

**The Front Door of Psychotherapy:
Aspects from General Medical Practice**

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He who knows others is learned

He who knows himself is wise.

Lao Tse (6th century BC), *The character of Tao*

It is far more important that one's life should be perceived than it be transformed; for no sooner has it been perceived than it transforms itself of its own accord.

Maurice Maeterlinck (1896) *The Deeper Life, The Treasure of the Humble*

Healing and growth, through the exploration and expression of the hidden inner-world, is certainly as old as the written word, and probably as ancient as the earliest forms of communication of abstract thought. The last few decades have seen a rapid and diverse organization of such quests, in the form of 'psychotherapy' in its many guises. What these variegated and sometimes discordant schools have in common is the point of departure: the person seeking psychotherapy is already consciously committed (albeit ambivalently!) to the task of expanding their realms of self-awareness and self-responsibility. All such people may be said to commence from the 'lobby' of psychotherapy.

The General Medical Practitioner, however, is faced with very different, though related and equally challenging, psychological and existential tasks. Those who come to him for help are often unaware, or denying, of how their physical or mental dis-ease may derive from their on-going conflicts and dilemmas, and thus see any affliction or help as coming from outside their personal sphere of influence, awareness and responsibility.

The doctor's opportunities and challenges thus occur at the 'front door' of psychotherapy and it is always uncertain whether or not the patient will wish to enter. The doctor's role of 'doorman' here is a complex and interesting one, demanding much in the way of tact, timing and imagination, all of them skills particular to the setting. Unlike the professional psychotherapist, he has often had a long, punctuated and varied contact with the patient, often at crucial life-events, and this can offer him a vantage point and informal, though powerful, rapport that is unique.¹ The following descriptive and narrative case-histories or scenarios illustrate not only the problems of dealing with 'psychosomatic' syndromes which may be construed as the doctor's special territory, but more generally with the 'elements' of

psychotherapy which underlie every genus of verbal healing.

CASE NO. 1:

Clarification or exorcism? Very simple psychotherapy

Mrs R seemed edgy and truculent when she entered Dr S's consulting room. Amanda, her four-year-old child, looking frightened and bemused, was thrust sharply towards Dr S. as an accusatory portent, an Item of Evidence for the Prosecution. Amanda stood with pale and compliant immobility as her mother quickly and purposefully unbuttoned her daughter's blouse, to reveal a small annular lesion on her chest, which the doctor immediately recognized as Tinea. He sighed privately with relief; he had expected something far worse.

'It's only Ringworm, Mrs R Nothing to worry about. I'll give you some cream to apply, and it will clear up very quickly.' Dr S. averred with bright and brisk reassurance.

Both his conviviality and authority were unexpectedly assailed:

'That's exactly what you said last year, but it's back *again*', retorted the flushed and angry mother, disconsolate and her eyes beginning to brim with hapless tears.

Dr S. sighed again, now less privately and with the exasperation of a busy man obstructed. Biting back a mounting petulance, he struggled to retain a courteous image of helpfulness.

'Look, Mrs R, Amanda's skin has got a small Ringworm infection, that's all. It will soon clear up, even if she has had it before. But I don't understand your anxiety about all this – there seems to be something else that's bothering you, that I don't know about...'

replied the conciliatory doctor, now feeling as bemused as the silent and compliant small girl between them. It seemed to him that the mother had her own private, and as yet indecipherable, agenda, and he needed her to share this with him.

'It's all very well for you to say that, doctor, but what am I to think when she's full of worms...?' exclaimed the preoccupied mother.

'Worms!! Ah! I see ...' exhaled the doctor, a sense of benign command returning with a fresh and growing comprehension of this uneasy and cramped impasse.

'Yes, doctor. She can't go on like, this with worms inside of her. ... it can't be good for her...!' continued the pressured Mrs R, hoping that enough leverage against the doctor would somehow rid her daughter of this largely invisible pestilence.

The doctor was now quick to understand and salvage the dialogue that had so nearly foundered from the mother's misconception, arising from the colloquial misnomer of this superficial yeast infection, Tinea corporis. Mrs R, witnessing her doctor's fresh comprehension, was now receptive to his explanation and reassurance. She softened and listened, the colour returned to Amanda's cheeks and Dr S. stopped his impatient sighing. Their departure was one of tacit affection, peppered with jokes and reciprocated apologies. The doctor later that morning shared his story over coffee, an offering of comic relief, with his fatigued and embattled partner. It could, he realized, have turned out very differently.

