the conversion of emotional stressors into an organic disease, through the intermediary mechanism of an emotionally beneficial (although medically unsafe) behavior.

ACE Score vs. COPD024681012141618200123456 or moreACE Score % with COPD

Alcoholism:

One's own alcoholism is not easily or comfortably acknowledged; therefore, when we asked our Study cohort

if they had ever considered themselves to be alcoholic, we felt that Yes answers probably understated the truth, making the effect even stronger than is shown. The relationship of self-acknowledged alcoholism to adverse childhood experiences is depicted in Figure 3. Here we see that more than a 500% increase in adult alcoholism is related in a strong, graded manner to adverse childhood experiences.14

ACE Score vs. Adult Alcoholism 02468101214161801 234 or more ACE Score % Alcoholic

Injection of illegal drugs:

In the United States, the most commonly injected street drugs are heroin and methamphetamine. Methamphetamine has the interesting property of being closely related to amphetamine, the first anti-depressant introduced by Ciba Pharmaceuticals in 1932. When we studied the relation of injecting illicit drugs to adverse childhood experiences, we again found a similar dose-response pattern; the likelihood of injection of street drugs increases strongly and in a graded fashion as the ACE Score increases.

(Figure 4) At the extremes of ACE Score, the figures for injected drug use are even more powerful. For instance, a male child with an ACE Score of 6, when compared to a male child with an ACE Score of 0, has a 46-fold (4,600%) increase in the likelihood of becoming an injection drug user sometime later in life.

ACE Score vs. Injected Drug Use 00.511.522.533. 501234 or moreACE Score % Have Injected Drugs

Discussion:

Although awareness of the hazards of smoking is now near universal, and has caused a significant reduction in smoking, in recent years the prevalence of smoking has remained largely unchanged. In fact, the association between ACE Score and smoking is stronger in age cohorts born after the Surgeon General's Report on Smoking. Do current smokers now represent a core of individuals who have a more profound need for the psychoactive benefits of nicotine than those who have given up smoking? Our clinical experience12 and data from the ACE Study suggest this as a likely possibility.

Certainly, there is good evidence of the psychoactive benefits of nicotine for moderating anger, anxiety, and hunger.9-12

Alcohol is well accepted as a psychoactive agent. This obvious explanation of alcoholism is now sometimes rejected in favor of a proposed genetic causality. Certainly, alcoholism may be familial, as is language spoken. Our findings support an experiential and psychodynamic explanation for alcoholism, although this may well be moderated by genetic and metabolic differences between races and individuals.

Analysis of our Study data for injected drug use shows a powerful relation to ACEs.

Population Attributable Risk* (PAR) analysis shows that 78% of drug injection by women can be attributed to adverse childhood experiences. For men and women combined, the PAR is 67%. Moreover, this PAR has been constant in four age cohorts whose birth dates span a century; this indicates that the relation of adverse childhood experiences to illicit drug use has been constant in spite of major changes in drug availability and in social customs, and in the introduction of drug eradication programs.17

American soldiers in Vietnam provided an important although overlooked observation. Many enlisted men in Vietnam regularly used heroin. However, only 5% of those considered addicted were still using it 10 months after their return to the US.15, 16 Treatment did not account for this high recovery rate. Why does not everyone become addicted when they repeatedly inject a substance reputedly as addicting as heroin? If a substance like heroin is not inherently addicting to everyone, but only to a small minority of human users, what determines this selectivity? Is it the substance that is intrinsically addicting, or do life experiences actually determine its compulsive use? Surely its chemical structure remains constant. Our findings indicate that the major factor underlying addiction is adverse childhood experiences that have not healed with time and that are overwhelmingly concealed from awareness by shame, secrecy, and social taboo.

The compulsive user appears to be one who, not having other resolutions available, unconsciously seeks relief by using materials with known psychoactive benefit, accepting the known long-term risk of injecting illicit, impure chemicals. The ACE Study provides population-based clinical evidence that unrecognized adverse childhood experiences are a major, if not the major, determinant of who turns to psychoactive materials and becomes 'addicted'.

Given that the conventional concept of addiction is seriously flawed, and that we have presented strong evidence for an alternative explanation, we propose giving up our old mechanistic explanation of addiction in favor of one that explains it in terms of its psychodynamics: unconscious although understandable decisions being made to seek chemical relief from the ongoing effects of old trauma, often at the cost of accepting future health risk. Expressions like 'self-destructive behavior' are misleading and should be dropped because, while describing the acceptance of long-term risk, they overlook the importance of the obvious short-term benefits that drive the use of these substances.

This revised concept of addiction suggests new approaches to primary prevention and treatment. The current public health approach of repeated cautionary warnings has demonstrated its limitations, perhaps because the cautions do not respect the individual when they exhort change without understanding. Adverse childhood experiences are widespread and typically unrecognized. These experiences produce neurodevelopmental and emotional damage, and impair social and school performance. By adolescence, children have a sufficient skill and independence to seek relief through a small number of mechanisms, many of which have been in use since biblical

times: drinking alcohol, sexual promiscuity, smoking tobacco, using psychoactive materials, and overeating.

These coping devices are manifestly effective for their users, presumably through their ability to modulate the activity of various neurotransmitters.

* Population Attributable Risk is a simple concept, although a complex calculation, that describes in a population that portion of a risk factor that can be attributed to a particular cause.

Nicotine, for instance, is a powerful substitute for the neurotransmitter acetylcholine. Not surprisingly, the level of some neurotransmitters varies genetically between individuals18.

It is these coping devices, with their short-term emotional benefits, that often pose long-term risks leading to chronic disease; many lead to premature death. This sequence is depicted in the ACE Pyramid (Figure 5). The sequence is slow, often unstoppable, and is generally obscured by time, secrecy, and social taboo. Time does not heal in most of these instances. Because cause and effect usually lie within a family, it is understandably more comforting to demonize a chemical than to look within. We find that addiction overwhelmingly implies prior adverse life experiences.

The sequence in the ACE Pyramid supports psychoanalytic observations that addiction is primarily a consequence of adverse childhood experiences.

Moreover, it does so by a population-based study, thereby escaping the potential selection bias of individual case reports. Addiction is not a brain disease, nor is it caused by chemical imbalance or genetics. Addiction is best viewed as an understandable, unconscious, compulsive use of psychoactive materials in response to abnormal prior life experiences, most of which are concealed by shame, secrecy, and social taboo.

DeathBirthAdverse Childhood ExperiencesSocial, Emotional, & Cognitive ImpairmentAdoption ofHealth-risk BehaviorsDisease, DisabilityEarlyThe Influence of AdverseThe Influence of AdverseChildhood Experiences Throughout LifeChildhood Experiences Throughout LifeDeath

Our findings show that childhood experiences profoundly and causally shape adult life. 'Chemical imbalances', whether genetically modulated or not, are the necessary intermediary mechanisms by which these causal life experiences are translated into manifest effect. It is important to distinguish between cause and mechanism. Uncertainty and confusion between the two will lead to needless polemics and misdirected efforts for preventing or treating addiction, whether on a social or an individual scale. Our findings also make it clear that studying any one category of adverse experience, be it domestic violence, childhood sexual abuse, or other forms of family dysfunction is a conceptual error. None occur in vacuuo; they are part of a complex systems failure: one does not grow up with an alcoholic where everything else in the household is fine.

Treatment:

If we are to improve the current unhappy situation, we must in medical settings routinely screen at the earliest possible point for adverse childhood experiences. It is feasible and acceptable to carry out mass screening for ACEs in the context of comprehensive medical evaluation. This identifies cases early and allows treatment of basic causes rather than vainly treating the symptom of the moment. We have screened over 450,000 adult members of Kaiser Health Plan for these eight categories of adverse childhood experiences. Our initial screening is by an expanded Review of Systems questionnaire; patients certainly do not spontaneously volunteer this information. 'Yes' answers then are pursued with conventional history taking: "I see that you were molested as a child. Tell me how that has affected you later in your life."

Such screening has demonstrable value. Before we screened for adverse childhood experiences, our standardized comprehensive medical evaluation led to a 12% reduction in medical visits during the subsequent year. Later, in a pilot study, an on-site psychoanalyst conducted a one-time interview of depressed patients; this produced a 50% reduction in the utilization of this subset during the subsequent year.

