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Editor:
Tom McAnea

Cover image: *'The Doctor'* 1891, Sir Luke Fildes 1843-1927

The attendees at the Whalley Abbey Weekend Workshop.

The Balint Society:

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

Membership of the Society is open to general practitioners and all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year. These were held at the RCGP premises in South Kensington until the College moved to temporary headquarters in 2010. Since then we have held a reduce number of lectures other London venues and we hope to be able to use the new College premises in Euston Road when they are opened. Balint weekends are held each year in Northumberland, Whalley Abbey, Lancashire and Oxford. There have been two February Balint Study Days in London in 2009 and 2010 and we hope to resume these at a future date.

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

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

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

PROGRAMME OF EVENTS:

The Balint Society Website news

The revised Balint Society website was launched on 25th June 2012. We hope you find the site easy to navigate and informative.

The web address is unchanged: http://www.balint.co.uk but we have a new email address: contact@balint.co.uk. **We are keen to hear about Balint activities and groups across the UK, so please use our email to let us know what you are doing.** The Balint Council is working on some topics such as 'Leadership training and accreditation' so look out for new content as well as photos of Balint activities.

You can also:

- find us on **Facebook** (http://www.facebook.com/pages/Balint-Society/260364547406441)
- follow us with **Twitter** (https://twitter.com/#!/BalintSocietyUK)
- use our **RSS feed** (What is this? Try http://www.bbc.co.uk/news/10628494 for an explanation - I did!)

so it should be easy to keep up with our news and send us comments or questions.

Ceri Dornan

Editorial

Fractured Clinic

Miss Finola Brooke-Williams BA (Hons.) Dunelm

If I had been given a list of rotations to choose from at the start of my first clinical year, Orthopaedics, for all its stereotypes, would have appeared at the very bottom; that is, if it made my list at all. However, on a Thursday afternoon I found myself in the bustling, frantic Fracture Clinic in the basement of UCH, strangely enjoying myself.

On this particular afternoon, I was encouraged to be a complicit cog in the machine, patient's notes were thrust into my hands, bed number announced and a patient' s history and examination expected. On each occasion, as I progressed through what seemed like a conveyor-belt of patients, I took a sharp intake of breath before the final draw of the curtain. This feeling of purpose and usefulness as a medical student was a novel and exciting feeling. For the most part I embraced this new challenge and sense of independence. However, I was acutely aware, that this new and more useful role I found myself undertaking, could be removed as quickly as it were granted if I were to somehow be seen to 'let the team down' or create more work than there was before I arrived. I felt as though I were teetering on the edge. The swift speed had been set by my seniors, so my time at the patient's side did not extend beyond that required to acquire the necessary information. Histories were stripped right back to only those that bore relevance to the presenting physical injury. I marvelled and almost enjoyed the sense of frugality and economy of communication that was encouraged and deemed 'best practice'.

Being a cog in this particular machine gave me the first taste of working as part of a medical team. It was satisfying to see a patient and know that my interaction with them had a direct impact upon their care-pathway. Being in an environment that welcomed student participation felt alien yet pleasing. However, the hierarchy was still apparent and this was still a working afternoon, so any slip-up that would add to the team's workload would not be welcome and you may not be welcomed back. Fortunately, no such slip-up occurred but the fear of humiliation and failure did linger throughout this oddly exciting shift.

I walked out of the Fracture Clinic dazed and relieved. I had managed to contribute and received praise from the surgeons. This was not an environment I had expected to be able to function in and I had a strong sense of achievement. My steps towards the lift felt laboured and I felt overwhelmed by tiredness. My usual routine would see me change into my cycling gear, to ride home, but today that seemed like all too much effort. Instead, in the anonymous airport hanger of University College Hospital, I slumped into a seat, the type of fixed seat you would expect in the departure lounge at any airport, and reached only for my trainers.

As I folded myself over to tie my laces, I noticed a figure to my left shrouded in black, leaning forwards over their knees, head in hands, slowly rocking. Time slowed and I thought to myself 'that guy doesn't look too great…'. I continued tying my laces, processing this thought. Without a cognitive acknowledgment I also knew that he was homeless. I knew this without looking at his face. The tattered, stale-smelling clothing and sense of vulnerability were outward signs. I felt an urge to ask him if he was okay but I felt an equal urge to retreat home and recover from my afternoon of teetering on the edge.

My thoughts were left in limbo. I finished tying my laces and was about to decide which direction to turn and the figure turned his head towards me and huskily asked "Have you got the time babe?" This interaction had made the decision for me. I felt relieved but the sense of desperation in his eyes was penetrating. I gave him the time and then asked "Are you okay?". I have never seen anyone look so desperate, nor have I ever seen anyone look so worn, frail and neglected. As I listened, I could see that not a tooth lay in his mouth. Instead of teeth he had bulbous purple, ruby and ink swellings lining his gums. I wondered, "What on earth could have happened to this man? What cards had he been dealt?" This was not something that an orthopaedic clerking could or *would* even broach. Ironically, the frugality of the history-taking I had marvelled at earlier, itself, seemed fractured and broken. His destitution and the deficit that the earlier history-taking model leaves in patient care left me with a compulsion to steer my career in the direction of those at the margins of society.

My first concern was that he didn't look 'medically' fit but this would not have taken a Medical Student to realise. As we spoke he was slurring his words, and his eyelids were heavy. I felt myself move back into 'medical mode' but felt stunted by my lack of medical knowledge, or knowledge of how to deal with this man. Before I knew it, with this total stranger, I had started to take a 'history' – my instinctive priority was the drug history. I asked if he had taken anything that day. He revealed with ease that he had had his methadone that morning and one can of 'Special Brew' at lunch but that he had not eaten. As he spoke to me, I sat at his side trying to absorb everything he said, whilst wracking my brain for my next options. I knew he did not look healthy, and that he was not fully alert, but I didn't know whether this constituted the need for medical help or if this would just be attributed to lifestyle. I asked him how he had been over the past few days and he mentioned that he had had a temperature. Alarm bells rang in my head. Tuberculosis? It has been drummed into every Medical Student's head that *all* homeless people have TB until proven otherwise. I tried to convince him to go to A&E, but am ashamed to admit, that I was acutely aware that I did not want to take him over there myself, as the attitude towards homeless people precedes the department. More importantly, he was really against the idea based on previous experiences where he has been shunned and told he was wasting time.

I asked him why he came to be in the hospital if he did not want any medical help and he said it was somewhere "warm and free" to be. It was icy cold outside. He had been out trying to sell the '*Big Issue*' that morning but because of a sleepless night on the streets and the bitter cold he had surrendered and retreated to this anonymous hanger. I think he had an extreme case of acute on chronic exhaustion. Despite the A&E option being ruled out, I knew that this man was far from okay. I didn't feel able to leave him but I didn't have any obvious options for help. It frustrated me greatly that here I was in an internationally-renowned hospital, in the developed world, that there was no one I could think of to approach for help. I thought about going to the receptionist but quickly ruled that out given the rudeness I had experienced firsthand. For a moment, I thought about going back down to the Fracture Clinic and speaking to my Consultant but then swiftly remembered that in clinic, a man of 'no fixed abode', who needed a shoulder replacement was not given this option, as it was decided that he would not be able to suitably rehabilitate.

Having done some volunteering at a Homeless Night Shelter I asked if he had any connections with a shelter. He said he had none and that he sold the '*Big Issue*' in order to pay for a £8 bed in a hostel. If that failed he slept on the streets. This was not something he was keen to do for reasons he soon revealed. He told me some weeks ago that he had been sleeping rough in East London and that three teenagers had set him alight in his sleeping bag. As he told me, his lip wobbled and he lifted up his jogging bottoms to show me the deep burns that this sadistic act had left him with. I was and am still astounded at this act of cruelty but at the same time I could not help but wonder what must have befallen those three boys to carry out such a horrific act. I felt this man desperately needed a place of shelter. Feeling almost option-less, I decided to ask him for his mobile phone number – something I would never have thought he would own before I volunteered at the shelter. It turns out the vast majority of homeless people do and they are treasured possessions. I said that I could speak to the social worker at my Shelter and see if there was any way he could help, and that if he was happy for me to, I would pass on his mobile number. As I went to store his number, I realised that we hadn't even introduced ourselves. I asked for his name and then, almost out of habit he said "do you want my date of birth too?". I sensed that this was something he had done countless times before and there was something detached and militant to it. I said that I didn't need it but asked how old he was out of interest. I was gobsmacked when he told me he was thirty but hurriedly hid my disbelief. I assumed that he was in his sixties. This man was only three years older than me and yet looked like he had lived twice as long; in many ways he had.

Before we parted ways I asked if he would like something to eat. He eagerly said "yes please!" and stood up with me as if to go to the canteen. I quickly said, "you wait here! I'll bring you a sandwich". I felt unnerved when he got up to come with me because I was worried what people would think if I brought him into the canteen. My comment for him to "wait here" was for me to protect my image and because I felt uncomfortable at what 'society' might think of me. Part of it was also to set a boundary. Unfortunately, I feel my act perpetuated the stigmatisation of the homeless. Fortunately, I don't think he was aware.

As I walked towards the canteen I still felt as though there must be some option within the hospital for this man. By sheer chance, as I walked, I saw the hospital Chaplain and thought 'surely the Chaplain will know what to do'. I wandered up to him and told him all about my predicament. He listened attentively and said 'you do know there is an in-house Homelessness Service here don't you? Look, just through that door, to your right, there is the Homeless Team!". I felt gleeful at the serendipitous situation I had found myself in, thanked the Chaplain and approached the doorway. Whilst I was gleeful, that earlier feeling of frustration seeped back in just before I went through this 'magic' door. This 'magic' door, the door through which I hoped to find the appropriate help for my new acquaintance, had not a sign, not a hint, not a clue, as to where it lead. If I hadn't had the impulse to approach the Chaplain I would never have known it existed and what is the point in a service if people don't know it exists?! However, if I had not been asked what the time was, I might not have been there at all, I might have unwittingly taken a wrong turn at the crossroads.

I walked into the office, introduced myself as a Medical Student and recounted what I have told to two social workers. They acted promptly and asked me to take them to him. I gladly did so, but just as we were nearing him, I realised that he had had no say in the

contact I had made with the team and the last thing I wanted to do was betray his confidence. I turned to the ladies and said I wanted to seek his consent first. He was willing and utterly grateful. A smile cracked on his tired face. I introduced the two parties, and shook his hand warmly as we said goodbye. I watched as he hobbled off with the social workers, and felt a little broken inside as I saw him shuffling along. Once he was some distance away, he slowly turned around, clasped his hands together and mouthed, "Thank you".

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I brought the above encounter to discuss in the Balint setting as it was a meeting that had a lasting impact upon me. It was really useful to go through what had happened with a group of other medical students who are at the same stage as me and could therefore empathise with the situation I found myself in. I explained to the group that for some time after the meeting I still played the situation over in my mind. We explored the possible reasons for this and it brought to light interpretations I had not thought about before. It was helpful to be asked questions about the case and to hear how other people might have approached it. Through the act of sharing the case I found myself sharing details of the story that I may have otherwise overlooked. It was, when I shared the case that I realised how important the contrast between the Fracture Clinic and meeting this man had been to me. As I shared the case, and indeed wrote my account above, I did revisit the feelings I had at the time and this 'revisiting' helped me unpick what had actually happened.

I think the fact that he was so close in age to me and that his physical appearance jarred so much with this was one of the parts of the encounter I found the toughest. I realised, through the discussion, that when we meet patients who are in some way close to us, whether that be age, beliefs or culture that those interactions can have an effect on us quite different to those with patients we feel more distanced from.

There was something quite cathartic about telling the story to the group. I think the act of telling the story was therapeutic and has allowed me to deal with its emotionally disturbing nature in a way that that I would not have otherwise been able to do. There was a lot of discussion about the role of the medical student within hospital life and it was apparent that the majority of us are unsure of what is expected of us and where the boundaries lie. It was refreshing to hear others sharing the same feeling.