What Dr S. had here achieved with Mrs R cannot be called 'psychotherapy' in its more formal sense, and yet the successful outcome of this short, highly-charged and rapidly shifting interchange depended on principles of communication and response which are cornerstones of psychotherapy at all levels of intensity and complexity.

The doctor had first to listen and observe afresh – the mother's shrill and remonstrative manner clearly conveyed much beyond the small, harmless lesion presented, and he had thus to consider that the meaning of the 'Ringworm' had very different connotations to himself and to his two frightened patients. It was only by allowing a hiatus in the usual structure of his interview, that Mrs R's fantasy or misconception of worm-infestation, her 'internal reality', could be crystallized, communicated and understood. Only

then could both patient and doctor arrive at a new understanding of one another.²

Had Dr S. needed to be in control at every stage of the interview, and forged ahead uncompromisingly with his initial frame of reference and didactic reassurance ('Nothing to worry about Mrs R, just use the cream ...') all three participants in this transaction would have left with further difficulty in store: Dr S. would have gone home with a headache from frustrated ingratitude, Mrs R and Amanda a symbiotic complex of anxious and unattended dread, coupled to an increasing mistrust of their conscientious but harassed doctor.

The medical prescription, the fungicidal cream, would be an adequate antidote to the physical lesion, but it was the development of understanding in the relationship that healed the growing emotional lesion. Mrs R's gruesome misconception – of 'Amanda being full of worms' – seemed to the doctor fortuitous, and due to misconstruction from the oddly termed 'Ringworm'. His task of exorcizing this damaging notion was thus much simpler and swifter than the psychodynamically generated complexes that challenge the skills of the psychotherapist or analyst. Had Mrs R's fantasy of worms arisen instead from deeper, perhaps unconscious compounds of guilt, nameless dread, and inchoate destructiveness – the elemental stuff of psychoanalysis – she would not have departed as easily and lightly as she did, and would surely return with other tense and tangled communications.

CASE NO. 2:

Inner and outer listening: emotional literacy

A large and plethoric man, Mr B looked briefly and searchingly toward Dr C, smiled nervously, moved away, and then shifted his doleful, heavy frame back toward the doctor.

Dr C, realizing his patient's first utterances would be difficult and important, put down his pen and sat back quietly.

'Doctor, I think I'm an alcoholic ... well I know I'm an alcoholic, I suppose.

I know you can't do anything about that, so I'm probably wasting your time ... I just thought there might be something...'

Several routine questions offered to retrieve the fading Mr B revealed to Dr C the severity and pattern of retreat into the haven of alcoholic oblivion in this unhappy and anxious man. But it was Mr B's underlying unhappiness itself, rather than a medically precise definition of his alcoholic abuse, that the doctor gently probed towards:

'Most people who have your kind of difficulty are attempting to get away from a feeling, or a situation, that is difficult or painful for them to manage or put into words, and I have the sense that's so with you, Mr B..', proffered the doctor, in a tone inviting but, he hoped, unintrusive.

'Yes, that's true. I do most of my drinking when I'm upset and all churned up. I think "I can't stand all this aggravation, I want "Out", and then start drinking', elaborated an alert and engaged Mr B

Dr C usually found himself pessimistic and patronizingly 'tolerant' with alcoholics, who, in his experience, seemed to have more guile in dissembling their problem, than he had talent or commitment to intervene in any way that might be hopeful or helpful. But Mr B was a disarming and refreshing contrast in his candour, and the transparency of his underlying difficulties.

'I have a sense of you as being easy-going and genial on the outside, but hiding your hurts, grievances and resentments inside, where no one can see them ... so that there's a big gap between how people see you and what's really going on inside of you, and that gap makes for a lot of loneliness and fear ...', Dr C suggested, attempting to integrate his own experience of Mr B with what Mr B was saying about himself.

'Yes, that's just how it is ... there's this whole other side of me, like a small kid that's really angry and unhappy, and doesn't know what to do...'

'And drinks as a way out?'

the doctor suggested before hearing more specifically of Mr B's lifelong difficulty in facing conflict and 'aggravation'. The only child of an unhappy and tense union between a timorous, phobic mother and domineering, bullying father, he had learned early to survive by obedience, almost to the point of invisibility. But such early survival strategies, now fixed and long outmoded, had long ago rendered Mr B mute in the face of challenge, passive in his needs, and emotionally inarticulate in his closest relationships. It did not surprise the doctor to learn that Mrs B reacted to her husband's stalwart but hurt silences by bullying provocation, in an exasperated effort to create some sense of contact and definition with her sullen and inscrutable partner. The fact that her attacks led only to his further retreat into the morass, accelerated by his drinking, did not lead her to abandon her pattern, but amplify it.