However, the reduction occurred only in those depressed patients who were high utilizers of medical care because of somatization disorders. Recently, we evaluated our current approach by a neural net analysis of the records of 135,000 patients who were screened for adverse childhood experiences as part of our redesigned comprehensive medical evaluation. This entire cohort showed an overall reduction of 35% in doctor office visits during the year subsequent to evaluation.19

Our experience asking these questions indicates that the magnitude of the ACE roblem is so great that primary prevention is ultimately the only realistic solution.

Primary prevention requires the development of a beneficial and acceptable intrusion into the closed realm of personal and family experience. Techniques for accomplishing such change en masse are yet to be developed because each of us, fearing the new and unknown as a potential crisis in self-esteem, often adjusts to the status quo. However, one possible approach to primary prevention lies in the mass media: the story lines of movies and television serials present a major therapeutic opportunity, unexploited thus far, for contrasting desirable and undesirable parenting skills in various life situations.

Because addiction is experience-dependent and not substance-dependent, and because compulsive use of only one substance is actually uncommon, one also might restructure treatment programs to deal with underlying causes rather than to focus on substance withdrawal. We have begun using this approach with benefit in our Obesity Program, and plan to do so with some of the more conventionally accepted addictions.

Conclusion:

The current concept of addiction is ill founded. Our study of the relationship of adverse childhood experiences to adult health status in over 17,000 persons shows addiction to be a readily understandable although largely unconscious attempt to gain relief from well-concealed prior life traumas by using psychoactive materials. Because it is difficult to get enough of something that doesn't quite work, the attempt is ultimately unsuccessful, apart from its risks. What we have shown will not surprise most psychoanalysts, although the magnitude of our observations in new, and our conclusions are sometimes vigorously challenged by other disciplines.

The evidence supporting our conclusions about the basic cause of addiction is powerful and its implications are daunting. The prevalence of adverse childhood experiences and their long-term effects are clearly a major determinant of the health and social well being of the nation. This is true whether looked at from the standpoint of social costs, the economics of health care, the quality of human existence, the focus of medical treatment, or the effects of public policy. Adverse childhood experiences are difficult issues, made more so because they strike close to home for many of us. Taking them on will create an ordeal of change, but will also provide for many the opportunity to have a better life.

***Footnote**: Abstracts of all past and future ACE Study articles may be found by searching under the author name (Felitti VJ) at the web site for the US National Library of Medicine: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi Free subscription is available to an electronic newsletter dealing with various aspects of the ACE Study.*

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LE « POST-BALINT » : UN EXEMPLE ANGLAIS#

dr. John Salinsky, Londra

Un travail de recherche a débuté en Grande-Bretagne ŕ l'initiative des leaders par nos amis de la Société Balint anglaise. Une expérience « post-balintienne » en quelque sorte qui a aboutit ŕ la rédaction du livre désormais célčbre de John Salinsky et Paul Sackin. La naissance de ce groupe et sa méthode de travail sont abordées au chapitre 4 de cet ouvrage ainsi que les « principes » qui ont peu ŕ peu émergé et qui ont ensuite guidé le travail du groupe. Petit avant goűt pour donner envie d'en achever la lecture.*

En Grande-Bretagne, la plupart des séminaires Balint se déroulent toujours selon le « format » initial établi par Michael Balint. Un groupe de 6 ŕ 12 médecins généralistes se rencontre pendant une heure et demie, traditionnellement une fois par semaine. Si possible, les leaders sont un médecin généraliste et un psychothérapeute. Invariablement, Michael Balint commençait la séance par « Qui a un cas ? ». Aprčs une pause de longueur variable, un ou deux cas étaient « offerts ». Les cas étaient pour la plupart en relation avec des patients qui avaient en quelque sorte « dérangé » le médecin. Habituellement, deux cas étaient discutés par séance mais un moment était aussi réservé aux « suites de cas ». L'absence de « notes » du présentateur était l'une des caractéristiques du travail de groupe. Ce que le présentateur oubliait ou ce sur quoi il hésitait dans sa présentation n'était pas critiquée. Au contraire, cela était considéré comme le reflet de la relation médecin malade, au centre de la réflexion. Une fois la présentation terminée, le groupe pose des questions au présentateur pour établir les « faits ». Aprčs cela, il est important de ne garder qu'un minimum d'interrogations. La façon dont le groupe réagit émotionnellement et les difficultés rencontrées par les participants rendent compte trčs probablement de ce qui se passe entre le patient et la médecin. Les membres du groupe doivent travailler avec créativité pour explorer et comprendre la relation médecin malade. Une meilleure compréhension autorise le présentateur du cas ŕ aller de l'avant. Les autres membres du groupe peuvent aussi améliorer leur perspicacité, ce qui les aidera avec leurs propres patients.

Notre méthode de travail fut calquée sur ce modčle. Pour des raisons pratiques, nous nous sommes rencontrés un jour entier cinq fois par an. Nos leaders étaient Michael Courtenay et Erica Jones, deux médecins généralistes retraités, trčs expérimentés dans le leadorat des groupes Balint ŕ la fois versus formation et versus recherche. Toutes nos discussions étaient enregistrées et la plupart retranscrites. Aprčs nous ętre réunis ŕ plusieurs reprises ŕ propos d'autres sujets de recherche (et constitué un vrai groupe établi en toute « sécurité »), nous avons décidé qu'il serait plus profitable de porter notre attention sur les défenses des médecins et de relever quelques uns des défis proposés par Tom Main (chapitre II).Les présentateurs exposent des cas en rapport avec « eux-męmes » en quelque sorte, les cas qui rendent incertaines leurs façons de procéder ou d'agir. Bien qu'aucun cas ne soit exclu du moment qu'il a « troublé » le médecin, le groupe est particuličrement intéressé par les exemples de comportements « sur-défensifs » qui ont empęché le médecin d'écouter avec empathie et de se comporter en professionnel efficace.

A la fin de chaque présentation puis discussion, des questions formelles sont posées ŕ propos des mécanismes de défense possiblement enjeu.

Au début de chaque séance suivante, aprčs lecture du compte rendu de la derničre séance, une rétrospective de chaque cas est effectuée (avec possibilité de « suivi ») dans le but de s'assurer de ce que le groupe ait pu aider davantage le médecin et de réexaminer quels mécanismes de défense avaient été mis enjeu.

Nous avons senti que cette approche était importante pour assurer la sécurité du groupe parce que considérant les défenses, il ne serait possible de donner un sens aux relations médecins patients qu'en autorisant l'émergence des expériences propres ŕ certains membres du groupe. Ceci rompait avec le classique dictât de Balint : seuls les problčmes professionnels peuvent ętre discutés. Néanmoins, il nous apparaissait clairement, pour paraphraser Balint qu'un « changement considérable bien que limité » de notre méthode de travail était nécessaire si nous voulions relever le défi de Tom Main.

Nous sentions aussi que déplacer un petit peu le curseur de la relation médecin-patient vers le médecin pourrait ętre un modčle qui attirerait nos collčgues de médecine générale stressés ou en difficulté.Néanmoins, nous étions tous d'accord qu'aucune révélation personnelle n'était intéressante pour nous aider ŕ comprendre la relation médecin patient et ŕ poursuivre notre recherche sur les défenses des médecins. Cela aurait pu ętre un « effet secondaire » intéressant si les membres du groupe s'étaient sentis confortés par le groupe lui-męme. Mais ce groupe n'avait pas vocation ŕ ętre plus thérapeutique que n'importe quel autre groupe Balint. Cette approche plus humaniste du travail Balint ressemblait beaucoup ŕ celle de groupes allemands et représentait peut ętre ce facteur de popularité que l'on retrouve lŕ-bas.

La séquence habituelle des questions formelles nous sembla essentielle pour pointer les mécanismes de défense. Il fallut un certain temps pour élaborer la version finale de la liste de ces questions. Nous avions eu besoin de discuter d'abord quelques cas et de développer le climat de sécurité nécessaire au groupe pour que chacun se sente en confiance et que quelques révélations personnelles soient émises. Les éventuelles questions sur lesquelles nous étions d'accord étaient les suivantes :

• Quelle était la nature de la ou des défenses ?