I don't think I would necessarily change the way in which I handled my patient encounter but I think I would have more self-confidence in myself if I were to find myself in a similar situation. It has taught me how to deal with situations that don't necessarily have an 'algorithm' to follow and trust instinct and judgement. However, I do feel that I have really benefited from being able to share this story in a safe environment and that were I not to have had this opportunity I might feel quite different about my encounter. The Balint group allowed me to process the information in a unique way. I hope to join some Balint groups in the future and embed this reflection time into my practice as I am sure there will be many more situations that I will find myself in that would benefit from being shared and analysed within such a group setting.

What emerges in the life of a Balint Group?

These brief imperfect meetings
have a tale to tell.
Emily Dickinson (Dickinson 1851)

Introduction

A primary task of a Balint group is to explore the doctor-patient relationship in order to enhance its potential as a therapeutic tool. Furthermore, Balint thought that these groups have the potential to generate a "limited though considerable" change in the doctor's personality (Balint 1957).

A session typically starts with a doctor[1] talking about an interaction with a patient, including the feelings that arose in the doctor. The group then provides immediate responses and ideas. What emerges as the group progresses is unpredictable and perhaps initially unthinkable.

My aim in this paper is to observe what emerges as we move chronologically through two Balint group sessions. To help understand what is happening, I link the here-and-now moments of the sessions to ideas about the therapeutic frame, and to Bion's concept of containment as applied to Balint groups. Specifically, I consider how the safety and permissions of the frame of the group permit us to move beyond the security of things that we knew before. The group can then act as a container for the various elements of the doctor-patient relationship that the presenter communicates to the group. Towards the end of one session, a personal question was raised that highlights the boundary between Balint groups and group psychotherapy – I discuss how pitfalls in this area have the potential to disrupt the therapeutic frame that permits the work of the Balint group to happen.

Characteristics of the Balint group under consideration

The group comprised of up to ten junior doctors in psychiatry. I was the group leader for these two sessions. The groups lasted an hour and met weekly for a year. The sessions described in this paper took place within the first two months of the group. One difference from the classic Balint group structure is that, after the presenter's initial description of the doctor-patient interaction, I did not routinely ask the presenter to sit back and observe. This was not a conscious decision, but reflected my experience of how such groups were run when I had previously been a participant. I return to this feature later in the paper, and reflect on why it might be helpful to instate the classic structure of the presenter taking more of an observing role after their initial contribution.

Beginnings

The group begins with a doctor presenting a 'case.' The presenter is encouraged to talk about how they felt in the interaction and what may have disturbed them.

To introduce the two sessions, I now summarise the presenter's initial vignettes:

1 I refer to participants in Balint groups as doctors, as the groups in this paper consisted of doctors; although, of course, participants need not be doctors.

Session 1 - Dr A's interaction with a teenager with bulimia nervosa. The presenter describes his interaction with a teenage boy, who is causing him worry. The teenager is losing weight and cutting himself. His family seem very nice, but maybe a bit "sat back". The teenager had not told his parents how serious things were. A school trip is coming up – the doctor "had" to advise him not to go as he needs monitoring. The doctor feels awful for "ruining" the trip, and is worried he is overreacting. The doctor feels like a "killjoy" and wonders if he is making things worse.

Session 2 - Dr B's experience in admitting a woman to hospital. The doctor feels sympathy for this woman ("But for the grace of god there go I"), noticing her fragile physical state. The doctor is aware of the patient's previous convictions for violent offences. The doctor describes how his "sympathy evaporated" for her when a colleague said that he had heard this patient had "got away with beating someone unconscious". The doctor feels like he had been duped by the patient. He continues to treat her professionally and consistently, but his fear is he that he might treat her differently from then on. In describing the violent act – the details of which were shocking – the Balint group responds in horror, faces grimaced, intake of breath.

Although the group was only two months old, these initial histories sound different to those from a medical ward round. Rather than pure histories of the patient, they also tell of the doctor's experience of being with the patient. What has enabled the doctors to tell these different histories, allowing in more of their own experiences?

I think that setting up a therapeutic frame may be important here. Michael Parsons compares therapeutic spaces with entering a theatre, a religious building or a playground (Parsons 2007). A boundary is crossed "which tells us that the reality we are going to meet on the inside works differently from the reality outside". Similarly, in a Balint group there is an explicit frame: with a start and end, of regularity, and where permission is given for presenters to talk about the doctor-patient relationship in their own words. I think this frame allows the group to take a different direction from that of the ward round, more towards the world of the sandpit: a safe place where ideas can be played with.

The group's initial responses

Here are some quotes of responses by group members from early on in the session about the patient with bulimia:

- I wonder how the self-harming went on for years before anyone realised?
- He sounds very private, keeps what is bothering him to himself. Don't know why.
- I know how you feel – you feel bad when you have to just tell it how it is, I would also feel bad like that.
- Maybe there isn't anything wrong with him?

What was happening here? Members of the group had all been listening to the presenter, in shared attention – like in a play, cinema, or religious service. As everyone is different, this allowed for multiple different experiences. One of my roles here, as group leader, was to try and facilitate tolerating multiple views, rather than coming in and giving a verdict on what is being said (Johnson *et al.* 2004) – this can help to generate and preserve this plurality of ideas.

The emergence of something deeper

The Mind is so near itself —
it cannot see,
distinctly —

Emily Dickinson (Dickinson 1862)

Staying with the session about the teenager with bulimia, here is some material from halfway into the group. At this stage, it looks like new ideas are now being thought about by the group:

Alan [Following on from some discussion about how the presenter feels he may be blowing the whole thing out of proportion] Could this be his [the patient's] feelings? Is this how he feels? He doubts himself and is worried about making a bit of a stir in the family, so he keeps things to himself?

Katie So he's maybe getting you to, sort of, speak for him. But that puts you in a very awkward position. And he may not like you for it either.

Presenter Yes, I think he was quite cross with me. When I spoke to him on the phone once he was upset to hear from me, but he didn't hang up on me. In fact, I think that he would have stayed on the phone with me for an hour.

Katie I think that's quite positive that he didn't hang up on you. Maybe he does want to be taken seriously by you.

Group leader Following on from what you are saying I'm just thinking about these two aspects. He stays in his room concealing his self-harm and his worries, he keeps things to himself. But he perhaps also wants you to notice what's going on and take him seriously.

[pause]

Donald I've got an idea – probably a bit woolly [laughing at self, uncertain, self-deprecating]

Group leader Well let's hear it! [trying to keep same jokey feel]

Donald Well, if he's grown up being the peacemaker, feeling he has to be good and strong, maybe he thinks it's not allowed for him to have any problems or worries, and is worried about what disturbance that would cause.

Presenter Could be you know, as he seems very ashamed and furtive about what is going on, what is worrying him, what is making him anxious. Most of the time he seems quite unconcerned about things, but sometimes it does come out…

It sounds like the group were chewing things over and reaching towards a deeper level of understanding. How did this happen? In thinking about this process I have found it helpful to draw on Bion's theory of containment as applied to the workings of a Balint

group (Rüth 2009). Rüth describes how the presenter, with permission, evacuates disagreeable emotions and impressions to do with the doctor-patient relationship into the group via projective identification. The group then "tries to digest what could not be seen before or looked bizarre when listening to the facts of the story alone". In this way the group can serve as container for "all the aspects of the doctor-patient relationship… as well as anything to do with the emotional difficulties arising in the patient, in the doctor…" Looked at in this light, in the extract above the presenter projected into the group his concerns about his patient and his role in the predicament. The group received these projections and in trying to "digest" what it has heard offers various ideas back to the presenter: that the patient had anxieties and worries but concealed them; and the link between the "killjoy" role which both the doctor and the patient inhabited.

How the second session proceeded.

As mentioned above, the group responded with horror when the presenter recounted the violence of the patient, according to what he heard. From quite early on in the session, the group started to ask the presenter quite difficult questions:

- Were there any times at all, honestly, when you just wanted to say 'piss off'?
- How could you keep working with her?
- Why did you question what your consultant said about breathalysing her?

The presenter responds, "But I *still* feel I like her…" (conveying a sense of defending himself, as if he felt under fire)

I think to myself: the presenter has described how his feelings had turned against the patient. Now it looks like the group has also turned against the patient, as represented by the presenting doctor. For my part, I am aware of feeling irritated at the group for doing this, and notice a decrease in my ability to think in the face of the intense mixed feelings in the room (anger, outrage, feeling attacked, sympathy, confusion…). Grasping onto the idea that a Balint group leader should protect a member if they may feel under attack I say to the group:

"Pffuh, It seems really hard to think about this, it brings up very strong feelings… can I suggest it might be helpful to let the presenter sit back for a bit and see what comes up for us about all this?"

Without particularly realising it at the time, I tried to re-instate the classic Balint group structure of encouraging the presenter to sit back and observe, and to let the rest of the group work amongst itself.

The group then enters into a debate with itself (instead of with the presenter) about whether the patient is good or bad. After a while I comment that it is interesting the group is divided about this, as if she has to be one or the other (trying to maintain the Balint group stance of holding contradictions and looking for meaning). This leads on to new responses from the group:

- This reminds me of a patient from the ward who also told a story about herself that missed out the bad bits, I can see why you might do that
- I wonder what her background must have been like, for her to drink from a young

age – I'm guessing that it must have been pretty awful
- Maybe she had to embrace violence as that's what her family was like. Maybe it felt safer for her to be violent than be horrified by it

There is an ongoing switch between sympathy and repulsion, which leads to the group realising how hard it is for them, and presumably for the presenter, to hold onto both aspects.

Drawing on the Rüth / Bion model, it seems that in the face of disturbing material being communicated to the group, initially projective identification was taking place in a reversed way. In other words, the ideas and feelings that the group were unable to tolerate were re-projected back to the presenter (Rüth 2009). Hence the group directed tricky questions to the presenter as it felt overwhelmed by what was being projected into them. After I intervened and asked the group to think amongst ourselves and leave the presenter alone for a while, the dynamics of the group seemed to change. Within this different format (in fact, the classic Balint group structure) the group was instead encouraged to try and digest the material, rather than pass the disagreeable elements back to the presenter. This seemed to allow the group to survey new territory: feeling sympathy for the patient as well as horror; wrestling to comprehend how someone could commit a brutal act; and wondering how might someone manage interactions with others once they have been seriously violent towards another person.

Here are my notes about the end of the session:

The session ends without conclusions or answers. The presenter reflects that it is helpful to see that this situation is hard for the group – that it was not just him. I leave, however, wondering if the presenter may have some ongoing feelings of having felt under attack from the earlier part of the group.[2]

This has led me to reflect on the benefits of the classic Balint group setting, where it is routine that after the presenter has described the doctor-patient interaction he then "keeps silent, everything happens *within* the group working together like on a stage." (Rüth 2009) Might this have prevented or reduced the initial handing back of unmodified projections to the presenter? I wondered how some of the group's early questions to the presenter might have been reformed if they were kept within the group:

- "Were there any times at all, honestly, when you just wanted to say 'piss off'?" - if kept within the group might have been: "I feel like telling her to 'piss off'"
- "How could you keep working with her?" might have been "I don't know how the presenter kept working with her"

Subsequent to the preparing of this paper, I have, in fact, followed the classic Balint group setting, and found it beneficial in this regard.

1 I refer to participants in Balint groups as doctors, as the groups in this paper consisted of doctors; although, of course, participants need not be doctors.

A potential pitfall – the borderline between a Balint group and group psychotherapy

We must be careful what we say.
No bird resumes its egg.

Emily Dickinson (Dickinson 1872)

In the closing minutes of the second session a member turns to the presenter and asks:

> You said, 'but for the grace of God there go I,' when you were talking about the patient – I was wondering did this touch on something in you? About alcohol and how you could have taken a different path?
>
> I feel a sense of anxiety that something could happen that should not… but before I can think about saying anything, the presenter matter-of-factly says he thinks it does not touch on anything in him and the session moves onto other topics. I relax and the group feels safer again.