In this first, and a later, longer interview the doctor gently guided this perplexed and hitherto inarticulate man in his efforts to make sense and connections, amidst the cycles of impotent resentment and retaliatory and palliative drinking. Thus encouraged, Mr B took up the doctor's suggestion of seeking further counselling.

'I'm not drinking at all now, doctor', reported a direct and proud Mr B, and when the doctor asked him how he saw these first important steps of mastery, the reply was of great interest and edification to Dr C

'When I first came to see you I thought you'd have little time for me, tell me to stop, that it was my problem and I was damaging myself – that sort of thing. That's what I expected, and I knew it wouldn't help. But you did something quite different: you really listened to me, and thought carefully about what I said. That hadn't happened to me before, and it's very important because it's started me listening to, and thinking about myself. With my counsellor now I'm beginning to see all sorts of things that I'd spent years running away from. I'm really pleased I came when I did.'

Dr C was pleased, too; it is not often that a patient comes to him in such a state of readiness to express and explore the underworld of conflicts and dilemmas, that are essential for radical and healing changes in the attitudes to oneself and relationships to others. The doctor had read much psychiatric literature concerning the efficacy or viability of psychotherapy in different clinical

syndromes, suggesting that it is the clinical diagnosis which will determine the outcome of such endeavours. Such 'scientific' formulations never appealed much to his more humanistic temperament, and as the years have gone by he has been more impressed by determinants that can be more ordinarily expressed.

The capacity for candour, courage, curiosity and contact – both with what is within oneself and the other person – have seemed more accurate indicators of a healing dialogue. With many of his patients suffering from 'minor' neurotic complaints, he has never, despite his best efforts, been able to find a way through to these health-generating qualities: his words and attentions seem to bounce back at him. Others with more 'major' psychiatric stigmata, which numerous learned and specialist tracts would deem unsuitable or unlikely recipients of verbal healing, have surprised and inspired him with their readiness to enter the cauldron of challenge and change.

In these many journeys and encounters he has come to a new understanding of the word 'encourage' – as a young practitioner his encouragement consisted of convivial utterances designed to 'make the patient feel better', or at least appear grateful, if only for short periods. Fostering and nurturing the courage that inspires all health and growth, a more literal and substantial 'encouragement', had taken years of his own inner struggles and searchings to develop: encouragement must arise from a position of resonance, not rhetoric. We heal from our own healed wounds.^{3,4}

In parallel with Dr C's growth of understanding of encouragement has been his perception of 'emotional literacy' as a core element in health, growth and psychotherapy.⁵ To remain 'in balance' with ourselves and others we need to be clear about our feelings; to name them, to read them, to articulate them. Without this emotional literacy there can be no solid sense or affirmation of the Self, from which any meaningful negotiation or mutuality with others becomes possible.

Mr B was suffering from such illiteracy; raised in a family where needs and feelings were persistently distorted and discounted, he grew into a man effec-

tively mute and affectively stunted. His alcoholic balm, intended to ease the pain of alienation from himself and others, only deepened the chasm. Many patients, it seems to Dr C, consult him because of such patterns of the inchoate and ineffable. With Mr B it was his behaviour that led him to seek his doctor's counsel, but more often it is the patient's body that signals and expresses such dis-ease and disequilibrium. The doctor's task is then clear, but often difficult, in helping his patient in the reclamation and deciphering of their disowned and neglected Self.

The long abandoned term of 'Alienist' for what we now call the Psychiatrist – a title connoting the re-engagement of those afflicted by alienation from themselves and others – seemed to encapsulate much of what Dr C must achieve in any healing endeavour with his patients. The doctor, though, is mindful of how demanding this is of the practitioner: as his use of 'encouragement' reflected the painful growth of his own courage, so his efforts at fostering 'emotional literacy' in his estranged patients could only parallel his own capacity for emotional clarity and articulation. To hear others we must listen to ourselves.

CASE NO. 3:

Feelings as wounder, feelings as healer

Dr T was only outwardly acquainted with Bill, an angular wiry man in his mid-fifties with an air of contained and circumspect vulnerability, and when he came with a recent exacerbation of his duodenal ulcer, the doctor wondered what had rekindled this invisible and self-generated wound. Prefacing his tense, though not unpleasant, communications with self-discounting apologies for bothering the doctor, Bill appeared to regard his hurts and needs as being unworthy of others' attention and care. A Council gardener in a small and meticulously tended local park, this well-regulated and compliant man always attended an evening surgery after his day's work, attired in his regulation green overalls.

