

Then and Now

Presence in Mind
Foundations of health, happiness and healing

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How and why is it so necessary for we humans to show our significance to one another, in ways that bridge our non-contact, our absence from one another's lives? To demonstrate to others that we keep their virtual presence in mind?

A multidecade vignette with contemporary reflections explores.

You don't really understand human nature unless you know why a child on a merry-go-round will wave at his parents every time around – and why his parents will always wave back

– Bill Tameus

October 2024

Marion had somehow found my contact details. Despite the passage of so much time I immediately recognised her name, which headed her short email. This triggered a warm, sad glow, followed by a flurry of images and recollections – her face, her voice, her many tangled predicaments and pains.

After nine years retired from my four decades in the same general practice, this contact was unexpected: an unwarned yet warming blast from the past. Her text was disarmingly direct, brief and spare, yet rich with abject sincerity. I felt a lump in my throat – an awakening of an ancient resonance – as I read this bleak and hopeless declaration of gratitude:

Thank you so much for all your help and support. I miss you so much – there's no help or support now for people with disabilities or mental health issues. I thank you so much.

Love Marion

I am certainly no saint, genius or hero, so what is the story here? What is this shared and enduring significance between us, between one and the other? And does this have yet greater significance?

July 1989

Marion's first meeting with me. She enters the consulting room tentatively, as if already apologising. She is a young, large-framed woman with inconspicuously dark, loose clothes. As she hesitantly approaches I see her face: it is softly expressed, but her eyes seem to me to signal an inner conflict – of wariness v neediness, of fearful avoidance v hopeful approach. I do my best to palliate this: I think of Horse Whisperers.

She needs a presenting complaint – she has several, a constellation: insomnia, episodic dizziness, suffocated feelings, nausea, 'palpitations'... As she talks I think: 'This is functional illness. This shy and fearful young woman feels trapped by problems of which she cannot yet speak.'

My 'just in case' examination and conventional tests seem to support this. I invite Marion for a longer appointment, to talk, if she wishes. She comes, and she does. With hesitant beginning, but then greater fluency, she unfurls a lifelong story of painful adaptation to, and damage by, the damage and incompetence in others. Marion is the older sibling of two. Both are the product of a stably and shabbily discordant marriage held together by a kind of toxic glue: the parents' reciprocal displeasure and mistrust finds a kind of companionship and convergence only in their long-shared alcoholism. If they cannot swim together they can, at least, sink together. Marion cannot remember either, ever, being employed – clearly they are now unemployable.

Marion endures in a family that is impoverished, not just financially, but domestically and emotionally. Her parents' health, competence and availability are all failing: when sober they are feckless, exhausted and vacant, when delirious they render only fitful, fractious instability and incomprehension. She remembers early childhood: she came to realise that, as the older sibling, she must take whatever care she could to keep her parents, her home, her family together – to 'keep them going'. Later on, Social Services were alerted 'to make an assessment'; Marion learned precocious canniness – she worked out ways to dissemble and conceal. 'I knew what would happen to us: I had heard ... I didn't want my family to be split up ... for me and my brother, Stephen, to be taken into care ... I knew Mum and Dad weren't good parents, but they were *my* Mum and Dad: I loved them.'

Fate had other blows. Marion developed a treatment-resistant form of epilepsy; learning disabilities followed, despite her evident (to me) emotional intelligence. Several years later – in a tragic and amplified echo of their parents' lives – Stephen truanted school, drifted into severe drug abuse and dealing and, in his early twenties, was consequently and permanently disabled by a severe left-sided paralysis. Stephen is now a wheelchair user; Marion is now the Carer for all three chaotically self-damaged and damaging Victim-Perpetrators: this doomed cul-de-sac of a family.

This is the human hinterland driving and feeding Marion's many symptoms – her ineluctable distress and dis-ease...

What to do? I can, at least do my best to offer resonance and understanding.

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1989-2016

My introduction to Marion's unique world of problems runs parallel – quite coincidentally – to a change in health culture that I, and she, will find ever more problematic. We – all of us – are, increasingly, subject to a governance-of-all regime. Due to a mixture of rapidly advancing digital technologies and a saddling neoliberal ideology, healthcare is increasingly sectorised and proceduralised. Whatever is encountered now requires a rapid and approved technical designation, computer code, management plan, protocol subjection, algorithm submission...

All problems are to be treated, managed or referred according to institutional formulae.

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So what can I do with Marion – both now, and in the possible years that lie ahead in this streamlined and fast-trafficked world? Her many guises of distress – both physical and mental – are ill-suited to such systems. What remains possible? I continue to offer her what I started with: the head-space and heart-space to safely express and unravel her painful personal hinterland. I help her find a language and a safe chamber for her intense, entangled and often conflicting feelings: grief, guilt, sorrow, rage, longing, mistrust, fear, despair... She has never shared these before. I am her first witness, guide and translator. I cannot reverse, undo or abolish any of

her predicaments.