If the focus had not moved quickly away from his personal life I would have moved it on. This was a searching question addressed to the presenter that took me by surprise. This led me to reflect that putting people together and framing a safe space is a powerful tool. The Balint group, however, is not necessarily the right setting for doctors' sensitive personal matters to be explored. I try to hold this in mind to prevent overly personal disclosure by a group member to their peers that they might regret. There appears to be a tension between the leader's encouragement of participants to express their feelings and personal reflections, whilst also putting in a protective boundary around disclosing information that may not be in their best interests to reveal.

It is not that personal matters cannot be thought about per se; but that if they are we may be straying over the border into therapy. However, the members have not chosen to go into a therapy group, especially one consisting of their peers. The disclosure of a personal matter and later regret about this could therefore make the group no longer feel a safe enough place to explore feelings and reflections in connection to the doctor-patient interaction. This might limit the group's capacity to allow unthought-of and unbearable elements to emerge and be contained.

Endings

Both sessions ended unfinished and with some questions unresolved. As mentioned above, this is part of the process, and can help to validate the complexity and difficulty of the material that has been brought. Like the ending of a play or a religious service, there is then a transition back to world outside the frame. In the spirit of the Balint group, I will resist my urge to summarise or pull together or solve, but instead to end here, with things up in the air.

Note

Certain patient details have been removed or changed to preserve their anonymity. Consent for publication was given by the doctors participating in the Balint groups, except for one doctor who was uncontactable. The participant names have been changed.

Acknowledgments

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"What beast is this? Experience of Balint Groups"

By Dr M. McLoughlin

In this paper I would like to share my reflections on the nature of the psychiatric trainees' experience of Balint-style groups. These case-discussion groups are a mandatory part of Psychiatric training and serve as an introduction to psychodynamic concepts and a preparation for taking on supervised psychotherapy cases. I believe they also play a valuable role in challenging doctor's style of interaction with patients, help to develop capacity for reflection and for empathic support of their colleagues.

When I started thinking about this talk, my first feeling was anxiety and my first association was Lewis Carroll's "The Hunting of the Snark". Both perhaps are also applicable to the trainees' experience of Balint Groups.

I started leading Balint groups in the last year of my Core Psychiatry training when I resembled the Bellman in the poem, who "Had only one notion for crossing the ocean, and that was to tingle his bell". Like the Captain in the poem I had arrived with a map that was "a perfect and absolute blank!" and had to serve out additional rations, literal and metaphorical. It was certainly an experience of learning on the job, frustrating and enjoyable in equal measure. I was also grateful for having previously worked as a co-therapist in a psychoanalytic group and being familiar with group dynamics since, to an extent, it helped me to contain my own anxiety.

From the trainees' point of view, Balint group discussions might be equally daunting, and frequently it feels as if they are on a quest for an animal they have never seen before and that the process of discovery would lead to disastrous consequences. On the other hand these sessions also allow trainees to venture into lands hitherto unknown and play with various ideas in an unrestrained and humorous way.

The first, often unvoiced, and ongoing question is "What is a Balint Group?" Perhaps one way of answering this question is to think back to psychoanalysis as the origin of these groups. Freud in 'Analysis terminable and interminable' said that "the analytic relationship is based on the love of truth – that is, on a recognition of reality – and that it precludes any kind of sham or deceit" (Ref 1). Ferenczi developed this idea further, applying it to his own feelings in an analytic situation and was first in using his emotional reactions as a tool for understanding the process of analysis. Ferenczi thought of the countertransference as an opportunity to increase understanding and empathy with his patients (Ref 2). It is not surprising that a man, who was Ferenczi's analysand and pupil, continued this process in his own analytic sessions and later on in developing his groups with General Practitioners. Balint's propositions also placed on the analyst a great demand for personal investment, "a high degree of honesty and much sensibility" in their work (Ref 3).

On one level a Balint Group is an educating group based on case- presentations within a small group of professionals. On a deeper level it is a group devoted to understanding doctor-patient interactions through frank discussions of the practitioner's countertransference feelings and often that is a difficult place to be in.

In a traditional Balint Group up to ten general practitioners would meet in the same group, in the same setting for a number of years and the patients' progress could be followed up (Ref 4). In that sense Balint Groups in a psychiatric hospital are different but they still follow the principles of more traditional Balint Groups. We still have open-minded discussions of doctor-patient relationship in a safe environment with the aim of encouraging the doctor to see their patient as another person and reaching a deeper level of understanding of the therapeutic interaction.

Over the course of four years when I was leading a Balint-style Group for trainees at the Royal Cornhill Hospital my groups consisted of first year Core Trainees in Psychiatry, GP trainees and Foundation Year 2 doctors on placement at the hospital. The groups were held for one hour throughout the year, on the same day and at the same time. Attendance was mandatory for Psychiatry trainees but voluntary for GP trainees and the FY2 doctors.

The group membership was fluid. Core trainees were in the group for the whole year but the GP trainees were there for six months and later, due to a change in the local curriculum their placements got shortened to four months. FY2s were always on 4 months placements. It is interesting that each year trainees would also invite medical students attached to their team and these students would come to the group for one or two sessions. I had always hoped that these invitations were an altruistic and appreciative gesture on the part of the trainees rather than a sadistic wish to share an anxiety-provoking situation with an unknowing student.

An additional feature was that attendance was not, and could not have been, consistent and regular. This was due to multiple on-call duties, special study days, annual and study leave in preparation for the College membership exams.

In the first three years I lead the group by myself but in the last year I had help from one of my colleagues in the Department, who became a co-leader for these meetings.

Tea or coffee and biscuits were provided as I felt it was necessary to create an atmosphere of ease that would be different from the atmosphere of a ward or of a tutorial and that would allow some space for reflection. At times I observed that trainees would take more biscuits on leaving a session that felt especially productive.

As I mentioned earlier, trainees had no experience and no real understanding of what Balint Groups were like so it was necessary to prepare them. Initially I would spend the first session getting to know each other and explaining what the group is about and what it is not. I would always be very clear that even though the Balint Group is an opportunity to discuss emotions it is not a setting for personal therapy and that whatever is spoken of in the group stays in the group. In the last two years I also gave a more formal talk about the basic psychodynamic principles and defence mechanisms before starting the group meetings.

At the beginning of each group a trainee would present a case that they found puzzling, challenging or difficult and the other members of the group would ask questions and then offer their reflections on the situation.

Over the course of 4 years with different groups of medics I noticed a few trends in functioning of the Balint-style case discussion groups. I shall speak of each of them in turn.

First of these observations was the fact that:

- Many might attend the initial meeting but several doctors would fail to return to subsequent meetings. Those, whose attendance was mandatory did come but at times gave excuses of forgetting or being busy on the ward or in their own CMHT. Doctors, who attended regularly, were usually already interested in psychological matters and got the most benefit out of Balint Groups.

I think this happens because for many reasons being in a group is an anxiety-provoking experience. Junior doctors are used to functioning as part of a team but they are trained to take on a specific role that comes with a task list particular to that job. A Balint-style group offers a completely new environment where the focus is not on practical tasks but on one's own emotions in relation to one's own work. Add to the mix the fact that these discussions happen in a group of peers where professionals with highly critical superego feel de-skilled and vulnerable and one can understand why this situation may be experienced as frightening and even persecutory. Some trainees manage this transition better than others.

I also agree with the authors of the 2009 paper evaluating Balint-style case discussion groups (ref 5) that another explanation of doctors dropping out, attending inconsistently or being persistently late may be related to the fact that these groups are potentially good at picking out medics "lacking in reflective functioning and/or the ability to work effectively in group settings". Trainees, who are interested in reflecting on their work, tend to return to Balint Groups and make good use of this opportunity to expand the range of their skills.

- Lateness was frequent despite the fact that I was trying to maintain firm boundaries.

Frequent lateness may be related to the anxiety I spoke of earlier but I also wonder whether it might be related to the general culture of the NHS where the understanding of timing is rather loose. This in turn might be explained by the constant feeling of pressure to manage one's work and the wish to find ways of relieving this pressure.

- The group was frequently silent at the beginning and after a case was presented.

I believe the main reason for silence is related to uncertainty, the anxiety of not knowing what the "correct" thing to say is and a desire to avoid sounding "stupid". This was usually managed by asking multiple questions of the presenting doctor or even by bringing out a similar or a different situation of one's own. As the groups progressed from being new to free-flowing discussions to being well acquainted with this approach silences became less frequent. The trainees also understood that having a ready case to present was more conducive to learning than sitting in tense silence.

- The doctors tended to present the problem in terms of diagnosis, management and solution-seeking and were reluctant to say what it was like to be with the patient.

At times they would not know much about the patient's upbringing or past significant events.

Usually trainees started their presentations by speaking in a stilted, generic medical manner, listing the patient's symptoms and the management plan. It took a lot of encouragement and leading by example for the trainees to begin exploring their own emotions in relation to their patients and what these emotions signify. Falling back on a familiar way of presenting in a situation of uncertainty is not surprising. Uncertainty is uncomfortable and doctors are taught to seek answers and to come up with solutions. When a solution is not easily available we are likely to feel totally at sea.

Finding personal information about a patient brings the situation into a more personal realm, where the patient's background might be recognized as similar to one's own. Also, many of the cases presented were assessments out-of-hours when there is more of a pressure to dispose of the patient as quickly and as appropriately as possible and this pressure might influence the doctor's decisions on what information they seek.

- Similar cases were discussed a lot. ("They sought it with thimbles, they sought it with care…")

The cases brought up for discussion were most often the cases of managing patients with a diagnosis of personality disorder, both out-of-hours and within a CMHT. These patients require consistency, don't respond to short-term management plans and are highly likely to provoke in a professional a strong emotionally primitive response. The retaliatory attitude to such patients was described in Tom Main's "The Ailment" (ref 6), and I quote from it - "The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment." Intense feelings of hatred for patients are usually well-hidden by trainees but these break through in discussions about the patient's manipulative behaviour and the desire to get rid of the patient and never see them again. Sending the patient into space in a hot-air balloon has certainly been mentioned in my groups.

One of the ways of emotional defence is to see all vulnerability as belonging to the patient and all fortitude as belonging to the member of staff. There is an ongoing need to remain as professional as possible, feeling detached and superior, maintaining as Balint described it, the "apostolic function" – firmly held personal beliefs on how patients should participate in their treatment and how they should behave with doctors. This, however, does not really manage the emotions experienced in the 'here and now' so trainees return to the discussions time and time again. Perhaps this is a demonstration of the usefulness of the Balint Groups that allow for repetition and gradual working through.

- Death or any other ending was rarely discussed though self-harm was often spoken of.

There was a reluctance to mention endings, especially death. In my experience in the group, there was only one presentation of an elderly patient, who was likely to die on the ward. Risk of suicide was discussed often but in an abstract and detached way; the trainees thought more about the potential risk of critical incident reviews than about what wishing to be dead might be like. I wonder if as medics we don't often concentrate on

endings but move from one beginning to the next in a partially oblivious way since any kind of loss is hard to contemplate.

- I, and my co-leader later on as well, had to speak in the group more than a leader of a traditional Balint Group would.

Traditional Balint Groups are consistent, regular and have a stable membership of experienced professionals. Case-discussion groups for trainees in Psychiatry are very different. Trainees are mostly unfamiliar with psychodynamic concepts. Even if they had psychotherapy teaching as medical students they safely put it out of their mind as soon as the finals are done and gone. On top of that, as often as every 4 months, they are trying to fit into a new team, the new demands of a job and manage the emotional responses this job provokes. It is a necessity that psychiatric trainees' case-discussion groups should be led in a more supportive manner than the traditional groups. The leader needs to remain active in order to maintain an atmosphere of safety; at times this involves a brief explanation or a reminder of psychotherapeutic concepts. Prolonged silences are unhelpful as they encourage feelings of persecution, intensify anxiety and reduce the capacity for reflection. The leader needs to pay close attention to individual and group expressions of upset, anger or manic defence and manage these without recourse to individual or group interpretations. I also found that it is important to return time and time again to what patients' feelings might be as trainees ignore these in favour of the discussion of clinical management. In short, I often felt as a mother described by Bion, who is on the receiving end of the infant's beta-elements and who has to manage these in order for the infant to survive emotionally.

