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'The Courage of Our Stupidity' or Developing the Discipline of Being a Balint Group Leader

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This day is a result of a lot of thinking and planning by the Training and Education Committee with the Council's support. I think we wanted to get leaders together to continue working on what Andrew Elder recently called 'the Balint Project'. I took that to mean the ongoing work in noticing how we are working as Balint leaders, with whom we are working, what they are bringing and how we think about that theoretically so we can take the project onwards. My other idea is that for theory to move forward one has to know the previous work upon which a lot of our present-day work rests. This thinking is not usually elaborated explicitly. One reason might be the books which describe it aren't always easily available, although they are from second hand online bookshops.

I have been invited to Bristol a number of times over the last years and there I got into the habit of talking about some of Michael Balint's core concepts from *The Doctor, His Patient and the Illness*, which is the first book about the Balint project. Concepts like the 'apostolic function', 'the doctor as drug', collusion of anonymity are all I think absolutely relevant today and if you are not familiar, I am happy to expand these in the discussion at the end. The other books I use as reference are *Six Minutes for the Patient*, edited by Enid Balint and Jack Norell; *While I'm here Doctor*, edited by Andrew Elder and Oliver Samuels; *The Doctor, the Patient and the Group*, with contributions by Enid Balint, Michael Courtenay, Paul Julian, Andrew Elder et al.; and *What are You Feeling, Doctor?*, by John Salinsky and Paul Sackin (2000).

Balint groups came about as a result of a chemical reaction between General Practice and psychoanalysis. The result was a body of theory and observations that may have some resonance with interactions in many fields. Today there is a large number of psychiatrists in the society and their culture and work will also begin to react with Balint. To elaborate that new chemical interaction, I think it is essential

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to know the essence of the theory. In particular internalised theory effects, the stance of the leader is important to the quality of data we then get from our groups. By that I mean you need to be in a proper Balint group to get observations that one can use to develop Balint theory. In my mind Balint is not like anything else, it is not a technique, it is a way of listening informed by the experience of being in Balint groups led by experienced leaders who know their heritage. I think we will all have experienced that. The first cohorts of leaders knew implicitly from their long experience and contact with the Balints and those trained with them that something needs to be passed on and made more explicit. I think that my personal main aim as the President is that we have these dialogues as leaders together using this rather remarkable heritage.

This leads me to want to talk about the second book from the Balint project, *Six Minutes for the Patient*, edited by Enid Balint and Jack Norrell. Each chapter was written by a member of the study group in their own way. It is in part a valiant attempt to prove some things that I describe in what follows, but my intertest is more in the description of the evolution of the ideas. For me Enid Balint always quietly seems to make key points. In the epilogue she mentions how Michael Balint was looking for what could be brought in and adapted from psychoanalysis (the long interview) here, and psychotherapeutic skills in *The Doctor, his Patient and the Illness.*

In *Six Minutes for the Patient*, the influence of the popularity of short term focussed psychotherapies seems to be around. Enid Balint describes how she thought it was about noting something that was already present in the work of GPs and drawing that out rather than importing something. I think this is terribly important. The aim of the book was to measure the therapeutic potential of doctor-patient interactions in its everyday setting. This is why it is 'six minutes': that was roughly how long a consultation in General Practice might last.

They chose to ask the GPs in their group to bring ordinary cases where they felt something therapeutic had occurred. Then they looked at these cases in detail and followed them up over time using a variety of forms they had developed. They described the previous work and its limitations quite honestly. They noted that psychotherapeutic techniques were of limited value in day-to-day work. They noted how they had chosen special patients for long interviews and really had functioned like detectives using the family history and their own listening to come up with what were essentially psychodynamic formulations. They called this the 'Great detective'. It meant a two-tier split system though, as some special patients got the long interview and essentially a form of psychotherapy. Others were relegated to something else, ordinary practice one might say.

I think here there is a resonance for psychiatry. All trainee psychiatrists will have done a long case and a good question is why, and is this of any use in their day-to-day work? This is exactly the territory this book is in. What makes a consultation have psychotherapeutic value? This question is being explored. And it is not applying the techniques and methods of psychoanalysis in those other zones of interaction. But maybe in General Practice it is about looking to see what happens when something 'clicks' in a consultation.