I often think of my offerings to Marion in nautical metaphors: I can provide a safe harbour, anchorage, buoyancy aid and (occasionally) an outboard motor; together we can create maps to identify perilous rocks or currents, and where safe coastlines can be found.

Marion responds to all this with evident relief: it is a promising start. Yet I know that what I – as her GP – can offer her is too little and piecemeal. Others are needed to help her, us. In the earlier years this is easier; I work closely with my practice counsellor and we both make use of other community facilities to provide additional support and affiliation. At times of more uncontained distress I turn to an accessible and senior psychiatrist, Dr B, a decade older than me – a clever, wise and kindly man. Over the years Dr B and I have found an informal way of providing joint care – his access to in-patient and day centre facilities effectively complement my more vernacular, background guided support.

Dr B and I like one another. We meet periodically and have wide-ranging discussions that include exchanging experiences, ideas and facts about our work and then any patients that we share. We have both expressed our sense of encouragement and enrichment from our conversations. Marion knows of such meetings. One day she says, ‘I really like it that you and Dr B talk to one another in the way I think you do.’

‘Why is that?’, I ask.

She bites softly on her lower lip, wipes a tear from her eye, smiles demurely and says, 'I think it means that you sometimes think of me, even when I'm not there... It means that you *care* ... I feel safer'. She is silent for few seconds, her smile vanishes, her voice lowers, 'I don't think Mum and Dad ever had those kinds of talks... Did they ever really think about me and Stephen?'

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In later years the family-like professional network I have to help me help Marion best endure her lot is dismantled by successive reforms. These reforms are designed to expedite procedural treatments, but become heedless and uncomprehending of any more humanly nuanced care.

Marion is a victim of this systemic oversight. Dr B and my practice counsellor have been replaced by remotely-managed and carouselled, relaying practitioners with strict intake criteria and short-term tasks. Marion, even if she is accepted for 'service provision', is most likely to be soon bounced back. The community support and affiliation agencies are mostly gone. I, now, am the only practitioner who provides any personal continuity of care, the only one who has depth of personal knowledge, who 'cares'. I am marooned.

So what can I do? What *do* I do? Well, whatever it is, it's very different to what's indicated by the current lexicon, terminology or feel-good slogans: there's no definitive diagnosis, treatment plan, recovery programme or oven-ready algorithm to guide all this. Obviously, I can't change her past, nor can I much ameliorate her present – I may possibly be able to influence how she views and manages some of it.

What I know I can do is be a steady and compassionately engaged witness. I can be a refuge of personal and medical understanding.

I can keep her present in my mind, and signal this to her.

Such things help us all endure. She has said as much.

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Marion is a highly-distressed example of this need for witness and recognition, yet it is there for all of us – even the most fortunate. Why else do we attach such significance to recognition-rituals: birthdays, funerals, Christmas cards, neighbourly salutations ... even (sometimes) probate. And why the sense of hurt, injury – dangerous outrage even – if these are not forthcoming?

We must, somehow, find presence in absence. Absence alone and unmitigated may be intolerable.

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2024. Broad reflections

It seems to me that we humans are unique amongst all living species in how we are haunted and how we are driven. We all, at some level, in some way, have to deal with four basic existential anxieties.¹ These are:

1. **Aloneness.** Every person's consciousness is unique. Without linkage and resonance with other consciousness, our minds are dangerously hazarded by distress and instability. We must build and maintain our contact with other minds.
2. **Insignificance.** Humans are aware of the vastness of space, time and all that is 'not-us': in reality we realise we are, individually, insignificant. The best we can do is to seek and invest in relationships where we demonstrate and express reciprocal significance with others. Together we create personal significance.
3. **Meaninglessness.** The universe has no inherent meaning, yet humankind needs to create this to avoid the already painful void of aloneness and insignificance. A naked and uncompromised sense of meaninglessness is penultimate to despairing and unsurvivable nihilism.
4. **Death.** After mid-childhood we all know our lives are limited and we will die. We can deny or mitigate this by refuge in religious doctrines of 'it's not *really* death'. Yet our most effective counter to our death-anxiety comes from our creative responses: how we compensate for our inevitable aloneness, our ultimate insignificance and the World's meaninglessness.

These anxieties are universal, yet far from clearly or uniformly manifest: we may deny, conceal, camouflage, displace, project ... or, rather, we may acknowledge, own, and invest in creative compensations. Which responses we choose (or are limited to) determines much about the nature and course of any individual life and, more broadly, a culture.

The underlying principle here is that anything that counters or contains any of these anxieties contributes positively and broadly to our welfare: our sense of internal and external harmony, our trusting identifications, our capacities to endure, comfort and heal Life's losses, traumas and Fates. All such influences are *therapeutic* – for individuals, through to the largest human groups.