Based on my experience of leading the Balint Groups I would say that

- Change in thinking styles and interest in psychological matters does develop to various degrees in most regular attendees.

From personal experience I can say that trainees who attend regularly learn to question their countertransference and use it in their interactions not only with the patients they discussed but also with other patients and the members of staff.

I had regularly asked for feedback and it is interesting that the written feedback I got was always positive. The trainees would say that they found the group of use and helpful in thinking about difficult cases, that the group of peers is "a good opportunity to learn from each other's experience", that "sharing one's thoughts and feelings with others is a good alternative to what often is a solitary job" and that it is "very helpful to identify the impact of certain cases on your reflections of the cases".

When I had asked for trainees opinions in a more informal way I was told that being in a group is "false in a way, we speak to each other at lunch-time", "we do reflect all the time, there is no need to come here" and that things are "easier in other jobs than in Psychiatry". As I mentioned earlier, trainees consciously or unconsciously realise, that it is simpler to deal with physical or mental problems reduced to the point of concreteness (such problems are easier to externalise) than deal with an abyss of a patient's mind, which always gazes back at you.

I believe that both positive and negative opinions of the Balint Groups are true. There is an initial reluctance to engage in an alien way of being and for some trainees this reluctance persists despite the mandatory attendance of psychotherapy teaching programme. There is also a gradual acceptance of an alternative perspective on patient-doctor relationship and a deeper understanding of the usefulness of the countertransference.

As I continued leading the groups I started thinking more and more about the medical student training and the training of future psychiatrists in particular. Often I would see enthusiastic medical students, interested in their patients but by the time they arrive on the wards as doctors some of that enthusiasm has been lost. In the current curriculums of the Medical Schools there are tutorials and lectures dedicated to communication with patients and ethical questions, there are even lectures on psychotherapy but it seems there is no space dedicated to considering the future doctor's feelings about their relationships with their patients. On a few occasions that I brought this topic up when teaching medical students I was met with a tense silence or a laughing dismissal.

We are all individuals but we all are also the members of our profession, a specific group, and the culture of this group begins to penetrate our very being from the day one enters the Medical School. As Malcolm Pines put it " The full nature of an individual's psychic reality can only be seen by situating the person in context, on the ground from which they originate" (Ref 7). By the time trainees reach psychiatric wards it is already in their nature to speak of patients in terms of symptoms and diagnoses and willingly consider the necessary treatment but to keep personal feelings well hidden. When they encounter the Balint Group it comes as a shock akin to encountering a Snark because in these groups we are asking trainees to forsake their defended style of consultation and go against the medical training.

Perhaps it is also important to ask who are the doctors coming to train in Psychiatry, what their work place is like and to what extent are they aware of difficulties of their job?

Tom Main stated in "The Ailment" that doctors "undertake the work of alleviating suffering because of deep personal reasons" and "that the practice of medicine, like every human activity, has abiding, unconscious determinants" (ref 6). Trainees in Psychiatry choose the specialty because of a conscious interest in the workings of the mind (or because they think it's an easier job than Surgery) as well as those personal, at times unconscious, reasons Tom Main spoke about.

In a psychiatric hospital the emphasis is necessarily on the mental and emotional suffering of our patients and, unlike in a general hospital, there is little opportunity for a newly starting doctor to deflect the awareness of this suffering somewhere else. Therapeutic failure is frequent, many patients have chronic illnesses and the wards are full of 'revolving door' and long-term patients. Psychiatry is a field that has difficulties in recruiting doctors, training numbers have been reduced over the years and staffing is often a problem. In addition, depersonalization, detachment and denial of feelings are implicitly reinforced by the system (Ref 8) although staff's personal opinions might be different.

When Foundation Year 2 doctors apply for specialty training jobs they might or might not have had previous experience of a psychiatric placement. If they have then they are aware that despite their liking for the profession it is a job resembling fire fighting. If they had not then they are in for a surprise.

All of the above puts the trainees under pressure 'to manage' work at any cost, to find solutions at the expense of seeing the patient as another human being and of repressing their own emotions. Failure to attend to emotional reactions provoked by clinical situations is likely to lead to acting out on primitive libidinal or aggressive impulses, subsequent treatment mistakes and iatrogenic harm. It can also cost dearly to the doctor as increased stress levels may lead to burnout.

Psychotherapists from medical and other mental health backgrounds are well placed to offer psychiatric trainees the necessary guidance and support. Likely this requires consistent "feeding" within the Balint Group setting until a certain flexibility of thought could be established and maintained. Like the Snark that, frightening and mysterious though it is, is still an opportunity for an adventure and a reason for not drifting off course, Balint-style groups are an opportunity for psychiatric trainees not to get lost in more senses than one.

I would suggest that starting Balint-style case discussion groups in Medical School and continuing them throughout the span of a doctor's working life might be helpful. By not offering students a chance of considering their feelings in a professional context at an earlier stage in their career we might be failing in guiding the most suitable candidates for psychiatric training and losing potential colleagues. Doctors, who on the other hand chose to become psychiatrists, do so without being fully informed about what being a psychiatrist really entails.

Being a psychiatrist is a challenging job. We don't have sophisticated scanners or other complicated diagnostic and treating equipment to help us to do our work. We have our minds and our feelings and in that sense we are the instruments that could promote or delay our patients' recovery.

Perhaps being a good psychiatrist is similar to being a "good enough mother" and this can not be formally taught but is arrived at only from within, linked in the first place to a spark of curiosity about one's own condition. The role of the Balint Groups is to promote this curiosity and in doing so to train good psychiatrists.

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The Problem of/with the Elderly Patient

Most media headlines are concerned with ageist comments arising out of dire treatment of elderly patients in the NHS. But there is another problem which receives scant attention, and that is there may be pitfalls when good doctors seek to be consciously un–ageist. In 2010 my excellent GP was seduced by a research paper which advocated being rigorous in the prescribing of anti-hypertensives regardless of the age of the patient. My wife, Jane, had had long-standing labile hypertension, originally treated with a diuretic but changed to enalapril after the dosage of the former had come under scrutiny. Seeking to control her blood pressure more rigorously, the dose was steadily increased from 2.5 mg a day. This very low dose was instituted because Jane is very sensitive to all drugs, and I blame myself for not emphasising this point. 5mg a day was tolerable, 10mg led to fainting after a week, then 20mg was prescribed but was never administered because I realised this increasing of dose was toxic. Jane developed a lower respiratory infection, which probably had nothing to do with enalapril, but which became serious and needed hospitalisation. Unfortunately she developed confusion which has persisted until the present day. This has left me as her principal carer. 18 months ago I awoke one morning with a severe loss of balance. I saw the registrar at the surgery, who I found quite splendid. I thought of his handling of a 90 year old, retired GP was superb. After a thorough neurological examination and when he had taken my blood pressure, he just handed me the digital syphgnomometer, showing my very raised reading. A cerebellar stroke was diagnosed and I have been on a calcium channel-blocker and low dose asprin ever since. But is it a good idea? If I wasn't a principal carer I think I would give up the medication. I've got to die of something, and would prefer it not to be prostate cancer. My last surviving school-friend died of a myocardial infarct a month before his ninetieth birthday. Is my medication protecting me or sentencing me?

Mike Courtenay

From the Outside, In:

Reflections on the Balint Annual Oxford Weekend Meeting 2012 from a first-time participant

I had heard of Balint Groups, and years ago even knew contemporaries, training in general practice, who attended them. But I had never attended a Balint Group, and was not even sure they were still in existence. I had certainly never encountered them in a career in secondary care. So I had not thought to explore their potential until recently, as part of a growing sense that the time is right to revisit how to provide long-term support to healthcare practitioners in ways that are effective and sustainable. When the poster for the Oxford weekend appeared, on one of the many boards along the many corridors of my hospital, it struck a chord, and I made arrangements to attend.

Though Balint was a new experience, I am not new to reflective practice or the power of a peer group to provide support, challenge and new insights. Perhaps revealingly, though, my journey to Balint comes more from insights I have gained through leadership coaching and mentoring in the course of several years as a Medical Director, than it does from my clinical practice.

In the latter, which has focused on a sub-specialty interest in bone and joint infections, we have many challenging patients with complex physical and, usually, attendant psychological, morbidity. As a team we have acknowledged this, but done little to move beyond that acknowledgement. Doing more remains an unfinished work. But as a medical manager, it seems more and more clear to me, over time, that many of the present-day dysfunctions in healthcare owe much to our collective inability to recognise and counter the psychological impacts on the carer of the process of delivering care. That failure assumes an organisation-, an NHS-, and a profession-wide significance because of the likely role it plays in creating organisational cultures that fail staff and patients.

And suddenly, of course, areas that have occupied the members of the Balint Society in thought for many years have now become topical and urgent to the wider NHS. In the wake of the second Francis Report, how to assure the sustainable delivery of compassion has become a pressing matter. And while we await formal responses to the Francis Inquiry from the Department of Health, perhaps we could do worse than to think about the potential impact of providing safe spaces for groups of healthcare professionals to process individual cases that are creating emotional challenges for those practitioners, so that they might increase their wisdom, resilience, and recharge their compassion through the process?

When I attended the Oxford weekend I had little idea of what would happen beyond a basic understanding that cases would be discussed in a group. I was impressed by the open and welcoming nature of the whole meeting, while also being intrigued by the longstanding "Icelandic connection" that brought an additional diversity and universality. The work group to which I was assigned functioned well; I was very struck by the simplicity, and the "portability", of the reflective model in use. Doctor presents case… .group clarifies without problem solving….."pushback" to take doctor physically slightly out of the group, while still being present, emphasising doctor's temporary removal from the case….group discusses doctor's case in the third person and with an emphasis on

hypothesising and curiosity, not judgement or lecturing....doctor rejoins group to close discussion. It was simple and effective, and one could see immediately how it could translate to a meeting of any willing group, uni- or multi-disciplinary, clinical or even, perhaps, managerial.

I am sure that my experience is in part a reflection of the skill of the two group facilitators, but it does also illustrate the robustness of the process itself. I could see how, while I might be bringing my own awareness of group dynamics to it, it could work well enough with practitioners who might not have a strong interest in such ideas. The "light touch" around the psycho-analytic premises, to the extent that it would be possible to attend a group with no understanding of an underlying theory beyond "tell us a tricky case and we will chat about it for you", was quite surprising, but equally, made sense. What did strike me was how at the first level, the "processing" of one doctor's problem provides a potential benefit to him or her, while also being an enactment of a parallel issue I might be experiencing with one of my own patients. The discussion about the doctor's case therefore has resonance for my own, both in the insights that others offer, and in allowing me to benchmark my own views and responses against those of my peers, something that is helpful in allowing me to calibrate my own behaviours and consider areas of vulnerability.

When it came to my own presentation of a case, there were of course unexpected perspectives from others in the group, as my blind spots were brought into consciousness. That in itself was beneficial, but what also struck me was the sense that for the period of the discussion, the burden of that case is lifted from the presenting doctor, to be carried collectively by the group until, at the end of the discussion, it is kindly and calmly handed back. This is not to say that I am one to be overwhelmed with ruminations about my patients, indeed, I am generally not; but I believe that the burdens of providing care are not all consciously experienced, but are present nonetheless. If carried off effectively, sharing those burdens, however briefly and however tangentially to the actual encounter with the patient, offers a moment for renewal and a chance for the doctor to provide better care next time, or simply to "stay the course".

Other elements of the meeting were interesting too; good fellowship among like-minded individuals, and some interesting plenary discussion including the "mass group" session. But the main impact on me was, as expected, experienced through the group work, and I found it stimulating and intriguing.

What now? I have not rushed to find a group to attend more regularly, but that reflects more the day-to-day hurly-burly than any lack of interest. But I am actively pursuing a series of discussions about how a range of methods, one of which might involve a structured meeting such as is conducted in the Balint group, might not only be translated into more broad clinical and even healthcare managerial contexts, but also be rigorously evaluated for effectiveness. Even without the pressures we face at present, further consideration of what Balint has to offer would have seemed desirable; in the post-Francis era, mixed in with so many other issues that society, politicians and individual patients are bringing to healthcare, it now seems mandatory. If not now, when?