From previous contact, Dr T had been witness to his limited but loyal life: his father dying in wartime combat, an only child, he had lived with his mother in their small late-Victorian flat until her death five years previously. Her demise had been slow and

demanding, and he nursed her throughout this long and gruelling decline with fierce but quiet dedication, parrying any suggestion of her 'going away' to hospital. She died at home, a task painfully and painstakingly completed. When, some months later, Bill had requested an embrocation to soothe an overworked muscle in his thigh, a casualty of his silent and earnest training for the Marathon, Dr T mused on how, symbolically, his stoic self-sacrificing relationship with his beloved mother had been soon replaced. The doctor, while dealing with the matter of Bill's strained muscle, recalled with poignancy the title of an old black and white film: 'The Loneliness of the Long Distance Runner', but Bill's manner then had seemed dour and uncompromisingly matter-of-fact. The doctor did not share his image.

On this occasion, though, Bill seemed softer, and the doctor felt less prohibited from approaching his personal World, and when Dr T carefully asked him if there was anything in his recent life that had opened up his old internal wound, Bill's jaw trembled, his sinewy, tight-body sagged and he wept the copious, ancient tears of a man released from a long imprisonment.

'It was Frank going like that ...' he sobbed, attempting to stem the tears with a peremptory and remonstrating hand. 'He was my best mate. There was nothing the matter with him, but he just went... just went.'

From Bill's spontaneously articulated fragments of narration, and from his own delicately interposed questions, Dr T was able to assemble something of the significance of this much beloved and irreplaceable companion. Frank, another single man of similar age, had worked alongside Bill for a decade in the small and intimate park that had become a kind of child for these two childless men. Frank, apparently healthy and sanguine, had collapsed and died, at the verge of a flower bed, suddenly and without portent.

Bill was able to command back his tears and create a brave, red-eyed hiatus as he shared with the doctor something of his cherished friend and the painful void his sudden departure had left. As Dr T understood, more than ever before, the fragile and lonely courage lying behind the rather impassive exterior, Bill convulsed with another involuntary wave of recent and archaic grief. Dr T sat touched, attentive and silent, feeling like a mother cradling an anguished infant.

'I'm sorry, doctor to be like this... it's stupid, a grown man like me crying like a baby...', a finger and thumb pressed tightly and censoriously to his eyes, a vain attempt to enforce his usual containment.

'Not at all', Dr T uttered softly. 'I'm sad with you that you have this pain and grief, but very pleased you're able to share it with me; that's not at all "stupid". There are times for all of us when we need to cry and be cared for by others. I've long had a sense of you as being both courageous, but very hard on yourself in this way; that you won't allow yourself these very natural and human needs. I'll give you some tablets which will help cure your ulcer but, you know, what you've started here with me, sharing and expressing your feelings, may be the best medicine you can give yourself. I know it's hard and strange for you, but it's something I'm more than willing to help you with if you wish. It can be a great comfort, to have a safe place to talk about things that are kept hidden in other relationships in your life. I don't want to intrude, but I'm here to listen if you want me.'

'Yes, I do see what you're saying ... and thank you, doctor. It's good to know you're here'.

Bill replied, his voice more sonorous; a quiet, economic and characteristic coda.

Dr T remembered from his earlier training, reading long and complex treatises on which, among the innumerable physical ills to which the flesh is prey, were thought to be 'psychosomatic', and what the diseased part was symbolically, unconsciously, but precisely expressing and enacting.⁶ Dr T's view has evolved into something rather more ordinary and less scholarly, for it has seemed to him that any illness can signify the discordance, the 'unfinished business',⁷ the mere unhappiness of its host, and that the important question is not 'Is this illness "psychosomatic"?' but 'How may this person's inner and relationship life contribute to their illness, and (how) can I usefully and tactfully intervene?'⁸ Aware, too, of the growing research on how immune and repair systems in the body reflect unexpressed and unresolved feeling,⁹ Dr T has now a far wider perspective of how the expression of hidden and trapped feeling is so often

crucial to recovery and the maintenance of health: Bill's expulsion of painful and palliating tears, a 'natural' therapy, are quite as important as the synthetic compound the doctor gave him to quell the acid production in his stomach. Such is 'Holistic Medicine'.