• Qu'est-ce qui venant du patient déstabilisait le médecin ?

• Est-ce que cela aurait aussi déstabilisé d'autres médecins ?

• Si le médecin avait pu prévoir ŕ temps ce trouble et sa nature, que se serait-il passé? Quelle aurait été alors l'issue de la consultation ?

Nous avons passé un certain temps, parfois avec beaucoup de fougue, ŕ discuter les enjeux exacts de ces questions. Le débat le plus angoissant concernait le mot « UPSET ». ** Peut ętre que le mot résonnait un peu « dramatique ». Le médecin ne devait pas se sentir affligé de présenter un cas.

Les mots qui vinrent ŕ la longue en alternative au mot « upset » étaient : déconcerté, confus, sous-pression. Cependant, nous n'avons pas pu choisir un autre mot que « upset » au sens littéral du mot, impliquant une certaine instabilité du médecin, ce qui traduisait trčs bien ce que nous voulions transmettre. Le problčme de l'effet qu'exercent les patients sur certains médecins était au centre de notre recherche. Manifestement, quelques patients, comme les patients violents ou atteints de maladie grave, perturbent un certain nombre de médecins. Ce qui nous intéressait était de prévenir les défenses inappropriées ou inconscientes et nous nous appliquions ŕ rechercher les cas ŕ mettre sous le projecteur, qui semblaient ętre ŕ l'origine du « bouleversement » (« upset ») du médecin présentateur du cas en particulier. Les questions semblaient ętre la meilleure façon de centrer notre pensée sur l'identification des défenses des participants et d'étudier ce qui pourrait ętre fait pour les rendre plus conscientes et appropriées.

Lorsque le moment est venu de savoir si on discutait de la transcription de la discussion initiale ou des consultations suivantes, nos questions ont été légčrement modifiées. Voici la version finale ŕ laquelle nous sommes arrivés.

• Une ou la discussion sur la transcription des cas ou la discussion sur les « suites de cas » apporte- t-elle un éclairage nouveau sur un quelconque mécanisme de défense?

• Est-ce qu'un quelconque mécanisme de défense récent est discerné lors de suites de cas?

• A quel point le médecin perçoit - il plus profondément de la nature de ces défenses?

• Comment les rencontres ultérieures sont elles modifiées par cette perception et le commentaires du groupe?

A notre grande surprise, en quelque sorte, une fois arrivés ŕ une version commune des questions, il nous est devenu plus facile, ŕ nous les participants de comprendre et de révéler nos défenses. C'était rarement possible juste aprčs la présentation du cas. Cela arrivait habituellement aprčs avoir discuté de la transcription de la discussion initiale, souvent pendant l'étape formelle du travail du groupe, lorsque nous essayons de répondre aux questions chacun notre tour.

Parfois, la discussion des « suites de cas » apportait de nouvelles perceptions importantes dans la relation médecin-patient et la nature des défenses. Les membres du groupe furent poussés ŕ donner des suites de cas comme dans n'importe quel groupe Balint. De plus, pendant la troisičme année du travail de ce groupe, nous avions donné ŕ chaque médecin l'opportunité de revenir bričvement sur tous leurs cas ? C'était en partie pour satisfaire la curiosité des autres membres du groupe. Du point de vue de la recherche, c'était important pour revoir les quelconques changements dans les mécanismes de défense pour voir si les discussions du groupe avaient ou non aidé le médecin rapporteur du cas. Cependant, le groupe fonctionnait sur plusieurs niveaux. C'était un groupe « ordinaire » discutant les cas qui avaient perturbé le médecin. C'était aussi un groupe ou les problčmes personnels étaient appréhendés plus en profondeur, du moins pour ce qui est des habitudes anglaises. En męme temps, la structure des débats était précise. Ces questions furent « revisitées » en discutant chaque transcription de séance, chaque suite de cas. Jusqu'ŕ la fin de notre travail, nous avions réexaminé bričvement tous les cas, en essayant d'en dégager des « modčles ». En plus de ce travail, nous passions du temps ŕ discuter notre présentation au congrčs international d'Oxford en Septembre 98 et cette façon de faire nous éclaira de nouveau sur notre travail. Il y eut aussi un bon nombre d'écrits. Aprčs chaque séance, Michael Courtenay nous envoyait un résumé de chacune des discussions de cas qui nous aidait ŕ nous rafraîchir la mémoire et cristallisait notre pensée avant l'arrivée de la complčte transcription. Finalement, ŕ plusieurs reprises, Michael Courtenay et quelques autres membres du groupe avaient diffusé leurs idées pour discuter de comment notre travail avait progressé et de quelles étaient les perceptions qui s'étaient développées. Nous espérons que les chapitres suivants témoigneront de la productivité de cette démarche.

Extrait proposé par Marie-Anne Puel.

** « How do you feel, Doctor? Identifying and avoiding défensive patterns in the consultation», John Salinsky et Paul Sackin (Radcliff éd. Londres 2000). Traduction française collégiale (Françoise Auger, Michel Nicolle, Marie-Anne Puel, Louis Velluet). «Que ressentez-vous, Docteur? identifier et éviter les modčles défensifs en consultation »*

*** Les traducteurs ont finalement choisi l'adjectif « déstabilisé » pour traduire ce mot.*

*# *Articolul a fost publicat cu acordul redactorului şef a Revistei Societăţii Medicale Balint din Franţa prin preluare din nr. 53/2007 al Revistei*

PREZENTARE DE CAZ – GRUP MARE
WEEKEND NAȚIONAL DE VARĂ, OCNA ŞUGATAG - 20 MAI 2007

Hegyi Csilla, medic rezident pediatru, Târgu Mureş

(Lider: Baka Tünde, Colider: Árvai Zsófia, Supervizare: Münzlinger Attila).

Grupul începe cu tradiționala prezentare a membrilor grupului. Sub aripile protectoare ale liderului de grup se formează atmosfera armonioasă necesară pentru începerea prezentării cazului, prin momentele de liniște caracteristice grupurilor Balint.

Medicul psihiatru "L", care aduce cazul însăşi defineşte relația ei cu pacienta ca fiind una confuză, nedefinită. Este vorba de o pacientă tratată pentru depresia ei de aproape toți medicii psihiatri din oraşul respectiv. Ea se dovedeşte a fi rezistentă la tratament, motiv pentru care ajunge şi la Psihiatria din Târgu Mureş, urmând ca în cele din urmă să ajungă pacienta lui "L". Este o pacientă care-i tot vine şi revine la cabinet şi de care îi este milă. Pacienta devine afirmativ fără acuze după tratamentul administrat de "L" şi doreşte să meargă în Spania la lucru, contra sfatului medicului. La următoarea vizită la medic, pacienta este din nou decompensată, cu gânduri negative. Se plânge că nu se simte bine, că nu-şi mai poate permite să cumpere medicamentele, iar nefiind asigurați, nimeni nu mai are cum să-i prescrie gratuit. Cere o favoare de la medic: soțul pacientei să fie angajat la firma soțului lui "L". Este prima ocazie a ei de a se întâlni cu soțul pacientei. Este un bărbat de 33 de ani, cu aspect fizic de cca 26 de ani, arătos, dar şi cu o personalitate imatură, cu VIII clase, fără meserie concretă. Bărbatul este în cele din urmă angajat la firma soțului lui "L", aceasta aduce beneficiul de calitate de asigurat întregii familii.

În etapa întrebărilor, din răspunsurile primite se conturează şi mai bine aspectele delicate ale cazului. Timpul petrecut în Spania era un eşec total al acestei familii: pacienta s-a decompensat, iar la revenirea în țară, soțul fără câştig, şi ea doar cu alocația pentru concediul de îngrijire a copilului mic. Toată responsabilitatea cade pe umeri soției, ea agățându-se de "L" ca de un colac de salvare. Pacienta merge la ea cu copiii ținuți de mână, considerat acest gest de membrii grupului, ca şantaj emoțional. Pe soțul pacientei „L" l-a cunoscut abia la angajarea lui.