Anthony Berendt
Oxford, March 2013

A project for the introduction of Balint groups in Greece

In November of 2012, Dr Jonathan Sklar, a prominent psychoanalyst of the British Psychoanalytical Society and Balint group leader, was invited by the Hellenic Psychoanalytical Society to give a lecture on a subject that wasn't directly relevant to Balint groups, but included nonetheless a patient presentation. During that time, two of my colleagues[1] and I were contemplating the idea of forming a peer supervision group, and were looking for a theoretical model of supervision to base our group on. When I attended Dr Sklar's lecture, I was impressed by the warmth and vivacity of his clinical presentation, and timidly went to congratulate him and tell him that I had never been so moved by a clinical presentation before. Intrigued as I was by his clinical perspicacity and sensitivity, I read the biographical note that accompanied the invitation to his lecture, and, there, I came across the term "Balint group" for the first time. When I learned that Balint was a psychoanalyst - and as I was training to become one- I immediately felt that this method could work well for our group. However, at the time, neither I nor my colleagues had thought that we could try to introduce the Balint method to other health professionals yet. As we saw it then, this was something that would help us –and those who would join later- to become better therapists.

In the beginning, although we followed the basic rules of Balint groups, we didn't have a permanent group leader and we all presented cases alternating in the position of the leader. As soon as a couple of more colleagues expressed their wish to join our group, we knew it was time for one of us to be trained as a leader, since the group now needed a fixed coordinator. And as I was the one who was more acquainted with the method, the role was assigned to me. There was no question of finding a training setting in Greece, since Balint groups had only had an ephemeral and informal presence here -in some hospital settings- and then disappeared, probably because there wasn't a formal organization (e.g. a Balint society) to support them. Thereafter, I sent an email to Paul Sackin -whom I had found through the IBF website- and he encouraged me to look for training in another country. As I used to travel to France more often than the UK, I contacted the French Balint Society first, only to be informed, to my disappointment, that the new training group would run on a week day and on a frequent basis, something that made my training there impossible. A proposition was made by the French Balint Society[2] to organize group meetings in Greece, provided that a sufficient number of participants would gather. Unfortunately this wasn't a viable option for us as we were very few.

After this drawback, I momentarily lost my optimism, only to regain it when I read on the Balint Society webpage about the structure of leadership training in the UK which made training possible for someone like me who lived in another country. I remember exchanging a number of emails with Ceri Dornan and Caroline Palmer who welcomed and guided me through my first steps before even meeting me in person. And if my first acquaintance with the Balint spirit, through Dr Sklar and his lecture, got me interested in Balint groups in the first place, my first weekend at Whalley Abbey prompted an important psychological investment in Balint groups on my part. It was the combination

1 My colleagues were Ms Daphne Papanikolaou and Ms Ntina Bezioula who are psychologists and psychotherapists. They are members of our group and the British Balint Society and Mrs Papanikolaou will begin her leadership training this year.
2 My communication was with Mrs Alice Polomeni who was extremely kind and supportive in my quest to find a setting to do my training.

of two factors that made me decide that this was really something worth pursuing and passing on to others.

To begin with, it was the spirit of collaboration and sharing that made me feel I belonged there even though I was a foreigner and a newcomer. People were amazingly friendly and hospitable. And they were all clinicians! This was hard for me to believe because usually among health professionals relationships are mostly marked by competition, elitism and assertion of authenticity. So being among colleagues who wanted to help me to do my job better was something new and inspiring to me. Then, it was the group experience per se that was incredibly interesting and stimulating. My group was led by Gearoid Fitzgerald and Caroline Palmer and the rest of the members were all GPs. I didn't know what to expect when I entered the room where my group had gathered but anyone who has attended a Balint weekend knows it can be a life-changing experience. I still recall in awe how my group peers –who I suppose didn't know much about psychotherapy- helped me with a difficult psychotherapy case, a young patient that I still see in my private practice and often wish I could present again in a Balint group. Of course, I have the privilege to be the leader of my group, but I often miss being a member, as the only chance I get to be one, now, is only in international meetings. However, I do hope that after we train more leaders in Greece, with the help of the Balint Society, we will run leaders' groups in which I will have the opportunity to present my clinical cases on a regular basis.

In that weekend, I also had the chance to meet there David Watt who spoke to me about Sotiris Zalidis, a GP and Balint leader who lived in London for most of his life but was originally from Greece. David suggested that I should meet him, as he could probably help us in our effort to form a proper Balint group, and perhaps introduce the method to physicians and other health professionals. The idea sounded promising, and, not too long after the weekend, David brought me in contact with Sotiris who had an impressing resume as a doctor, group leader and educator. In his next trip to Athens, we met in person and had our first discussion about our project of introducing Balint groups to health professionals in Greece. I remember Sotiris being a bit pessimistic regarding the possible acceptance of the method by Greek physicians, since, as he remembered, a previous attempt was made by the rapporteur of psychosomatic medicine in Greece[3], an attempt that proved short-lived. What we didn't know then –but found out later by doing some research - was that this wasn't the only occasion that Balint groups were formed in Greece, as Balint-type groups had been organized in several hospitals in the past decades.

In our first meeting with Sotiris, we laid the foundation of an important collaboration and we both expressed our ambition to organize a Balint weekend in Athens in the near future. Our ambition was fulfilled less than a year later, when Sotiris travelled to Athens to co-lead my group composed of five psychologists and one neurologist in February of 2014. It was a stimulating experience in which our group members had the opportunity to witness a different leadership style and participate in a group where there were more than one doctor, something that brought variety and pluralism of thought to the group and was very educative for all of us.

Of course, the task of bringing Balint groups to Greece hasn't been a path strewn

1 My colleagues were Ms Daphne Papanikolaou and Ms Ntina Bezioula who are psychologists and psychotherapists. They are members of our group and the British Balint Society and Mrs Papanikolaou will begin her leadership training this year.
2 My communication was with Mrs Alice Polomeni who was extremely kind and supportive in my quest to find a setting to do my training.

with roses. We as a group, and I personally, faced many difficulties from the beginning, and if it wasn't for my supervisor, Gearoid Fitzgerald, it is very probable that I would have lost heart in my role as a leader and coordinator of this project. As a psychoanalytic candidate I know –and of course Balint himself knew from his own training at the Hungarian Psychoanalytical Society- that supervision is very important when one deals with the unconscious dynamics of a person or a group. If you add to that your own unconscious and the blind-spots it creates, then it's self-evident that you need someone who can "see" what you can't. And in leadership training this person is primarily your supervisor. Given that our project was something completely new and the participants didn't know much about the Balint method, it is understandable that quite a few misunderstandings, mistakes and conflicts occurred on the way. Fortunately, and thanks to Gearoid's contribution, reparations, corrections and improvements followed. After almost two years, I can say that I feel more confident about our task. Our group is more solid, the members know how to do Balint work and we all have the development of Balint work in our minds. This is why we created a webpage and an electronic newsletter in both Greek and English. Also, we will participate in an international psychiatry congress[4] that will take place in Athens in October where we will speak about Balint groups and our work, and organize workshops for next year in order to give the opportunity to more people to sample Balint work. We are oriented towards attracting more participants from the medical field, as, until now, we mainly have more psychologists and psychotherapists interested in joining a new group.

I hope and believe that Greek physicians are more ready than before to be trained in a method that perceives the patient as a psychosomatic entity and considers the doctor-patient relationship as an indispensable part of treatment. Moreover, the GP specialty has just begun to thrive in Greece and more Greek physicians of various specialties are trained abroad (mainly the UK, USA, Germany and Scandinavian countries), and return to their country to exercise their profession. Many of them are exposed during their training to clinical environments in which the patient plays a more active role in his treatment, even if their medical approach can't be qualified as "patient-centred" in the strictest sense. I think that these doctors, and especially the younger ones, will be interested in a method that not only helps the clinician to become better at his job but also provides a context for psychological support and solidarity. And especially at a time when a country and its people are going through an economic and social crisis, professionals that are involved in providing care to others need all the support they can get.

The 2nd Athens Balint weekend will take place from the 21st to the 22nd of February 2015 with Dr Gearoid Fitzgerald as a guest co-leader of the Hellenic Balint Group.

Lida Bitrou
Clinical Psychologist
Psychoanalytic Candidate
Accredited Balint Group Leader

4 2nd Interdisciplinary Congress of Psychiatry and Related Sciences (30 October-2 November 2014). For more information please visit http://www.psych-relatedsciences.org

Interview with Dr. Sotiris Zalidis, General Practitioner and Accredited Balint Group Leader of the British Society, to Daphnetatiana Papanikolaou, Member of the Hellenic Balint Group

DP: *How did your involvement with Balint start? What aspects of Balint work moved you the most? Tell us your story.*

SZ: I first became interested in Michael Balint when I read his book "The doctor his patient and the illness". When I first read it, Greece was still ruled by the military junta. I entered the medical school of Athens in 1967, at the start of the dictatorship and graduated in 1973. I was one of those students who were against the oppression. I was a member of a group that were against the authoritarian rule of the dictatorship and wanted to find a way to oppose it. I thought that as medical students we had to find a way of resisting that was appropriate to the work we were doing. When I first read Michael Balint's book I was very impressed by the antiauthoritarian spirit of his work that I thought was revolutionary. He talked about doctors treating patients with respect; doctors who did not force the patients to comply with whatever they were advocating, but who actually tried to understand what was exactly going on with their patients. For me it was a revelation. So I started reading Balint's books that were exploring the application of psychoanalytic ideas to medical practice before I even graduated and this knowledge resided within me.

I went to London in 1974 in order to become a psychoanalyst. I started my personal training analysis and I gradually realised that my heart belonged to medicine. Psychoanalysts can only listen to their patients but cannot examine their bodies..So i gradually started to change my mind and decided that psychosomatics was an area that interested me much more. I therefore left the field of psychiatry and psychoanalysis and switched to medicine. But after I started working as a doctor I soon realised that I was still very interested in psychoanalysis (laughter) and I did not want to abandon it altogether. Besides, I had invested a lot of energy in psychoanalysis.

I wanted to find a branch of medicine that would allow me to combine my interest in psychoanalysis and medicine. In 1986 I went for advice to Michael Courtenay, one of Balint's closest associates, who suggested that General Practice would be the specialty that would satisfy mydouble interest. With his support, I applied for a job in 1986 to a group practice where the senior doctor was a member of the Balint society and my application was successful. I have been a general practitioner since then and a member of the Balint society and have been attending regularly the annual Balint weekends organised by the society. Initially there was only one Balint Weekend a year but recently the interest in Balint work is increasing and at present there are four. In Oxford, Newcastle, Manchester, Ireland.

I have also been involved in co-leading (with the Director of the Psychiatric Clinic) Balint groups for third year medical students at University College Hospital.

This is one of the few hospitals in the UK that has a student psychotherapy scheme. This training is part of the student's psychiatric training and encourages interested students to take a suitable patient for psychotherapeutic treatment for a year under supervision from senior psychotherapists of the department. This scheme proved so successful that more and more students declared their interest to participate until there were not enough suitable patients for every interested student (laughter).

So the Balint groups were introduced in order to give these students the opportunity to recognize the idea that emotions are very important for sick patients and that doctors had to be able to talk about these feelings.

DP: Balint work is an established part of medical training in UK hospitals. What do you think is the greatest contribution of Balint to doctors?

SZ: Is not established in all medical schools yet. Medical education in the UK is based on teaching hospitals and not all teaching hospitals have Balint groups for their students. As far as I know, there are three hospitals in the UK that have a student psychotherapy scheme that involves Balint work(University College Hospital, King's College Hospital and Bristol). However, there is an increasing attempt to include teaching of emotional aspects of patient care in medical schools. This trend has been driven by reports of poor patient satisfaction with the doctor's attitudes to patients. Some doctors behave like mechanics of the flesh and ignore the emotional impact their behaviour has on the patients. Balint work helps doctors appreciate the importance of emotions in shaping the outcome of the medical treatment.