I have little doubt that the attention and telling their story will have been very helpful for many patients in these long interviews and the long case in psychiatry. I was a big fan of the nuanced personal history as a psychiatrist particularly focussed on transitions like going to school etc. However, I think in this book and in what comes after it something different is beginning to happen. In describing these consultations something emerged which they called 'the Flash'. This describes a moment of connection between GP and patient. In reading the examples it struck me that in each the GP had to have the courage of finding a way to say what had come into their mind unbidden and it was usually something that was a little outside what might be considered professional and polite. (I will read

one of the interactions from the book near the end). Then the GP had to find a way of translating that observation and choosing to say it. In noticing these flashes, they observed the GP and patient were somehow closer, and the patient felt the GP had got them, had really got them in a benevolent non-pushy way. The GP managed to be struck by something in their unconscious and put themselves in the patients mind for a while and then pull back and think about it. The effectiveness of the flash relied upon the intensity of that momentary flare between the two and wasn't a long process but seemed to move things onto a new level. Sometimes temporarily. It wasn't an interpretation but more a conveying by the GP of their understanding of how the patient really was in a micro moment. I was struck by the fact that these weren't great summing it up statements but just about what the patient who was sitting in front of them was conveying at that moment. It suggested that knowing about one's self might be secondary to feeling someone had got you at a particular moment and helped you then. It was catching hold of how the patient was in that moment, not some great formulation.

I would like to read an extract from *Six Minutes for the Patient* (p. 24):

> To summarise I think the main characteristics of our technique are
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> 1. In the intensity of the contact
> 2. In the freedom it gives to the patient to use the doctor in his own way
> 3. In the freedom it gives to the doctor to make his own observations
> 4. In the freedom it gives to the doctor to be used i.e. to give himself, without anxiety that his patients will abuse his time.
> 5. In the discipline it imposes on the doctor during the brief interviews to observe both the patient and his own thoughts and feelings.
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> In our work the doctor is freed from the primary task of trying to discover why the patient talks, thinks, feels and behaves in the way he does. The patient in due course may provide the answers to why; the doctor's task is primarily to observe a very small sample of how the patient talks, thinks and behaves, and why this causes him pain; what he is like and what he seeks in an obscure and confused way to share with his doctor; what really makes him want the doctor's attention. May I add that this aspect of our work has nothing to do with solving problems or averting crises. And it is very hard and disciplined work indeed.

> This method can perhaps be taught best by the way the seminar leaders behave by creating an atmosphere where such freedom and discipline exists; where it is not the leader who knows the answers but where his observations are as free and his attention as complete and his thinking as disciplined as that required by the doctors in their interviews with their patients. This is again a very difficult task indeed.

The project group were left with the worry of how or do you move forward with that. There is then an intriguing set of observations about when patients pick it up, when they leave it and move away and when they come back. They note the importance of the patients' right to hide, and a respect for their defences. The doctor is not trying to break through something as I think had been the more vigorous sense of the initial book.

Balint's GP roots are partly in psychoanalysis and the other is in the body/mind combination and its varied expressions. The body figures less in psychiatric and psychotherapeutic settings I think, or maybe we ignore it more. I find this 'flash' (and the 'great detective' model) fascinating ideas as they are linked with something I spent my whole career as a consultant psychiatrist in psychotherapy wondering about: I used a term borrowed from another independent psychoanalyst, Nina Coltart. She spoke of 'psychological mindedness' which is much more about a capacity to begin to use one's imagination in an indirect creative way to describe one's experience and sense of self. I think the majority of patients, ourselves included, have a lifelong ongoing struggle to develop a way of metabolising and describing to ourselves the interactions between our unconscious and the external world but particularly with our body and what it carries for us. These flashes are not insights, at least not only. I think they are a change in an unconscious capacity that may be temporary or permanent, but in that moment is there between the two people. Once it happens it is always somewhere in the unconscious. So, the question for me is: can patients and indeed, more relevantly, doctors develop that psychological mindedness? I think they can, but it is in the way this book hints at. Occasionally there is a moment when the doctor

and patient can suddenly be surprised by a new reality and the patient may feel understood. This moment may in some cases bring about a curiosity in the patient about themselves and how they have come to be as they are, and they may want to explore that further. In others it may bring a relief that one is understood and one's defences respected until they choose to come out again. I think this is the profoundly developmental work of good General Practice and good psychiatry in any of its subspecialties. A moment of potential change is brought about by careful listening. This tuned in listening is described as selective attention and selective inattention. Listening to one's unconscious promptings or imaginative upsurges, or not, and to discard if appropriate the way one's training can draw one away from just noting one's observations. This is the freedom referred to in the summary of the flash and the discipline that has to be used and developed in the doctor. Some of this ignoring may be due to the doctor's apostolic function but also to the primacy we give to illness diagnoses versus a more global holistic assessment of the patient. What is noteworthy in the book is the way physical illnesses and the person's state of mind are seen as linked and both given proper separate attention at times and when they overlap that is also given proper attention. Here there is a use of holistic assessment way before it had become fashionable.