"L" nu este primul psihiatru al pacientei, dar este cea care a găsit o soluție. Nu se ştie ce-i provoacă decompensarea, pacienta nu relatează factori extrinseci. "L" consideră că la baza problemei s-ar afla o depresie de epuizare, cu remisii şi recăderi. Este o familie modestă, dar nu săracă, cu copii îngrijiți, probabil părinții îi ajută. Nu relatează lipsuri materiale. "L" are sentimente contradictorii față de pacientă, oscilează între simpatie şi supărare, revoltă şi milă. Se întreabă, oare pacienta la rândul ei cum o percepe pe ea? Nu ştiu cum mă vede, ce crede despre mine? - ne spune "L", simțind că funcționează ca o mamă pentru pacientă şi se teme ca aceasta poate deveni dependentă de ea. Actual ea este incapabilă de a munci, abia îşi mai creşte copii, nu se poate mobiliza, este incapabilă să aibă serviciu. Este mamă a doi copii, născuți la intervale de un an, frumoasă, plinuță puțin, micuță de statură, binevoitoare. A terminat liceul, fiind mai şcolită decât soțul. "L" urmăreşte soțul pacientei, întreabă tot timpul de soțul ei, cum se descurcă la noul loc de muncă. Află că este harnic, fără să aibă alternanțe.

Începe etapa discuțiilor. Pacienta este o personalitate premorbidă. Membrii grupului consideră, că a existat întotdeauna un ataşament al pacientului proiectat pe mediul ei înconjurător şi înaintea manifestări bolii. Necesită în permanență o persoană pe care să se bazeze. - Eu, ca pacienta trăiesc într-un cuplu nu întocmai ideal. Nu sunt susținută de soțul meu, merg singură la medic, unde sunt refuzată, aflu că legea nu permite să mi se acorde facilitățile cerute. Caut cu disperare modalitatea de a face rost de medicamentul care s-a dovedit deja a fi potrivită pentru mine. Pentru mine, se continuă discuțiile, doamna doctor reprezintă stabilitatea şi siguranța în sine. Dintre toți medicii, ea a fost cea care m-a ajutat să mă simt bine, oare nu m-ar putea ajuta şi altfel? - merită o încercare, poate mă ajută şi în situația mea financiară, prin care o să am şi statutul oficial de a-mi procura medicamentul salvator. Nu am încredere în tovarăşul meu de viață, nu mă poate întreține, chiar eu sunt aceia care-l ajută. Am şi eu nevoie de ajutor la rândul meu. Am încredere totală în doamna doctor la care apelez, şi medical dar şi în problemele mele sociale. Pur şi simplu nu doresc să renunț la ea. Pentru prima dată m-am simțit extraordinar după atâția specialişti. Mă simt legată afectiv de ea, astfel refuzul ei nu m-a încântat deloc, dar nu am renunțat, cea ce a şi dat rezultatele sperate.

Acordând ajutoare, această pacientă va rămâne dependentă de medicul ei, astfel se măreşte responsabilitatea ei față de ea. Relația medic pacient între un bolnav psihic şi psihiatrul lui este una mai aparte, prin specific ei . Eu ca "L", simt această responsabilitate față de pacientă şi contra celor spuse de a lăsa mai moale această relație, a-şi continua să o ajut cu tot ce-mi este în putere. Eu ca "L" de la bun început simt ceva special față de acest pacient, căci altfel nici nu s-ar fi ajuns la această situație. Nu pot scăpa emoțional din această relație. Sunt pusă în rolul de mamă față de acest pacient. Întrunesc conceptul balintian de "medicul ca medicament" pentru această pacientă.

Pe de altă parte întăresc negativ personalitatea pacientei prin acordarea tuturor ajutoarelor cerute. Va trebui să găsească un al punct de sprijin, de care se pare că are nevoie în permanență. Nu este menirea medicului să fie acel punct stabil în viața pacientului. În rolul lui "L" mă vor satura de această relație, mă voi sufoca emoțional în cele

din urmă de această relație de ajutorare, voi ajunge la saturație. Această pacientă cred eu, că necesită paralel cu tratamentul medicamentos şi psihoterapie. Ar putea fi o modalitate de a aduce această pacientă cu "picioarele pe pământ". Trebuie să țin la distanță această pacientă, pentru că poate avea rezultate mai bune. Acest lucru trebuie introdus treptat, ca pacienta să nu-l resimtă ca o respingere din partea medicului. Ar trebui să îndrum pacienta către alți terapeuți, psihoterapeuți, ca să se divizeze responsabilitatea față de ea. Astfel pacienta ar putea avea mai multe puncte de sprijin., iar "L" ar fi doar una dintre acestea.

Soțul este un muncitor, cu personalitate infantilă, nu prea ştim mai multe despre el. Are VIII clase, este fără calificare, este cert mai puțin şcolit decât soția. Nu cred, că realizează boala soției, astfel nici nu-i poate fi alături. Poate ar dori ca să lucreze şi soția, ca toate celelalte soții, să-l întrețină, să înpacheteze mâncarea când se duce la serviciu, să-l aştepte acasă când soseşte de la serviciu, să aibă parte de toate lucrurile obişnuite întâlnite la celelalte familii. Poate îi este şi ruşine de situație, fiind aceasta chiar motivul pentru care nu se interesează de soție. Interviul dinaintea angajării a fost un prilej de a-l cunoaşte. Aflăm, că totuşi lucrează bine, este un angajat bun, dar se confirmă totodată, că este o personalitate inferioare soției, ea este nevoită să fie capul familiei, el fiind ca şi un al treilea copil în familia respectivă.

Am primit confruntări, sugestii şi idei vaste. Reintră în cerc „L". „Abia acum am realizat, că insecuritatea ei în relația maritală este cel mai degrabă cauza depresiei ei. Mi s-a confrmat temerea, că această pacientă este dependentă de mine, cea ce nu-mi doream. Trebuie educată această pacientă ca să preia cu siguranța de sine rolul de bărbat în casă. Psihoterapia la ora actuală înseamnă bani, ceea ce ea nu are, deci nu va beneficia deocamdată de acest suport. Simt că o să mă încarc şi mai mult. Am primit sugestii, chiar şi soluții. Nu mă mai tem de ea, pot să fiu şi categorică cu ea în viitor, nu mă mai sperie relația noastră. O să discut mai mult timp cu ea, voi acorda ocazia de a-mi spune şi despre problemele ei personale. În grup m-am simțit bine, într-un confort psihic. Grupul a fost foarte activ şi eu am fost impresionată de implicarea emoțională a membrilor grupului".

Grupul se încheie cu supervizarea acestuia. A fost un grup activ, cu mesaje verbale şi nonverbale. „L" a rămas tot timpul conectată de grup, fără să se detaşeze. A fost un grup mare care a funcționat ca şi un grup mic, cu excluderea simbolică a celor din cercul exterior. Grupul a început cu momentele de linişte atât de caracteristice şi necesare grupurilor Balint. Cazul a fost unul axat pe probleme de relație, cu depăşirea atribuțiilor profesionale, cu sistem transferențial, „L" fiind pusă în poziție de mamă. Liderul a simțit perfect până când se pot pune întrebări şi a întrerupt şirul lor în momentul oportun. În etapa fanteziilor grupul a funcționat dinamic, cu identificări proiective. S-au încercat chiar şi rezolvări, cea ce nu căutăm neapărat în grupurile balint. S-a lucrat foarte bine pe transfer-contratransfer. Liderul a condus activ, directiv, menținând constant controlul grupului.

RECENZIE

Csikszentmihályi Mihály: Az áramlat (Flow), Akadémiai Kiadó, Budapest, 2001.

Autorul pleacă de la conceptul aristotelic care spune că oamenii tânjesc după fericire mai mult decât după orice altceva în viață. De la Aristotel încoace s-au schimbat multe dar fericirea nici acum nu o putem defini. Este fericirea o stare de a fi tangibilă, există vreo modalitate de a o percepe, de a o trăi intens şi conştient.