DP: *Is my understanding true that in the UK individual doctors are also interested in Balint work, beyond the hospital requirements?*

SZ: Yes, it is true. But the doctors who are interested have a certain psychological mindedness. Traditionally, it is the general practitioners who are seeking participation in Balint groups because they are in contact with the same patients over a long period of time and very often it is not the medical difficulty that creates a problem but rather their difficult relationship to the patient can be problematic. Another group of doctors who are introduced to Balint work in their training is psychiatric trainees. And of course, any doctor from any speciality who is interested to discuss the difficulties in his relationships to his patients can join a Balint group. It is not compulsory to attend Balint groups but it is recommended as a constructive experience that can increase the understanding of the emotional communication between patient and doctor and of course protect against burn out in the doctor.

DP: *In your opinion, what are the greatest difficulties encountered in Balint work?*
SZ: When Balint groups first begun, the doctors met weekly. Gradually the frequency of meetings became less and at present most regular Balint groups meet once a month.

DP: *Why so infrequently?*
SZ: Because doctors are so busy. This is the greatest practical difficulty. The difficulty during the group work concerns the psychological defences of the doctors. They feel guilty when patients arouse negative feelings in them. Michael Balint taught that the doctor's feelings can become a guide for the understanding of the patient if they are viewed as

symptoms of the patient's illness. However, this is a difficult notion to understand and accept. Doctors can feel exposed if they admit that sometimes patients can arouse violent feelings in them. They need to develop awareness before they are able to open up.

DP: *I imagine how difficult the role of the co-leaders must be if the members of the group are not used to talk openly about the way they feel. They must not only protect the members of the group from criticism and create a safe environment but must also encourage them to talk. A double role therefore.*

SZ: You are right; one needs to be very careful.

DP: *We would be very interested to hear an experience from your journey that was very important in your development as a Balint doctor.*

SZ: Do you mean an individual case or a group experience?

DP: *It could be both. When I was composing the question I had in mind an individual case, judging from my own experience that some cases move me more than others. However, for a co-leader it may be a group that stands out more than others.*

SZ: In my case it is neither. I am very grateful to the Balint Society for recognizing my interest in psychosomatic work, especially the way I manage the hyperventilation syndrome. This is a condition that is characterised by a cluster of frightening physical symptoms that occur when the breathing pattern of the patient changes from the calm diaphragmatic pattern to an upper thoracic pattern that represents a posture of mobilisation. The patient feels that she cannot take a deep enough breath. I have a lot of patients who suffer from this syndrome when they are stressed. I wrote and presented a paper on this topic at the Balint Society that proved to be very successful. This success established me as a Balint doctor and encouraged me to continue with the Balint work. For me it is not only the discussion in the group that matters but also the way I deal with patients who present with psychosomatic problems. I am very interested in the way some physical symptoms can be understood as related to the physiological mechanisms that mediate emotional arousal. Instead of attributing every symptom to a medical disease, the patient can be helped to recognise, understand and modulate the emotions that can bring about an amelioration of the symptoms.

DP: *We have just started Balint groups in Greece but in Europe Balint groups are fairly common. As a Greek who works in England do you have an explanation as to why Balint groups did not become established in our country?*

SZ: Balint work is established in countries that have a strong tradition of primary health care. In particular, they have taken root in the UK, Sweden, France, Holland and Italy. In Greece we never had a tradition of primary health care. In London for instance, every neighbourhood has its own primary health care centre where groups of doctors work and who are responsible for the health of the population throughout their life cycle from the cradle to the grave. I have been working in the same group practice since 1986. I have had an ongoing relationship with most of my patients for nearly thirty years, and some of these relationships can be intense and I need to discuss them in Balint groups in order to take a new perspective and tolerate the stress they cause me.

DP: *All this sounds very interesting. A whole network of primary health care centres in every neighbourhood! We are envious (laughter). What kind of training do you need to have in order to become an accredited leader?*

SZ: The details of the training are laid out in the website of the British Balint Society. But essentially to become an accredited leader you must be a member of a helping profession such as a doctor, a psychologist, a psychotherapist, a social worker, or a nurse. You must have attended a certain number of Balint groups as a member and you must have co-led a certain number of Balint groups with an accredited leader.

DP: *Is supervision compulsory?*

SZ: It is recommended. In London we have Balint Leaders Workshops that meet four times a year. In these groups the leaders present their groups and the work is discussed among the experienced group leaders. The work we did during this first Athens Balint Weekend will be presented in one of those weekends.

DP: *Will you present the work jointly with Lida Bitrou, your co-leader?*

SZ: Yes. Ideally both leaders need to be present during the presentation so that the views of both can be heard. It is not always possible for both to attend but it is advantageous for both leaders to be present so that we can learn from any difference of opinion that may occur.

DP: *Thank you very much*

SZ: I am honoured.

‘Forty years with Balint’:

Address to the Annual Balint Society Dinner 7 February 2014

by John Salinsky

By a strange coincidence, exactly 40 years ago on this very date, the seventh of February 1974, I attended the first meeting of my very first Balint group. We met every Thursday afternoon at University College Hospital from 2 to 3.45 p.m. and I still had time for a leisurely cup of tea before going back to do my evening surgery.

Our group leaders were Michael Courtenay and Mary Hare and I believe that ours was the first group in which neither of the leaders was a psychoanalyst. Michael Balint had maintained that an analyst leader was essential, but after his death Enid took a more permissive view and thought that a GP or a psychotherapist thoroughly steeped in Balint might be allowed to take charge of a group. Both of our leaders, Michael, a GP and an early Balint group member, and Mary, a psychiatrist and psychotherapist, had plenty of experience. They were also very good at creating the kind of atmosphere in which we felt valued and safe enough to take few risks. We were really very lucky to be led by such a good team.

Paul Julian was also in the group and he and I are the only survivors: by which I mean the only two who have continued to be regularly involved with Balint work and to be active members of the Society (which we were allowed to join only after we had been in the group for two years.)

However, we also had in the group two future presidents of the RCGP. They were Lesley Southgate and, at a later stage, Iona Heath. Both have remained Balint sympathisers and I feel sure that they would count their experience in our group as a major formative influence.

I was the enfant terrible of the group. An early troublemaker. Not that I was trying to be difficult, it just seemed obvious to me that our two wise leaders had read all of Freud’s collected works and had a pretty good idea of what was going on in our patients’ minds. I couldn’t understand why they didn’t just tell us what to do instead of expecting us to work it all out for ourselves.

The leaders (and the other members) took my protest very seriously and it was decided to spend half of the next session discussing ‘Dr Salinsky’s problem’. You will note the use of my surname. In fact from the very first day we always referred to each other as ‘Dr This’ or ‘Dr That’ in a very formal way. It was only after about two years that someone asked, ‘Would it be OK to use our first names?’

Our leaders looked at each other and said, ‘Why not?’ So after that it was always first names.

At the end of the discussion of my problem, I had not really changed my view and one of my colleagues said, ‘Will you be leaving the group now?’

I said, ‘No, I think I’ll hang on for a bit and see how things go.’

And forty years later, I am still here. But my views did change and I am now beginning to get the hang of what it is all about.

After our group had been going for two years we took part in the 3rd International Balint Congress in Paris which was attended by several hundred delegates. We performed for the Congress in a kind of central arena, reproducing the kind of presentation and discussion that we did every week in London. In those days, the audience had the benefit of simultaneous translation. Whether this was accurate or not I have no idea, but after we had finished some of the audience became very noisy and excited. I was told later they felt that our presenter had become too emotionally involved with the patient. But at the time, as my French was and is very poor, I couldn't understand anything they said. I think most of us felt the same. We did hear our leaders stoutly defending our group and their leadership (in French). It was all very thrilling and gave me a taste for future international conferences.

Two years later, I became a group leader myself at the invitation of Oliver Samuel and Mark Sundle who wanted someone to help them lead Balint groups at the Northwick Park GP training scheme. I also became a course organiser at Northwick Park and subsequently at the Whittington, where I have been for 20 years, and where we still have Balint groups nearly every week.

More international events

In 1984 I attended another International Balint Congress in Montreux, Switzerland. In one of the coffee breaks, I found myself standing in a little circle of people discussing what was to be done about replacing the International Federation Treasurer who had just dramatically announced his resignation. The Treasurer was Dutch and the Dutch Balint Society had recently taken to holding hands in their groups, talking about their personal lives and generally carrying on as though they were in an Encounter group. The more conservative senior members felt deeply ashamed of this loose behaviour on the part of their rank and file and had decided to withdraw the Dutch Society from the Federation until they had mended their ways (which they subsequently did).

Meanwhile the Federation needed to find a new Treasurer. At this point I felt a firm pressure in the lumbar region as Erica Jones gently pushed me into the middle of the circle and said, 'John will be our Treasurer,'

And so it came to pass. I was Treasurer for four years until I had a phone call from the Secretary who told me that we would now change places: he would be Treasurer and I would be Secretary. That was how things were arranged in those days, when the International Federation was much smaller. I was in fact elected democratically but unopposed. I was Secretary for 10 years. As the Federation's meetings were now conducted in English (without translation) it was decided that the Secretary should always be British. So I was succeeded by Heather Suckling and she was succeeded by Paul Sackin who is the current holder of the post.

The British Balint Society since 1974

In the 1970s, our Balint Society was like a rather exclusive club for GPs who were passionately committed to the Balint group method but were unable to interest the majority of GPs who regarded Balint, at best, as an interesting footnote in the history of

studying and teaching what had become known as The Consultation. It seemed likely that the Balint Society would fade away and soon become extinct. This was all changed, in my view, by the beginning of the Oxford Balint Weekend. The idea came originally from the late Cyril Gill who thought it would be a good idea to offer a weekend 'taste of Balint' to doctors who were curious about what we were doing, but had no previous experience. The chance to live in an Oxford college for a weekend was an added attraction. We discovered that living and working together, with group sessions coming in quick succession, had a catalytic effect on the speed with which group members got to know and trust each other. The progress that was made would have taken months to achieve in a group that had a session only once every one or two weeks.

Those who attended the weekend also discovered that Balint doctors were gregarious, sociable people who liked to have fun, rather than followers of a strange cult who believed that everyone's symptoms were due to sex.

The Oxford weekend was declared a big success and has been repeated every September in one college or another for the last 25 years. It has been joined by other annual weekends in Whalley Abbey, Lancashire, in Northumbria, and most recently in Ireland.

So, instead of dying out, we have survived. We are reaching and influencing more people. We are taken seriously by the Royal College and the GP Training organisations. Books on GP training and psychotherapy supervision have whole chapters on Balint, not just a passing mention. We have groups for students as well as Vocational Trainees. Balint groups have also become a regular feature of psychiatry training and we are beginning to see more ongoing groups being started with established GPs.

In the last few years, as we have started to need more group leaders, we have developed an interest in how group leaders should be trained and supervised. We are thinking about what is different and special about leading a Balint group as opposed to a task-orientated small group or a therapy group.

It seems to me that there are two ways of being a Balint group leader. You can either intervene or you can stay quiet. Staying quiet is sometimes called 'Trusting the group'.

But can the group always be trusted? Too often, it will find it easier to look for solutions or suggest referrals or even to start discussing the problems of the NHS in general. As a leader, you can intervene when this happens. All you need to do is to ask, 'What about the doctor-patient relationship?', but to do this in as many different ways as possible. Alternatively, you can just keep quiet, and watch the doctor-patient relationship as it is reflected in the interactions of the group. Probably, good group leading involves a bit of both, but we need to get the balance right.

This focus on group leadership is an important sign, I think, of the fact that our Society is growing and flourishing. It is now open to everyone, it is respected by medical educators and it is full of ideas. We are playing an important role in supporting doctors and therapists who do this difficult work which involves our own feelings, whether we are aware of it or not. And it is better to be aware.