But there is more to this 'in vivo' psychotherapy than mere catharsis; for Bill may learn, through his experience with Dr T, that he can share powerful feelings with others, that both can survive it, and that from these a new growth and modus vivendi becomes possible. Whether or not he takes these tasks into the more deliberate territory of 'in vitro' counselling or psychotherapy, he has encountered, in its humblest form, what the psychoanalyst Michael Balint terms 'a New Beginning'.¹⁰ While the doctor's interest, skill and 'encouragement' are clearly important in these first steps of encountering such challenges, it is ultimately Bill's own capacities of courage, curiosity and candour that will decide how far through this 'Front Door of Psychotherapy' he decides to travel and explore.

CASE NO. 4:

Being there

It was an exceptional and dramatic illness that Alice had suffered when vacationing with her husband and two teenaged sons in a West Country resort. A detailed hospital letter, replete with technical details, chronicled how she had, from apparently good health, almost died from a rapidly spreading perineal infection which, within twenty-four hours, had spread to her blood-stream, rendering her comatose and moribund, to be plucked from death's door by the vigilant dedication and expertise of the Intensive Care Unit. A horror and a miracle, Dr D. had thought as his eyes scanned the scores of investigations that had guided the medical salvation of Alice, but which left Dr D. perplexed and ignorant as to why Alice had been so savagely felled in the first place.

She had rarely seen Dr D., and when she entered his room looking pinched, tired and grey, his attention was focused almost solely on the physical ramifications and sequelae of her nearly fatal complaint. An examination revealed a small residual abscess, and with a manner both apologetic and authoritative, the doctor referred her promptly to a surgeon to drain what he hoped would be the last outpost of this grim and mysterious

foe. His hopes were premature or ill-informed, for she soon developed a bowel complaint with loose, frequent motions and the passage of mucus. The hospital physicians, asked to assess this problem, investigated her story and internal tissues with zealous and impressive thoroughness, fearing that her relentless and severe constellation of complaints might be due to some concealed fault in her immune system. Perhaps to their disappointment, but to Alice's relief, they found nothing.

When she came to tell Dr D. of her 'progress'(!) and her most recent hospital odyssey, the doctor listened with courtesy and concealed despondency, before embarking on a lame but well-intentioned ritual of 'performing' a physical examination: he could not hope to unravel this Gordian knot, but at least he could be seen to be conscientious in his efforts. With a consoling but clueless hand on her abdomen he said:

'Events have moved so quickly and unpredictably that I haven't had a chance to get to know anything about you, apart from your illness. But I've been wondering if there's anything in your life, worries or frustrations, that you think might have brought all this on.'

Alice's abdomen tensed as her breath stopped momentarily, and Dr D. did not expect the succinctness of the reply:

'I think you've got something there, doctor. You know, I just can't settle into this second marriage...'

Realizing the pregnancy of Alice's confidence was likely to be both fragile and crucial to understanding her menacing afflictions, Dr D. acknowledged the importance of her statement, but desisted from asking anything more explicit from her, instead inviting her for a longer appointment where she could, if she wished, unfold and reveal her personal world.

Until ten years previously Alice had regarded herself as happily married to Tom. Their sexual relationship had always seemed a celebration of this; vibrant, full-blooded, enlivening and tender. Tom's confession had come with horrific suddenness: with shame but conviction, he told of an affair he was having with Alice's cousin, a woman much loved and valued by Alice. In a conflagration of shock, hatred and grief, this

apparently loving and companionable relationship became a bitter and empty ruin. Alice, shamed, resentful, and uncomprehending, became circumspect and prickly, directing what bruised love she felt safe to entrust, toward her two sons.

This turbulent and bleak period of her life was eased somewhat by a kindly and attentive, though somewhat phlegmatic, neighbour, Cyril. Cyril too, had recently suffered a painful and central loss through his wife's death from breast cancer. Now a childless widower in his middle years with no family around him, his loneliness was soothed and expunged by his growing acts of concern and protectiveness towards Alice, a widow of sorts, an injured soul-mate. The two became bonded by mutual commiseration. Her two sons, hungering for paternal presence and interest, accepted Cyril's good humoured and stable involvement with an almost incredulous joy and gratitude: they had expected to remain fatherless. Alice's siblings and, now elderly, parents, at first warily protective of Alice, grew steadily in their warmth, admiration and respect for this unassuming and devoted man. It all seemed like a miracle of restoration when Cyril proposed marriage, and Alice, to the joy of all those around her, accepted.