Autorul cărții este şeful Catedrei de Psihologie din Chicago. În cei aproape 30 de ani de activitate a fost preocupat de definirea şi înțelegerea condițiilor care permit oamenilor savurarea activităților cotidiene. Conducând un grup de cercetători a realizat în jur de 8000 interviuri care au constituit o bază de date pe care o folosit-o în conceperea noțiuni de Flow percepută ca trăire psihică. Cuvântul este de sorginte englezească şi acoperă noțiunea de curgere, plutire. Din momentul apariției cărții în 1990 desemnează o noțiune psihologică şi o categorie stiințifică, totodată şi un termen tehnic care devine parte a limbajului cotidian.

Concepția de flow nu este tocmai nouă. Referiri la această trăire optimă găsim în majoritatea textelor antice dar şi în alte opere din răsărit şi apus.

Dintre cele 10 capitole ale cărți sunt de menționat următoarele:

– Fericirea regăsită
– Calitatea vieți şi fericirea
– Condițiile trăirii fenomenului flow
– Gândirea şi noțiunea de flow
– Munca percepută ca fenomen flow
– Perceperea singurătății dar şi a vieții în colectivitate
– Cum să-i dăm vieții un rost

Cartea încearcă o explicare rațională a existenței omeneşti. Existența ca experință desăvârşită implică noțiunea de flow. Pentru evaluarea experimentelor dobândite prin interviuri s-a folosit Metoda ESM (Experience Sampling). Autorul este de părere că învățând să savurăm scurgerea continuă a evenimentelor vom înțelege scopul existenței omeneşti, vom scăpa de percepția negativă a cerințelor sociale care ni se impun.

Cartea se doreşte a fi unealta unei călătorii spirituale spre tărâmurile tainice ale sufletului.

Dr Zielinski Róbert, Arad

GÂNDUL VINDECĂ

Cules de Vintilă Marcel, Canada

Gândirea schimbă lupta trupului cu bolile

Medicina occidentală disocia, în Evul Mediu, mintea de trup, când exista o diferență de opinii între matematicianul şi filosoful francez Rene Descartes, care susținea că lumea materială reprezintă baza a tot ce ne înconjoară, şi Biserica Catolică care insista asupra puterii morale ca fiind creația sufletului.

Dar, Descartes ale cărui scrieri au fost introduse în Anexa Cărților Interzise ale Bisericii în anul 1667, considera că cele două interacționează în creier. Folosindu-se de o capacitate analitică extraordinară, Descartes a ajuns la concluzia că "mintea este într-un mod atât de intim dependentă de condițiile şi relațiile dintre părțile corpului uman, încât orice om care va reuşi să stăpânească aceste elemente va revoluționa medicina".

Deşi a fost nevoie de câteva secole, doctorii şi psihologii au descoperit recent că mintea poate îmbunătăți procesul de vindecare a corpului, într-un mod în care medicina tradițională nu va putea niciodată.

Spre deosebire de noțiunile din trecut cu referire la conexiunea dintre minte şi trup, care se bazau în mare parte pe poveşti de ficțiune, oamenii de ştiință pot astăzi confirma ceea ce numai Descartes a putut cu câteva secole în urmă: gândurile noastre sunt capabile de a produce schimbări radicale de ordin chimic şi fizic ce ne afectează în mod direct sănătatea.

Psihologii sănătății

Spitalele din ziua de azi angajează şi promovează psihologi pentru a găsi metode noi de a trata pacienții cu boli comune gen cancer, probleme cardiace şi probleme intestinale.

Astfel, doctorii au ajuns la o concluzie pe care mulți o neagă sau refuză să o admită: gândurile unui pacient pot afecta procesul de vindecare, iar efectul placebo nu este un exercițiu de bine dispunere, ci o reacție biologică a creierului față de boli.

"De-a lungul ultimelor decenii, dovezile empirice ale reacției organismului la efectul placebo s-au adunat, iar oamenii din ziua de azi sunt mult mai dispuşi să îmbrățişeze această metodă de vindecare" spune Kim Lebowitz, primul psiholog angajat cu normă întreagă la un spital specializat pe boli de inimă (Northwestern Memorial, Chicago).

"Psihologii sănătății" nu sunt ca psihiatrii care încearcă să găsească originea problemelor emoționale în copilărie. Medicina complementară care o practică ei se bazează pe studii care ne arată că: stresul, anxietatea şi depresiile, pentru care 60% din pacienți merg la medici, pot dăuna corpului în egală măsură cu microbii, dietele, lipsa exercițiului sau obezitatea.

Un rezervor intact de vindecare

Patricia Mumby, profesor asistent în departamentul de neuroştiințe complementare la centrul medical Loyola University, face parte din noua generație de psihologi ai sănătății. După ce a fost asistentă pentru o perioadă lungă de timp, a devenit sceptică în privința metodelor medicinii alopate şi s-a hotărât să studieze psihologia. Ea consideră că mintea noastră este un rezervor nefolosit de vindecare.

"Pacienții îşi dau seama de legătura dintre minte şi trup şi îşi doresc să aibă mai mult control asupra sănătății lor. Deasemenea, centrele de asistență medicală acceptă această metodă neconvențională de vindecare..."

Puterea vindicativă a metodelor şi exercițiilor folosite de psihologii sănătății – tehnici de relaxare, autohipnoză, yoga, acupunctură – se bazează pe două descoperiri revoluționare ale cercetătorilor în legătură cu modul de funcționare al creierului. Prima susține că o rețea vastă de nervi împânzesc corpul în foarte multe modalități având drept rădăcini terminațiile nervoase din creier. Cea de-a doua afirmă faptul că creierul transmite în mod constant valuri de hormoni pentru a regla sistemul digestiv şi imunitar, valuri care apoi răspund mesajului chimic din exterior.

Câmpul de cercetare, care poartă numele de psihoneuroimunologie, studiază modul în care factorii de stres şi emoțiile negative pe care le generează se transmit drept deficiențe de ordin fizic. Creierul, spre exemplu, comunică cu sistemul imunitar, iar stresul poate genera hormoni gen cortizon şi adrenalinaă, crescând astfel riscul unei posibile boli şi întârziind procesul de vindecare. Râsul şi jogging-ul pe de altă parte, pot stimula eliminarea unor hormoni care reduc inflamațiile şi combat integrarea microbilor în corp, ceea ce ar putea oferi o protecție mai avansată împotriva apariției cancerului.

Descartes ştia faptul că, creierul putea fi cu uşurință păcălit şi că entuziasmul unui om atunci când confundă o bucată de sticlă cu un diamant este echivalent cu entuziasmul unei noi descoperiri. Noile cercetări au arătat că în creier au loc reacții chimice care susțin aceste emoții. Deasemenea, s-a dovedit ştiințific faptul că, creierul persoanelor care sunt internate în clinică şi care iau ceea ce ei cred ca sunt droguri tari, dar care de fapt sunt pilule de zăhar sau placebo, produc aproape aceleaşi modificări neurochimice.

Într-un studiu, în care starea bolnavilor de Parkinson se îmbunătățea considerabil în urma utilizării unor medicamente "false", imaginile au arătat că, creierul lor producea aceeaşi cantitate de acetilcolină ca şi creierul pacienților care luau medicamentele adevărate. Efectele placebo îmbunătățesc capacitatea de vindecare a organismului în 30-60% din cazuri spre deosebire de medicamente, care adeseori nu fac nicio diferență. Dar, asemenea medicamentelor, substanțele placebo pot şi ele avea efecte adverse.

Emoțiile negative prelungesc bolile.

De abia în secolul 21 am găsit dovezi pentru ce zicea filosoful Lucius Seneca în urmă cu 2000 de ani: "Să vrei să fii vindecat este începutul vindecării."

PAGINA VĂ APARȚINE

Doctorul Patrick McCarthy, co-director al spitalului Northwestern Memorial, ne explică ce voia Seneca să spună de fapt: "Prin chirurgie putem vindeca problemele de inimă, şi cam atât" spune el. "Pacienții ar putea în continuare suferi de depresie şi stres care le-ar face mai mult rău la inimă decât o boală reală de inimă".

"În urmă cu 20 de ani, dacă îi sugerai cuiva să se ducă la o clinică de psihologie, acela s-ar fi opus cu siguranță" spune McCarthy. "Astăzi însă este mult mai îmbrățişată această metodă. Oamenii realizează că depresia este o parte a bolii".