Building and rebuilding: the story of a community Balint Group for family doctors and psychotherapists

By John Salinsky

A paper originally read at the American Balint Society's first National Meeting in Estes Park, Colorado, 21 July 2014

In September 2007, nearly eight years ago, my friend Tessa and I decided that we would start a new Balint group. We had both been at a meeting of the UK Balint Society council where there was some discussion about the shortage of groups for established family doctors.

You may find this surprising. After all, London, England is where Balint groups began in the 1950s, thanks to the presence of Michael and Enid Balint; and our Balint Society is certainly very active. We have four weekend meetings a year and a strong participation in the International Federation. However, our ongoing groups are mainly for trainee doctors in family practice and more recently in psychiatry. We also have some short-term groups for medical students which are very popular, especially in London. At the time of that meeting the secretary was getting enquiries from people who were looking for a group to join but couldn't find one- not even in London. So Tessa and I decided we would start one.

My co-leader, Tessa Dresser, is a retired GP who used to practice in North-West London and still lives there. My practice in Wembley is in the same area. Tessa and I had led groups at weekend meetings but had never had an ongoing group. We advertised the new group in a local e-mail bulletin received by all GPs in the area. We invited any doctors who were interested to come to an inaugural meeting.

About 10 doctors came along. We served coffee and cake and explained for the uninitiated what Balint was about. We then discussed a case so that they would get the idea. Six of the doctors said they would be able to commit to a fortnightly meeting. We decided that the group would meet on a weekday evening from 8 p.m. to 9.30 p.m. The interval would be every two weeks.

In that first year, we arranged to meet in the staff sitting room of my practice premises. At the time this was in a temporary building while our new Health Centre was being built. We tried to make the venue welcoming and relaxing. We served tea and coffee. We sat in comfortable armchairs. The first phase of the Wembley Balint group had begun.

The doctors and their patients

Who were the doctors who came?

Some were young family doctors who were working as locums or in short-term posts, sometimes moving from one practice to another. One had recently left her practice after 12 years as a partner, because she was increasingly out of sympathy with the philosophy of the other partners. They were working very long hours trying to make as

much money as possible, and seemed to have little interest in their patients as fellow human beings. So most of our members were without a permanent base. All of them were women. During that first year there was quite a high turnover. Some members left after a few months and others came, not always for very long. The patients they presented often seemed to reflect their doctors' uneasiness.

Some patients wanted long sickness certificates although they didn't seem seriously disabled. Others demanded inappropriate prescriptions or referrals or letters to excuse their appearance in court. Some had made complaints about previous doctors and seemed a bit threatening. Then there were patients who kept coming to moan about their lives and their symptoms. They would not accept that the doctor was unable to think of any other way to help them: but they seemed to like coming all the same. Dissatisfaction with patients led to discussions about the unsatisfactory state of the healthcare system and how it might need to change.

As leaders, Tessa and I felt some discomfort about these themes. After all, we were supposed to be discussing the doctor –patient relationship. Our doctors knew how the patients made them feel, but they seemed unwilling to try and see things from the patient's point of view. We responded by trying to encourage them to be curious about the patients' lives and find out more about them. How had they become the people they were today? What had gone wrong with their lives? What would it feel like to be in their shoes? You all know the sort of thing.

When the doctors talked about their own dissatisfaction with their practices or their colleagues, or with the healthcare system as a whole we wanted to say, yes, we know conditions are bad, but that's not actually what we are here for. Now let's get back to the patient. Well, you can do this up to a point, but I think we also have to bear in mind that it's a family doctor's job to listen to anything that the patient brings up, even if it sounds 'inappropriate'. As leaders, we have to listen to our group members and provide them with a model. If they feel listened to, they are more likely to listen to their patients in the same attentive and sympathetic way. And when the doctors' frustrations have been expressed, we can gently say, 'shall we get back to the patient? What sort of help does he want from us?'

Ending of the first phase: moving into the second phase

By the end of 2008, our group had entered its second phase. Of the original group, only two members remained; others had joined but stayed only a few months. It was difficult to tell how much those who left had gained from their stay in the group and we didn't ask them for an evaluation. They all left, they said, because of the pressure of other commitments. They may have just wanted to be polite, but they certainly seemed to enjoy the group and feel some support from it during their brief stay. Meanwhile we had acquired two new members who were to become part of the permanent core. One of them is a GP in his 50s who was recommended to apply by a friend who was also a Balint Society member. The other was a partner in my practice.

The visitors

During the second phase, we also had a number of rather unusual short-term members, who each made a special contribution to the group. I think of them as 'the visitors'.

Maria was a woman in her 40s who was a senior practitioner in neurolinguistic programming (NLP). She had contacted the Society via the website and asked if there was a group she could join. She wrote to say that she wanted to learn about Balint and also felt she might be able to help us. We were a bit apprehensive about the 'help' and wondered if she would try and convert us into an NLP group - but we needn't have worried. She listened to the discussion with sympathy and attention and made some very helpful but totally non-theoretical contributions. She only ever presented one case but this didn't seem to matter. After a few months we were so curious about NLP that we offered her a whole session to tell us about it.

Next came Dr A, who was had been advised by the fitness to practice committee of the General Medical Council that he would find it useful to join a Balint group. Omar had come as a refugee from Iraq, where he had been a paediatrician and general physician. He was currently doing locum sessions in different practices all round London. He often arrived late because of the distances he had to travel to get to us. He was often hungry when he arrived and as soon as he sat down, began eating his sandwiches.

Poor Dr A suffered a good deal from feeling unvalued and unrespected. At the practices he worked for, the patients would look at the strange doctor and say, rather coldly, 'I was expecting to see my usual doctor.' There were a number of complaints about him, usually that he had told people there was nothing wrong with them or that he was felt to have failed to make the correct diagnosis. The staff were also unfriendly and on his consulting room door, instead of his name, there was just a label saying 'locum'. It's no wonder that he felt like a non-person.

I felt rather antagonistic to him myself, to begin with. He came late, he was restless, he ate sandwiches, he complained a lot. He just didn't seem to fit into our cosy group. Sometimes when he was very late I found myself hoping that he wouldn't come; but he always arrived, tired and hungry after about half an hour.

And yet, after a while, we saw signs of change in him. He presented two depressed patients with whom he had spent time. He had listened to their stories and taken an interest in their lives. One was a teacher who was feeling suicidal because her career was in ruins and no one gave her any respect - surely a reflection of his own feelings about himself! The second patient he was able to follow up because he had found a job as a regular locum at the same practice. When she was feeling better, she had sent him a card saying he was 'the best doctor in the practice'.

Our other visitors during this time included a palliative care doctor working at our local hospice. She gave us a different perspective on the relationships a hospice doctor has with both dying patients and their relatives. She struggled with the feeling that she was supposed to like all her patients but some of them remained in their dying weeks, the difficult, ungrateful people they had probably always been.

We also had a six month stay by a local Family Medicine training programme director, herself a Balint group leader. She had some very keen insights and a wonderful capacity for empathy. And she felt that, though she had to leave, she had learned something memorable from us as a group.

The Near Death experience
After a time, two of our long-term members also left and were not replaced. There were no more visitors. The group shrank to four members plus the two leaders and then to three. On one occasion only one person came apart from Tessa and me. On another evening, when Tessa was on holiday, there was just one group member and me. I began to feel that we should wind up the group. Perhaps it had just come to the end of its natural life after about four years; but Tessa wanted the group to continue and said we should ask the remaining three members what they thought. They all said very firmly that they wanted to carry on and we should look for new members. So that is what we did.

By this time our new building had been completed and we had moved in. The old one had been dismantled and so we needed to find a new space in which to meet. In the new building there was no sitting room. The consulting rooms were too small and the offices uninviting. But there was a large waiting area with a separate room for podiatry patients. Here the seats were more severe, but we could close the door and be private. So there we have stayed.

The third phase
We didn't remain a small group for long. New members came, not through advertising, but by recommendation and through the UK Balint Society website. In the course of the next two years we were joined by two psychotherapists with an interest in Balint. They came, not because they wanted to become group leaders, but because they wanted to talk about their own patients.

We were also joined by more GPs who were eager to start and actively looking for a group. Some of these doctors only came for a few months but others stayed and became permanent. Despite some defections, our numbers steadily increased. So now we have eight regular members consisting of:

Three loyal core members (GPs) from the early days.
Our two psychotherapists

Three new GP members: one in his 40s, one in her 30s and one in her 20s.

Average attendance is about six plus our two leaders. Anyone who has to miss a session sends an apology. We have accepted one more member (a GP) and have now decided that we should close the membership. We have asked the Society to get another London group started.

Have the presentations changed?
There are fewer complaints about the healthcare system. There are still big problems there and we do allow ourselves to moan and rage about it every now and then, before getting back to the patients. On the whole, there is a much more positive and even affectionate attitude to the patients, even the difficult ones. There is very little bitterness or feelings that the doctor is being abused. We are more willing to empathise and to spend some time inside our patient's heads, to see their lives from their own point of view.

The group leaders
Our roles in the group have proved to be very different. I do most of the talking and Tessa says relatively little. Sometimes, she may sound more like a group member than a facilitator, but what she says is always helpful. I do most of the focused intervening, trying

to bring us back to the central theme of the doctor-patient relationship when we have strayed for too long.

Meanwhile, Tessa is quietly doing something very important just by being there. She is the beating heart of the group. She binds us together and makes everyone feel safe. She encourages me when I feel disheartened. She made sure that the group didn't die. She gave us the time to revive and grow into the lively, vibrant, enthusiastic group that we have today.

Theory? Who needs theory? In other words why do we do Balint in the way that we do?

(A talk given at the Balint Society Longhirst Weekend June 2013)

Esti Rimmer, Consultant Clinical Psychologist

As we gather at Longhirst for our annual Balint weekend, once again in midsummer, and at the same beautiful place, the magnificent Longhirst Hall with its beautiful grounds, we meet as the extended Balint family - old members, new members, guests, etc. The words that spring to mind relate to maintaining traditions, performing rituals, remembering histories and heritage, reflecting on our links to the past as well as developments for the future. However, other words instantly emerge to challenge those associated with traditions, rituals and the safety of the structured, predetermined, predictable and familiar framework of repetitive traditions; words such as meaning, significance, conflict, ambivalence, 'in and out group', cohesion, exclusion, understanding, knowing and not knowing - words which may stir up some anxiety.

While thinking about traditions and the paradox between the safety of the familiar and the anxiety aroused by the search for meaning, I would like to borrow from a different tradition to tell a story:

At the Jewish festival of Passover, celebrated every year at the start of spring as a reminder of the exodus from Egypt and liberation from slavery, families gather over a festive meal to retell this story. This tradition of oral (hi)story-telling is performed by the head of family, with the help of family members and guests. Rituals are performed according to a very strict order (in Hebrew, Passover is called seder, which translates as order); special foods are eaten, and four glasses of wine are drunk.

Leaving aside any uncomfortable feelings that my analogy evokes, let us continue by looking at a particular story in the Passover text. The story tells of four typical sons (and typically they are sons rather than daughters!), the Wise One, the Wicked One, the Naïve One and the One Who Doesn't Even Know How to Ask. The first knows it all. The Wicked One asks "what do these rituals mean to *you*?" Is this why he is considered wicked? With his question he excludes himself from the group, since he doesn't ask, "what do these rituals mean to *us*". (Inner and Outer Group). The third, naïve son, knows nothing and simply asks, "What is this all about?" And finally, the fourth son, who asks nothing at all, is perhaps the youngest-who has no words yet, but maybe also the compliant one. As the story carries on and tells us, it is then up to the head of the family-the leader of the meal, to open up the questions for the youngest son, and explain the history, the reasons, the meaning, the significance of each ritual and each glass of wine-which provides the pretext for telling the story of the exodus. Perhaps this is not only a clever literary device for telling a story but rather the actual act of encouraging and teaching a child how to put questions forward to its elders - the essence of the idea of liberation from slavery?