It seems to involve learning not to hurry after answers to questions that are not the patients worry but part of what we have to do in our job.

I will cite the example of the case here in *Six Minutes for the Patient* (p. 33):

> The doctors in this research group were already experienced in long interviews on selected patients in their practices, whom they tried to help with personal problems. Our aim in the present research was to examine the ordinary 10-minute GP interview and see what we were able to do in such short contacts. There are many possible types of interaction between GP and patient. One might distinguish the following three categories with an example of each.

1. Traditional medical interview

A fifty six year old single woman not well known to the doctor, complained of feeling tired and unwell. He got her to enlarge on this, and learnt that she had felt sluggish and cold lately. He took a full history and examined her, bearing in mind such possibilities as myxoedema (hypothyroidism) and anaemia, which occurred to him early in the interview. He found nothing on examination, but sent her for appropriate tests.

2. Detective type of personal interview

The tests were all normal, but she still felt ill, so he asked her to come for a longer interview. He asked various questions about her life, and learnt that a recent change in the office had upset her. She was not easy to talk with, but he got a past history of dominating mother, who rather isolated her, but made her feel she should take a pride in her job, but that she would achieve little. She was now lonely and frustrated, and her symptoms dated from the office change which exposed her to a new and larger group of people who seemed unfriendly. He summarized this picture for her, as far as it went and she agreed it was relevant to her symptoms and was grateful, so she said, for his interest. But at the same time she made the doctor feel that further questioning on these lines would meet resistance. He could never change her of her life situation. So he prescribed anti-depressants and asked her to return in a fortnight.

3. Flash type of interview

She returned even more depressed and the doctor said 'Oh dear, we must try again apologetically, at which she burst into tears. The doctor's immediate reaction was that she looked ridiculous crying in the hat she was wearing. This thought shocked him, since he liked to think of himself as sympathetic to his patients, but he realized at once that she might be making other people unsympathetic to her in a similar way. She started apologizing for her tears, and was surprised when the doctor apologized in turn for not letting her feel she could cry with him before. She felt at once the new relationship that this interchange had established and understood what the doctor meant when he suggested that she might have been keeping people at arms' length by a rather stern manner. He referred to the hat, which was a formidable affair and she took this point with interest and good humour. Finally, she was able to agree that her initial complaint of feeling the cold might be because there was nobody to warm her up, but her stern manner was hiding this need from other people.

The first interview was 'illness orientated' with the doctor very reasonably looking for myxoedema, anaemia, or other physical illness.

The second interview was 'patient orientated, in a detective way. The doctor organized the interview to try to make a diagnosis of the patient herself rather than of an illness. He was aware of her as a cold dominating person, but was not involved very much with her himself.

The third interview was also 'patient orientated' but involved the doctor patient relationship as well as the patient. The doctor had a flash of understanding and was able to share it with the patient. Where this could happen they both lowered the barriers, the doctor admitting his failure, and the patient letting herself cry. The interview was much warmer than the earlier ones and established a new relationship between doctor and patient, which should be useful in time, but also helping her to react differently with other people.

So, using this case as an example, the authors talk about the traditional medical interview, the great detective (long interview) and the flash interview. What is a 'flash'? As Enid Balint says, one recognises it easily but it's very hard to define.

Here, something simple, everyday and ordinary struck the doctors unconscious – the hat. The patient uses her doctor to convey something that is obscurely felt by her. Here, this evokes something in the doctor that seems a bit edgy and maybe ought not to be thought or said. It leads to a description of how the patient comes across to him in a flash. Then he chooses to notice what he has said and done and his feelings. But there is a moment of mutual awareness that is genuinely felt, genuinely comes about. So, it is not a fabricated intervention, it just happens. Part of Balint training is noticing our feelings and actions and then reflecting on what they say about how this patient is at that moment. It also involves a knowledge of the patient and a being open to them at a deeper level that draws the doctor in and is emotionally hard work and can't be conjured up at will or regularly. It means the doctor has to allow for personal discomfort and the discomfort of thinking one should be in control of what's happening and tune into the patient's distress.

My own observation is that some patients evacuate their distress and don't want it back at that moment or maybe ever, so I wondered if some of these cases used the doctor like that and that some subsequent reluctance to open up again was because they were relieved of some burden. Is this a use for doctors? And other professionals, or not?

I thought I would leave us with the rest of the time to discuss as colleagues what this presentation evokes or might mean in the context of the different places and professions we work in. I definitely don't see it as a question-and-answer session; more as a chance to talk about these theoretical issues in our practice as Balint group leaders.

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