Dolores Rogalski, o femeie în varstă de 57 de ani din St. Joseph, Michigan, a trecut printr-o operație de transplant de cord pentru că avea probleme grave de stres; după 4 luni în care a trecut printr-un divorț, o operație la plămâni, internarea fiicei sale, moartea unui prieten apropiat şi a mamei sale vitrege.

Tratamentul doamnei Rogalski s-a bazat pe şedințe terapeutice cu dr. Lebowitz, directorul de medicină complementară, pentru a se vindeca de stres. "Oamenii încearcă să prezică sau să controleze mediul în care trăiesc", spune Lebowitz, "dar când problemele se adună, rezultă anxietatea: ei tind să se concentreze la toate lucrurile care nu sunt aşa cum erau plănuite".

Înainte de transplant, Lebowitz a învățat-o pe Rogalski exerciții de relaxare a corpului şi a minții. A inceput cu respirații lente şi adânci şi a continuat apoi cu relaxarea fiecărui mușchi din corp. Faptul că a învățat aceste exerciții a ajutat-o să îşi concentreze gândurile asupra unor elemente care o făceau să se simtă în siguranță şi capabilă de vindecare.

"Nu mai sunt deloc ceea ce eram înainte" spune Rogalski. "Mi-am acceptat divorțul. Am acceptat toate lucrurile din viața mea față de care nu puteam face nimic. Mi-am aranjat lucrurile în funcție de importanța lor şi am privit problemele din toate perspectivele. Acesta este elementul cheie..."

Stresul cronic

Când oamenii de ştiință vorbesc despre stres, ei se referă la stresul cronic care durează cel puțin 2 săptămâni, nu la numeroasele varietăți de depresie sau frustrare pe care le experimentează oricine zi de zi.

Bruce McEwen, neuroendocrinolog la Universitatea Rockefeller, a descoperit faptul că acest tip de stres poate modifica configurația nervoasă a creierului în mod dăunător. Cercetările sale arată că hormonii eliminați de stres pot activa un răspuns dăunător care se întoarce la creier şi îl afectează în zonele care coordonează presiunea sângelui, ritmul cardiac, activitatea intestinală, memoria, frica şi anxietatea. "Se pare că circuitele în partea cognitivă a creierului sunt foarte sensibile la stres, şi de abia am început să ne dăm seama de consecințele grave pe care acest lucru l-ar putea avea la o persoană" spune McEwen. Caracteristica principală a stresului cronic şi a depresiei se numeşte "sindromul bolii".

"Te simți ca şi cum ai avea gripă sau ai fi răcit" spune McEwan. "Te simți total lipsit de energie, vezi lucrurile în ceață şi nu îți dai seama de ce se întâmplă în jurul tău. Te simți bolnav din punct de vedere fizic şi de fapt nu eşti. Toate acestea se datorează hormonilor eliminați de creier care trimit un răspuns dăunător organismului".

"Inima şi celelalte organe sunt practic coordonate în totalitate de sistemul nervos central" spune Dr. Michael Jones, director al secției de boli gastrointestinale şi neurologice ale spitalului Northwestern Memorial.

Ruptura s-a produs, spune el, încă din epoca iluminismului din secolul 18, când oamenii de ştiință au decis să studieze anatomia corpului uman iar Descartes a fost unul dintre promotorii acestui curent. "Asta s-a întâmplat deasemenea şi în perioada Inchiziției" , spune Jones, şi Biserica Catolică a subliniat: "Rene, este o idee magnifică dar vreau să ții minte faptul că mintea şi sufletul aparțin lui Dumnezeu şi Bisericii Catolice."

Puterea de vindecare a creierului

Dualismul minte-corp a fost deasemenea o idee de afaceri eficientă: dacă te simți bolnav, eu am antidotul. Dar acest lucru neglija capacitatea de vindecare naturală şi potențiala putere distructivă a creierului, spune Jones.

Efectul gândului asupra corpului a fost întotdeauna vizibil în diferite ipostaze: o situație stresantă produce o senzație de fluturi în stomac, acesta fiind unul din organele cele mai predispuse la boli provocate de stresul cronic. Hrana pe care o savurezi nu va fi la fel de bine digerată dacă este întreruptă de un telefon de la FISC care te anunță că îți vor fi majorate taxele pe care trebuie să le plăteşti.

Nu contează motivul stresului. Ceea ce contează este că trebuie să opreşti acest stres.

"Spitalul nostru deține ultimele versiuni de medicamente împotriva bolilor neurologice şi analgezice viscerale", spune Jones. "Deținem toată aparatura necesară, dar nimic din ceea ce avem nu poate face mare lucru atunci când stresul cronic s-a instalat". Dar în momentul în care vorbeşti cu oamenii şi te implici în viața lor privată şi îi înveți să privească problema în ansamblu, deja ei se simt mai bine.

În urmă cu 3 ani când Seth Knocke avea 16 ani, tânărul suferea de grețuri puternice după ce mânca. A consultat mai mulți doctori însă în zadar, iar în final a ajuns la Jones, care mai întâi a încercat aparatura sa sofisticată. Medicamentele împotriva grețurilor n-au avut nici un efect. Apoi, Jones l-a tratat cu andidepresive pentru a-i relaxa mușchii netezi ai sistemului digestiv. Această metodă a funcționat timp de 8 luni după care grețurile au revenit cu aceeaşi intensitate ca şi înainte.

Atunci Jones s-a hotărât să apeleze la un psiholog, Laurie Keefer, acum membru deplin al echipei de la Nortwestern. Jones şi-a dat seama că probleme lui Knocke au început datorită unui virus stomacal care îi provoca grețuri când mânca. Chiar şi după ce virusul a fost eliminat, mintea sa elibera substanțe chimice care îi produceau greață oricând consuma alimente.

Pentru a stopa acest ciclu, Keefer a încercat să-l trateze pe Knocke prin autohipnoză, proces în care pacientul rămâne conştient dar relaxat ca şi cum ar fi gata să adoarmă, pregătind astfel creierul să accepte informații ce aveau să disocieze mâncarea de greață.

Concentrându-se asupra unei imagini luminate dintr-o cameră întunecată, Knocke îl asculta pe Keefer care îi spunea să-şi imagineze că se afundă într-un nor fin ca apoi să cadă într-o barcă ce plutea pe un lac liniştit. Bând apa răcoritoare din lac, Knocke îşi imagina cum aceasta îi trece prin esofag şi mai apoi în stomac unde îi vindecă orice urmă de greață.

După 5 şedințe, senzația de greață i-a dispărut. De câte ori aceasta amenința să revină, el apela la autohipnoză, răcorindu-şi stomacul cu o sorbitură de apă răcoroasă. Acum, "boboc" la Colegiul Beloit, el plănuieşte să devină psiholog, inspirat fiind de propria sa experiență în vindecarea bolilor prin autohipnoză. "Ei spuneau despre creierul meu că era ca hardul unui computer", spune Knocke.

"Ceea ce s-a stocat în memoria lui era senzația de greață. Tot ceea ce trebuiau ei să facă era să "formateze" această senzație şi eu voi fi OK". Iritările stomacului sunt motivul principal pentru care oamenii apelează la gastroenterologi. De când terapia prin medicină alopată s-a dovedit a fi ineficientă pentru aceste boli, un număr impresionant de fiziologi consideră astăzi că mai întâi trebuie tratat creierul pentru ca mai apoi să poată fi tratată boală în sine.

Un studiu recent al cercetătorilor Universității din Manchester, a descoperit că la sfârşitul unui an, atât psihoterapia cât şi antidepresivele erau mai eficiente în reducerea simptomelor bolii şi îmbunătățirea calității vieții decât metodele clasice. Mai mult decât atât, psihoterapia s-a dovedit a fi cea mai ieftină metodă, costând cu 22% mai puțin decât antidepresivele şi cu 41% mai puțin decât terapia standard.