But Alice's secret and inner world rumbled, faintly at first, with a doubt she could not communicate. While her gratitude and affection for Cyril warmed her heart, her flesh remained dispassionate to his touch. Tom had been a vital and charismatic lover, who had rarely failed to arouse and satisfy her deep visceral hungers, and to her dismay Cyril's body had seemed waxy and lifeless; at this primal level she could find no love for him.

'At first I thought I could grow to love him in that way, that it would come if I was patient. He's been so good to me and the children – the boys adore him. And I kept thinking: "It's not much to do in return. I should be able to offer him the sexual love he wants". But I just haven't been able to. At first I'd pretend, though it always hurt, and I tried to hide it. Then it got worse; I felt repelled and sick and terribly guilty for marrying him when I didn't desire him. It's a terrible problem I have, doctor. I can't reject him or leave him now, not after what he's done for me, and what he's been through with his wife dying. I think he'd die of a broken heart...'

`And the terrible infection you developed was like a way of keeping him out, and killing yourself, without you having to tell him anything painful. It's as if your body expressed, and attempted to solve, your whole painful predicament,' Dr D. pondered, realizing that such metaphor might seem bizarre or obscurely distasteful to many of his colleagues.

`Yes, that's just how I've felt. The doctors at the hospital seemed amazed at my condition, but all the way through it didn't really surprise me. Secretly I thought of it as a way out, and as a kind of punishment ... It all made some kind of awful sense,' Alice replied with stoic and dark candour.

Dr D., gratified and deeply moved by his understanding of the deeply tragic nature of Alice's dilemma, found himself feeling disorientated and impotent with his wish to help further. Toward the end of their harrowingly intimate hour together, realizing that the severity and momentum of this woman's problem was quite beyond his usual scope of support and clarification, the doctor suggested that her problem should be shared further with a counsellor.

`No, doctor,' she said with firm conviction. 'I can't tell anyone else, and I know nobody can do anything to change my situation. But you've probably done more than you realize, because it's important that someone, just one person, knows my situation and what I'm going through. It may sound strange, but it will help me manage. Can you understand that?'

Dr D's nod was warm and sorrowful. He did not need to say more.

Alice returned a fortnight later and reported her bowel complaint quiescent. Mindful of Alice's words on the previous occasion he did not enquire about her life, but the mellow and tender tone of the interview indicated that an implicit and important rapport had been created between them: she would return and talk if she needed to.

Dr D's 'psychotherapy' with Alice was not in any way complex or 'clever', the

doctor merely provided a safe and attentive place where there was trust, time and containment enough for her to unburden herself in a way that was compassionately accompanied. Dr D., in allowing her to 'pour out' her secret pain and difficulties, had been struck by the way her bowel had no longer needed to fulfil this function symbolically and somatically. Putting her conflicts into words, it seemed, had thus shifted the locus of expression from her body.

There are other ways we can understand the healing encounter of Alice and Dr D. In providing a 'Safe Space'¹¹ for Alice to share her most anguished and burdensome secrets, she could, if only in that particular setting, bring together the self that was normally presented to the world and the self that she alone knew. From Freud onwards psychoanalysis has concentrated on the integration of the Conscious and Unconscious Self as the major task of psychological growth and healing. But the example of Alice illustrates a challenge more common in medical practice and counselling: for the integration of the split between her outer, Public Self and her inner, Secret Self, is in no way 'unconscious', and yet is cardinal to her difficulties.¹²

Dr D's skill here did not lie in subsuming her communications to his own specialist concepts and frame of reference,² but rather to create the kind of relationship and dialogue where Alice was 'encouraged' in entrusting and accepting herself. This could only happen if she felt she could trust, and be accepted by, Dr D.; and the doctor could create this kind of 'holding environment'¹³ only if he could manage a particular kind of unconditional listening and responsiveness.¹⁴ This is more complex than it might seem for, as we have seen with Dr B in Case No 2., such qualities of outer listening to another emerge from the long gestation of listening to oneself. The empathy mustered by Dr D. could not arise merely from curiosity and benevolent intentions; the resonance required demanded a deep and hard-earned inner sentience.

Alice's final communications to Dr D. at the end of her long interview have an intriguing and instructive message in the endeavour of psychotherapy. In a culture and profession increasingly obsessed with questions of active intervention, terminology and technique, we are, perhaps apt to overlook the

healing power of being known, with intimacy and volition, to another.¹⁵ It is often unmitigated aloneness that makes us sick; inclusion and acceptance that heal. It is here that the heart of the Alienist is most tested.

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