But conversely anything that amplifies or stimulates those anxieties – or anything that dismantles or erodes our creative responses to them – will lead to the reverse: such influences will sicken us. Anything that diminishes our sense of belonging, significance and meaning will make our inevitably problematic human lives more discordant, distressing and unendurable. Indifference or disrespect for our commonality of these basic anxieties is *pathogenic*.

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How is this relevant to our NHS?

Well, before our era of industrialising and commodifying NHS reforms I think our healthcare could better, if implicitly, incorporate all this. As a young practitioner I was mentored by Balint-infused² GPs and Psychiatrists who assumed 'Supportive Psychotherapy'³ to be a mainstay of their work. These doctors certainly respected that their first task was accurate and speedy treatment of all clearly fixable conditions. But they also recognised something equally important: that distress that is neither readily definable nor easily fixable can offer opportunities for substantial therapeutic and prophylactic benefits, but by a different approach and a different route. They realised that the personal understanding and therapeutic effect that

could emerge from the relationship could be pivotal in healing, creative adaptation, pragmatic endurance and growth. They also recognised how neglect of these possibilities could have tragic consequences. To incorporate this personal continuity of care, whenever possible and desired, was regarded as a *sine qua non*. It was often accepted as the most humane, effective, even economical approach in the longer term.

Only many years later did I crystallise my thoughts into and around the four basic existential anxieties, so I did not yet talk of these ideas with my early mentors. But I now know they would have quickly understood and strongly agreed – after all, they had shown me how to embed their technical expertise in such imaginative humanity.

Later I was to call this ‘Pastoral Healthcare’.

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I am now in my late seventies and apprehensively grateful for relatively good health. I have some usual wear-and-tears, involutions, and (well-controlled) risk factors. I still manage my habitual pleasures and activities, though now with less speed, strength or stamina. Mercifully I do not (I think) have any dread diseases. Yet I am growingly fearful; unless I die very rapidly how will I be cared for in my decline? Who will, not only look after me, but look out for me?

My NHS consultations now are with a relay of different healthcare professionals allocated to me by busy receptionists who ask for my date of birth, but do not

recognise my name. I see practice nurses, nurse practitioners, healthcare assistants, community pharmacists, locum and sessional GPs... Mostly they are professionally courteous, some are warmly friendly. I have rarely seen the same person twice, so no-one knows me – consequently this necessitates their need to spend more time interacting with the computer than me. There is little opportunity for head-space or heart-space here: the marching mandate of procedure makes almost impossible any venture into hinterland. How can there here be any presence in mind? I hear many accounts of staffing unhappiness – of stress-related symptoms, difficulty in recruitment and retention...

When, eventually, I fail, falter and fall, could I expect anything more than competent treatment and common, transient kindness from a carousel of unfamiliar ‘team members’? Who will *care*? How can they?

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I am thinking of Marion again. My life has been so much more fortunate and blessed than hers, but as my vulnerability grows I can now identify strongly with the help she so appreciated and now yearns for and grieves. In a way it was, tangibly, so little – what did I actually *do*? – yet has meant so much for so long...

I look back: I am deeply grateful that *I* could work at a time and under a system that enabled and encouraged me to offer such common but professional humanity ... and maintain such opportunities to keep people’s presence in mind.

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Notes

1. Ideas about the Four Basic Existential Anxieties are explored more fully in *Humanity's Conundrum. Why do we suffer? And how do we heal?* Zigmond, D. Filament Press, 2021
2. Michael Balint (1896-1970) was a pioneering psychoanalyst who did unprecedented qualitative healthcare research. For many years he met regularly with a small stable group of GPs to investigate the human hinterland of their patient-contact, ie the personal aspects of lives, experiences and consultations that lay outside the conventionally biomedical but nevertheless were very influential.

Those GPs found their work was galvanised by new kinds of knowledge and understanding: their diagnostic acumen sharpened, therapeutic influence deepened and vocational commitment vitalised.

Such influence spread rapidly throughout the profession from the mid-1960s to the late-1980s, leading to the high-point of the profession's morale, *esprit de corps*, positive sense of identity, and stability.

In this author's view, the equally rapid decline of Balint's influence has been due to the powerful hegemony of digital technology and the derivative remote and systems management, generic industrialisation and algorithmic consultations. All of these are inimical to personal continuity of care with its bedrock in individual understandings and bespoke interchanges.

3. At the same time as this Balint-era, the better resourced examples of psychiatric services then could similarly, often, assure personal continuity of care. As with the GPs, those psychiatrists saw themselves as 'specialist carers' or 'stewards' quite as much as 'fixers': they could attend to those many aspects of pastoral healthcare that lay outside treatment regimes.

'Supportive psychotherapy' referred to the eclectic and bespoke way that was often achieved: the repairing, healing, guiding, motivating dialogues were, each time, tailor-made rather than institutionally prescribed.

It is rarely heard of today: its demise has close parallels to the perishing of Balint's influence.

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