Selma Holme a adoptat o dietă de reducere a stresului în timp ce se trata de cancer uterin, în urmă cu 2 ani. După ce l-a îngrijit 14 ani pe soțul ei, Jack, care suferea de Parkinson, ea avea imunitatea foarte scăzută. Holme a folosit mai întâi tehnica prin care îşi ghida imaginația către relaxare şi mai apoi a folosit autohipnoza. Acum un an a început tratamentul cu acupunctură ca şi tehnică utilizată în programul de reducere a stresului utilizat de Loyola. Nu a durat mult timp până când soțul ei şi-a dat seama că nu este la fel de tensionată ca înainte, apoi fiica ei a remarcat cât de bine se înțeleg părinții ei.

"Am mai multă energie. Sunt optimistă", spune Holme, care acum s-a vindecat de cancer după ce a folosit radioterapia.

Stresul, Anxietatea şi Depresia necesită tratament

Evident, medicina complementară nu poate înlocui medicamentele, chirurgia sau alte tehnici ale medicinei alopate şi nimeni nu ştie exact cât de eficientă este. Dar se observă un acord general în comunitatea medicală, că stresul, anxietatea şi depresia dăunează sănătății şi trebuiesc tratate.

În 1995, cercetătorii Janice Kiecolt-Glaser şi soțul ei Romanld Glaser de la Ohio State University, au publicat un studiu inovator, care arată că persoanelor care îşi îngrijesc rudele bolnave de Alzheimer, o sarcină de altfel foarte stresantă, le sunt micşorate cu 24% şansele de vindecare a rănilor superficiale ale pielii, spre deosebire de persoanele de aceeaşi vârstă şi situație economică similară care însă nu au aceste obligații.

Acest studiu a fost urmat de un altul care arăta că vindecarea rănilor la studenții care urmează să susțină un examen, durează cu 40% mai mult decât la studenții care aşteaptă vacanța de vară.

Stresul face ravagii prin cortizonul eliberat, acesta fiind un hormon de stres, şi prin adrenalina eliminată, spune Glaser, directorul secției de Cercetare în medicina complementară. Aceşti hormoni cauzează pierderea echilibrului hematiilor, schimbarea funcției lor şi dereglarea sistemului imunitar.

Celulele imunitare încep să elimine proteine inflamatorii care, dacă sunt eliminate în cantități mici, pot grăbi vindecarea dar, produse în exces distrug țesuturi în întreg organismul crescând riscul apariției cancerului, a bolilor cardiovasculare, osteoporozelor şi diabetului.

"Când Jan şi eu am început să lucrăm împreună, nu credeam că vom ajunge la această concluzie" spune Glaser, referindu-se la impactul stresului asupra bolilor şi asupra vindecării. "Ei bine, o să studiem problema şi dacă nu vom găsi remediul ne vom opri. Iată-ne după 20 de ani de cercetări asidue, încă mai muncim în acest domeniu, fiindcă evident merită."

De fapt, schimbăm principiile medicale, spune el. "Medicii vor începe prin a întreba pacientii ce se întâmplă în viețile lor atunci când întâmpină probleme legate de boli infecțioase sau cancere, boli metabolice, diabet sau obezitate. Pentru că acum ştim motivul care afectează viețile lor şi motivul producerii acestor boli."

Primul indiciu, descoperit încă din anii 1900, de către Walter Cannon de la Harvard, arată că stresul nu este doar o mare neplăcere, dar poate nimici organele interne. El a descoperit că în orice moment când oamenii se simt amenințați, corpul reacționează neplăcut prin creşterea presiunii sângelui, a bătăilor inimii, prin contracturi musculare şi prin respirație îngreunată.

60 de ani mai târziu, în acelaşi laborator, al lui Cannon, Dr. Herbert Benson a descoperit antidotul stresului: "relaxarea".

Reacția de relaxare

În timpul cercetărilor sale, Benson a bănuit disprețul colegilor săi de la Harvard, aşa că, activitatea sa se desfăşura noaptea, când putea să aducă pacienți care practicau meditația transcedentală. El a descoperit că doar prin simpla gândire, aceştia pot transforma funcțiile corpului. Respirația scădea cu 25%, consumul de oxigen scădea cu 17%, tensiunea arterială scădea iar bătăile inimii erau mai reduse.

Şi nu numai meditația reduce stresul. Cercetările ulterioare arătau că respirația profundă, relaxarea progresivă a mușchilor, hipnoza, imaginația ghidată, rugăciunea şi alte tehnici pot îmbunătăți reacția de relaxare a corpului.

"Prin extinderea practicii de relaxare a organismului, care s-a dovedit a fi o practică eficientă, orice boală care a

fost cauzată sau s-a înrăutățit datorită stresului, a fost combătută", spune Benson – profesor de medicină la Institutul Medical Harvard. "Am descoperit că această practică este de mare ajutor în hipertensiune, anxietate, depresii mici şi mijlocii, furii sau nemulțumiri profunde, insomnii, printre multe altele."

Oamenii îşi dau seama intuitiv, că a face ceva pentru a-şi calma sistemul nervos îi ajută, spune el. Un studiu din 2004 bazat pe fonduri federale a dovedit faptul că jumătate dintre americani practică o formă de relaxare, deşi cei mai mulți din această categorie nu împărtăşesc acest lucru cu psihologii lor.

"Noi privim sănătatea ca fiind o piramidă triunghiulară" , spune Benson. "Prima față este reprezentată de medicamente, cea de a 2-a de chirurgie. Trebuie să existe şi o a 3-a față, iar noi am ajuns la concluzia că aceea este grija de sine, care implică elemente asemenea relaxării, nutriției şi exercițiului."

Investigațiile lui Benson în legătură cu efectul placebo, care este diferit de relaxare, l-a adus la concluzia că acesta funcționează prin accesarea urmelor din memorie care reglează hormonii de stres – proces pe care el îl numeşte "însănătoşire prin memorie".

"Sunt 3 componente ale efectului placebo", spune el. "Credința şi aşteptările pacientului, credința şi aşteptările fizioterapeutului şi credințele şi aşteptările care reies din relația celor doi.

Când cei doi sunt pe acelaşi plan, ies la iveală capacități de vindecare extraordinare. Dacă te consideri în stadiul de vindecare, există deseori posibilitatea ca tu să fii deja vindecat. Ar putea fi acesta răspunsul la toate bolile? Desigur că nu. Dar foarte multe medicamente îşi fac probabil efectul, datorită efectului placebo."

Intervențiile psihologilor pot îmbunătăți vindecarea, dar oare pot ele prelungi viețile pacienților foarte bolnavi? Acest lucru rămâne foarte controversat, în ciuda faptului că studiile făcute pe acest domeniu arată un efect pozitiv al psihologiei în medicină. Alastair J. Cunningham de la Institutul de Cancer din Ontario a descoperit faptul că pacienții bolnavi de cancer care încă mai sperau la vindecare trăiau mai mult decât cei care erau în acelaşi stadiu al bolii dar care erau frustrați de stres şi depresie.

"Avem nişte dovezi care ne arată faptul că atunci când oamenii se implică mai mult în a se ajuta pe ei înşişi, ei îşi cresc de fapt rata de viață", spune Cunningham. "Dar nu există nici o garanție că aceste lucruri se întâmplă cu adevărat."

Poate fericirea să ne ajute vindecarea?

Dacă stresul produce schimbări chimice dăunătoare corpului în creier, poate fericirea produce schimbări benefice? Această întrebare a fost scopul carierei lui Lee Berk, profesor asociat de promovare a sănătății şi educației la Universitatea Loma Linda din Los Angeles.

Determinat fiind de cercetările sale de dinainte care susțineau că râsul la comedii îl ajutau să evite boli care afectau sistemul imunitar, Berk a descoperit că râsul, ca şi exercițiul, muzica şi meditația, cresc nivelul de endorfină a corpului. Endorfina, care este de fapt morfină produsă de corpul uman, este o substanță care ne regleaza starea de zi cu zi şi care reduce hormonii de stres.

"Face ca ritmul cardiac să fie mai lent, scade presiunea sângelui şi reduce ritmul respirator astfel încât să nu fii nevoit să respiri cadențat", spune Berk. "Se instalează în celulele sistemului imunitar şi produce schimbări benefice."

Studiul lui Berk în legătură cu pacienții care au suferit primul lor atac de cord, arată faptul că cei care se uită la o comedie jumătate de oră pe zi sunt în mod semnificativ mai puțin predispuşi la un al 2-lea atac de cord în comparație cu cei cărora nu le-a fost recomandat tratamentul prin umor.

(sursa: Ronald Kotulak, U.S.A. Chicago Tribune, 7 decembrie, 2006, , publicat la Active Information Media).

Fanionul Balint pe vârful Uhuru de 5885 m din masivul Kilimandjaro

PAGINA VĂ APARȚINE

INIMA PERFECTĂ*

Se povesteşte că într-o zi, un tânăr s-a oprit în centrul unui mare oraş şi a început să le spună trecătorilor că are cea mai frumoasă inimă din lume. Nu după mult timp, în jurul lui s-au strâns o mulţime de oameni care îi admirau inima: era într-adevăr perfectă! Toţi au căzut de acord că era cea mai frumoasă inimă pe care au văzut-o vreodată.

Tânărul era foarte mândru de inima lui şi nu contenea să se laude singur cu ea. Deodată, de mulţime s-a apropiat un bătrânel. Cu glas liniştit, el a rostit ca pentru sine: şi totuşi, perfecţiunea inimii lui nu se compară cu frumuseţea inimii mele!

Oamenii au început să-şi întoarcă privirile spre inima bătrânelului. Până şi tânărul a fost curios să vadă inima ce îndrăznea să se compare cu inima lui. Era o inimă puternică, ale cărei bătăi ritmate se auzeau până departe. Dar era plină de cicatrice, şi erau locuri unde bucăţi din ea fuseseră înlocuite cu altele care nu se potriveau chiar întru totul, liniile de unire dintre bucăţile străine şi inima bătrânului fiind sinuoase, chiar colţuroase pe alocuri. Ba, mai mult, din loc în loc lipseau bucăţi întregi, lăsând să se vadă răni larg deschise, încă sângerânde.

– Cum poate spune că are o inimă mai frumoasă? îşi şopteau uimiţi oamenii.

– Cred că glumeşti, spuse tânărul după ce a examinat atent inima bătrânelului. Priveşte la inima mea, este perfectă! Pe când a ta este toată o rană, numai lacrimi şi durere.

– Da, a spus blând bătrânul. Inima ta arată perfect, dar nu mi-aş schimba niciodată inima cu a ta. Vezi tu, fiecare cicatrice de pe inima mea reprezintă o persoană căreia i-am dăruit dragostea mea: rup o bucată din inima mea şi i-o dau omului de lângă mine, care adesea îmi dă în schimb o bucată din inima lui, ce se potriveşte în locul rămas gol în inima mea. Dar pentru că bucăţile nu sunt măsurate la milimetru, rămân margini colţuroase, pe care eu le preţuiesc nespus de mult, deoarece îmi amintesc de dragostea pe care am împărtăşit-o cu cel de lângă mine. Uneori am dăruit bucăţi din inima mea unor oameni care nu mi-au dat nimic în schimb, nici măcar o bucăţică din inima lor. Acestea sunt rănile deschise din inima mea, pentru că a-i iubi pe cei din jurul tău implică întotdeauna un oarecare risc. Şi deşi aceste răni sângerează încă şi mă dor, ele îmi amintesc de dragostea pe care o am până şi pentru aceşti oameni. Cine ştie, s-ar putea ca într-o zi să se întoarcă la mine şi să-mi umple locurile goale cu bucăţi din inimile lor. Înţelegi acum, dragul meu, care este adevărata frumuseţe a inimii? a încheiat cu glas domol şi zâmbet cald bătrânelul.

Tânărul a rămas tăcut deoparte, cu obrazul scăldat în lacrimi. S-a apropiat apoi timid de bătrân, a rupt o bucată din inima lui perfectă şi i-a întins-o cu mâini tremurânde. Bâtrânul i-a primit bucata şi a pus-o în inima lui. A rupt, apoi, o bucată din inima brăzdată de cicatrice şi i-a întins-o tânărului. Se potrivea, dar nu perfect, pentru că marginile erau cam colţuroase.

Tânărul şi-a privit inima, care nu mai era perfectă, dar care acum era mai frumoasă ca niciodată, fiindcă în inima cândva perfectă pulsa de-acum dragoste din inima bătrânului. Cei doi s-au îmbrăţişat, şi-au zâmbit şi au pornit împreună la drum.

Cât de trist trebuie să fie să mergi pe calea vieţii cu o inimă întreagă în piept… O inimă perfectă, dar lipsită de frumuseţe… Inima ta cum este? O poţi împărţi cu alţii?

**Culegere de Marcel Vintilă, Canada*

ŞTIRI DIN VIAȚA ASOCIAȚIEI

Între *23-25 martie* am participat la *Şedința Biroului Federației Internaționale Balint* (Potsdam, Germania), unde s-a acceptat propunerea noastră de a organiza Congresul Internațional Balint din septembrie 2009 în România. După întoarcerea în țară am demarat organizarea prin desemnarea locului congresului. După analizarea posibilităților şi a locațiilor ne-am decis să stabilim locul congresului la complexul Ana-hotels din Poiana Braşov. Cu ocazia congresului internațional din septembrie (Lisabona) se va decide data exactă şi tema propusă.

Weekendul Național Balint de vară anul acesta a avut loc între *18-20 mai la Ocna-Şugatag*, gazdele fiind grupul Balint din Sighetul-Marmației.

Într-una din pauze am participat şi la referendum. 48 de participanți din 9 județe (MM, BH, SJ, NT, BUCUREŞTI, HARGHITA, CLUJ, ALBA,CV) ne-am adunat la Popasul din Deal, un complex, unde de prima dată am putut să vedem cum se poate încălzi o clădire prin folosirea geotermiei. A fost un nou prilej pentru a revedea meleagurile maramureşene şi de a ne lăsa răsfățați de ospitalitatea personalului hotelier şi a gazdelor noastre din Sighetu Marmației, în frunte cu familia Árvai.

Ca un unicat al weekendurilor naționale pot semnala lipsa noilor membri înscrişi şi absența tuturor membrilor noi care trebuiau să fie „unşi" ca membri cu drepturi depline.

Între *1-15 iunie 2007* s-a desfăşurat la UMF Tg, Mureş (Disciplina de Sănătate Publică), în cadrul unui curs postuniversitar cu titlul „Managementul resurselor umane în domeniul sanitar" a avut loc şi un grup Balint condus de Hegyi Csilla.

După cunoştințele mele, a fost primul grup Balint în cadrul unui curs postuniversitar organizat de o Universitate de Medicină din țară. În perspectivă, dorim să oferim continuitate acțiunii inițiate la Tg. Mureş. (Dr Farkas Evelyn).

Planuri de viitor:

6-8 iulie 2007: Weekend Interjudețean Balint, Bârlad, **10 credite EMC**. Cazare cu micul dejun la hotel. Cameră dublă: 120 RON, single: 90 RON. **Taxă de participare**: 15 Euro. Înscriere la **dr. Dorofte Rodica (0722-660.010)**

1-5 septembrie 2007: al 15-lea Congres Internațional Balint la Lisabona. Şi-au anunțat participarea 5 colegi balintieni.

28-30 septembrie 2007: a 14-a Conferință Națională Balint, Miecurea Ciuc-Şumuleu, Casa de Studii Jakab Antal. **16 credite EMC**. **Taxa** de participare: 15 Euro. Data limită de anunțare a participării: **23 septembrie** la mine (telefon sau e-mail). **Cazare** cu 20 Euro în sgl şi 14 Euro în regim dbl./pers./zi, cu micul dejun inclus. Prânz: 6 Euro, cina 5 Euro.Pentru membrii Asociației cu cotizația plătită la zi banchetul se include în taxa de participare.

Deoarece pentru Revelionul Balint propus a se organiza între 28 decembrie-2 ianuarie nu s-a prezentat decât o singură familie, renunțăm la această variantă.

14-16 decembrie vom organiza deci Weekend Interjudețean Balint cu Prerevelion, la Odorheiu-Secuiesc.

18-20 ianuarie 2008: Weekend Național Balint de Iarnă cu Postrevelion Balint, Gheorgheni, Motel 4.

Să avem cu toții o vară plăcută cu concedii odihnitoare.

Cu prietenie,

Bela Veress.