So how does this lead us back to Balint? As we continue the tradition of Balint work and train new leaders, with the hope that more young clinicians will join Balint groups, I

feel it is important that we allow some space for all four types of sons and daughters amongst us, even the wicked ones, so that they can ask why we do it the way that we do? For if we merely cling to the safety of familiar and predictable procedures, i.e. the repetitive ritual of Balint work, without asking ourselves what and why and how, the danger is that the meaning and significance of the work may be lost, the rituals becoming mechanical, empty, a habit, an old Spanish custom. Moreover, if we are to derive our sense of safety only from the repetition of rituals, the risk is that we avoid all anxiety by holding onto these rules so rigidly that we prevent any productive transformation from taking place. For I believe that it is in the nexus between safety and anxiety that creativity can flourish.

In this paper, I would like to briefly consider the following three questions:

What, Why and How?

1. What?
Theory, in itself a set of abstract concepts that offer understanding and meaning, is the secure base from which a set of actions/ interventions/ structures can be developed. If we divorce these from their secure base of theory, we risk losing the capacity for a deeper sense of security, as well as the capacity to withstand anxiety and to foster development. In his own personal exodus from Hungary to the UK in the 1930s, Michael Balint was well rooted in theory and tradition. Let us look, for example, at his family traditions. His father was a family doctor; his first wife Alice Kovac was a psychoanalyst, as was her mother Alma. His teacher, Ferenczi, was not only a psychoanalyst, but also for a time Freud's favourite pupil and a well-established figure in the intellectual milieu of Budapest. Ferenczi was surrounded by writers, journalists, scientists and artists, who were already intensely interested in the application of psychoanalytic ideas to medicine, art, literature, science and culture and in the link between mind and body. Naturally, Balint also drew on his own training as a psychiatrist and psychoanalyst.

I believe that it was this secure base that enabled him to later develop the application of the method of psychoanalysis to general practice, as well as the creative pairing with Enid Balint, his third wife.

What had been the tradition of psychoanalytic training in the Budapest School?
There were three main elements:
1. Personal training analysis
2. Seminars to discuss clinical papers and research
3. Supervision of clinical work with patients

The boundaries were not always so clearly defined between all these elements of the training. It only later became more clearly defined in the training institutes of Berlin, New York and London.

Balint allowed himself to take some elements of this training, integrate them and yet use none of them explicitly. He was not interested in training GPs to become psychoanalysts, or in providing them with personal therapy, nor in teaching research and theory. Yet the original Balint groups were implicitly about training; training doctors to

better understand their relationship with their patients. This has since become an important part of training for psychiatrists, psychologists and GPs. The early groups were also about research: observing the group, the leaders, the cases, the process, recording the process meticulously, looking at feelings, patterns of relating, moments of surprise, insights and the defences used against engagement with the patients and their feelings. All this led to the development of a more meta-theoretical understanding. Despite not providing personal therapy to doctors, they still challenged and pushed the boundary between the personal and professional self by concentrating on the doctors' feelings. Balint was also able to learn about the value of the group as an agent for containment and transformation from his secure base of adoption, the Tavistock, and from the work of his colleagues, Bion and Rickman.

There is another piece of integration, which may not be so explicit. Group discussions in the early days of psychoanalysis were more informal gatherings of interested peers. For instance, Freud's famous Wednesday evening meetings or Ferenczi's circle of friends and colleagues in the coffee houses of Budapest. By way of contrast, Michael and Enid Balint created a more deliberate and planned group structure, set out as a therapeutic milieu/ a learning tool and work group. Yet another implicit integration of the spirit of these early groups in Vienna and Budapest, is in the sense of a shared interest, a joint endeavour in the study of human relations,.

Let us go back to our Naïve Child and to the second question of why?

2. Why?

I would like to suggest that, in constructing his approach, Balint attempted to incorporate three basic psychoanalytic concepts into professional practice. He attempted to do so primarily through experience, which would lead to a process of internalisation. He believed that this would enhance the quality of the professional consultation. He used the following three concepts:

1. An awareness of the presence of the unconscious in our mental lives and in particular in the communication between doctor and patient.

2. An awareness of the relevance of the quality of earlier patterns of the patient's object relations, i.e. their transference projections (such as expectations, fears, needs and wishes) onto the doctor, as well as the doctor's own receptive/interactive role in the relationship, i.e. their counter-transference.

3. The facilitation of the development of a third position, in the interaction between subject and object, which forms the observing Ego. This Ego function, known as the reflective function, or as Bion's notion of the capacity to think, involves the ability to contain/hold in mind the self and the other and their relationships. This is often only possible with the introduction of a third other or a third position, either concretely or metaphorically. To achieve this reflective capacity, a certain distance from the intensity of a dyadic relationship is required, which enables observation as if from the outside of oneself and one's interactions. Being able to look at one's self and assume the participant-observer position in relation to oneself is what some psychoanalysts refer to as the internal supervisor. This creates an internal space of thinking for the clinician.

It is now becoming more evident how some of the earlier elements from the Budapest School are beginning to infiltrate Balint's model.

This takes us to our third question, *How?*

3. How?

How do the structure and framework of a Balint group reflect these concepts?

The structure of a Balint group is clearly defined to mirror the analytic space, i.e. number of participants, designated leaders and co-leaders, fixed boundaries of time, space, frequency and length of session, as well as the fixing of ground rules. This space, in which time and place are set aside, and set rules are established, requires suspended attention and an invitation to follow one's curiosity and the wish to understand. The aforementioned conditions provide a safe and secure base in which one can safely play creatively and tolerate the anxiety associated with the emergence of difficult or hidden feelings, once again true to form for an analytic session.

The open invitation to speak about a case that comes to mind, without an agenda, notes, or preparation, and to speak freely about it without interruption from the group, is the application of the free association technique. This opens the door to the unconscious by removing the censor, by encouraging the presenter to say what comes to mind about this case rather than follow a prescribed format or a rehearsed script; not such an easy task for many doctors or trainees. The application of the technique is, of course, limited to talking about a particular case. The doctor presenting does not physically lie on the couch and free associate, but in some way the doctor and patient relationship takes place on a metaphorical couch.

Questions are then limited to factual ones, which is, I believe, a compromise solution to allow for an urgent need in the group to know more details, to get some answers, to satisfy curiosity. Ideally, however, I believe that there should be no need for the questions, as in most cases the presenter has already taken us to the realm of the unconscious and we can begin to fantasise about our questions without needing to "know" the reality at this stage.

The presenter is then asked to remove herself from the group. (I shall not enter the debate here as to whether the chair should be pushed out, or not, or whether the presenter should remain but take a back seat in the discussion). Whichever way, the case is handed to the group, which is then asked to play /work with the case. This introduces several psychoanalytic techniques or ideas:

— The use of the group as the container for the anxiety associated with the removal of defences and the emergence of difficult or painful feelings, which hopefully can allow some transformation to take place.

— The use of the work group as helpful/curative factors such as recognition of the universality of the experience and the identification with different aspects of ambivalent relationships.

— The introduction of the opportunity for the presenter to observe the group working

with the case and thus experience her relation with the patient from outside; the facilitation of the development of a reflective capacity. (Interestingly, in a further application of Balint work, the Balint-Psychodrama, the presenter witnesses a re-enactment of the consultation and is, therefore able to experience himself in the role of himself, the patient and the observer.) These processes encourage the development of the observing Ego-or the internal supervisor. This may operate as a very powerful training tool, which in itself frees something in the way this particular doctor might have felt with this particular patient. More generally, it may also increase the capacity of our doctor and the other group members to feel freer in their relationships with their other patients or colleagues.

Perhaps, then, my analogy to the Passover meal is not as uncomfortable as it might have seemed at the start. Perhaps in Balint work we are also celebrating freedom from other, more internal forms of slavery or tyranny and perhaps it may explain why work, which often feels like hard labour, can also feel very liberating and a bit like a labour of love?

Book Reviews:

"Learning about Emotions in Illness"

Ed Peter Shoenberg & Jessica Yakeley

Routledge ISBN 978-0-415-64490-7

This book valuably addresses the question of how medical students can learn to recognise and harness their own, and their patients', emotions in practice, rather than the traditional course of suppressing them. It begins in 1958 when Heinz Wolf and Dorothea Ball, at University College London, had the idea to help medical students develop an understanding of the doctor-patient relationship by arranging for a number of them to see a patient in psychotherapy for a year, under strict supervision. This continues to this day. This was followed soon after, in the mid-60s, by Michael Balint running Balint groups for medical students at UCH, a project which ended around the time of his death, but which was reborn in 2004 under the leadership of Peter Sheonberg and Heather Suckling.

The two strands and their histories, are presented in clear chapters by various authors working on, and participating in, the schemes over the years. It is fascinating to hear the difficulties of running the schemes from the organisers and leaders, then the joy of participation from the past students. Unfortunately it is not possible to hear from the patients, apart from some comments and general feelings looked at in research on the projects. Being involved with the Balint Society over the last 20 years has enabled me to follow the work, as much of it has been presented at Balint Society lectures, and at International Balint Federation Congresses, and it is wonderful to see an excellent monograph supporting both of these schemes, supported by research.

Currently, at the beginning of the academic year, the two schemes are presented to the students at ULCH medical school at a lecture. They are invited to sign up for either scheme. The student psychotherapy scheme is limited in the number of students that can be accepted, a maximum of about 15. The Student Balint Group can accept more, up to 100 students per year, and it is run as a SSC (student selected component), with a reflective essay to be presented at the end. In the psychotherapy scheme the student joins a supervision group of students currently on the scheme for 3 or 4 months, before getting a carefully chosen patient to see in weekly therapy for 1 year, continuing in the same supervision group throughout, led usually by a medical psychotherapist. The importance of this supervision group, the learning and reflection which goes on there, is highly stressed and valued by students and teachers. Students experience authority in treating a patient, responsibility, develop listening, are well supported by the psychotherapy department, and talk to colleagues in an open professional manner about emotions. The Balint groups meet weekly for 11 sessions in the first clinical year, discussing patients, or incidents that the medical students have seen. Peter Sheonberg and Heather Suckling present the documents they use for introducing the scheme which will be useful to all Balint group leaders. Students who have participated write glowingly about how both schemes have deepened their understanding of patients and their empathy, changed the way they approached patients, and developed their professional lives, understanding better the role of the medical student and the possibilities for therapeutic interactions. These themes are beautifully expressed in an essay by Sotiris Zalidis.

The work at UCH has been the subject of research right from the beginning-all the originators, including Michael Balint, were research-orientated. This has been continued by Jessica Yakeley, who has been researching the work over the last 10 years or so, and presents the historical and current research work concisely. The clearest outcomes have been that participation in the psychotherapy scheme produces more psychiatrists from the medical students, and perhaps more GPs. Work on the Balint groups has been difficult (as we have found in the Balint world) trying to measure outcomes in terms of students changed attitudes. This is ongoing and more is needed.

The team are keen to show that similar work has taken place, and continues, both overseas, and at other medical schools in England. Bristol has a student psychotherapy scheme, albeit only 4 months of therapy, and they also give medical students some Balint group exposure (personal communication). But none of the work elsewhere sounds as profound and well supported as at UCH, and the team there over the years must be proud of their work as presented. They are also keen that the work in psychotherapy and Balint groups spreads out to other medical schools, and the Balint Society is keen to help this happen.

In summary, the book is an excellent addition to literature on teaching medical students and should be seen by all medical teachers. It makes an inspiring read. Unfortunately a library copy might be the most suitable way to access it at the moment, as the price is very high, until it appears in paperback (hopefully).

D Watt 20/6/14

Clinical Uncertainty in Primary Care
The Challenge of Collaborative Engagement

Editors: Lucia Siegel Sommers and John Launer
Springer (2013)
Hardback pp306

This is an excellent book and will soon be available in paperback. Taking 'clinical uncertainty' as its overarching subject, it looks at a variety of different conceptual models of collaborative engagement and peer group case discussion. Amongst its chapters are two that give a very useful, indeed first class, summary of current approaches to Balint work: 'Balint Groups and Peer Supervision' by Henry Jablonski, Dorte Kjeldmand and John Salinsky; followed by 'Research on Balint Groups' by the same trio of authors but with Dorte Kjeldmand as the lead author. It has often been lamented that there is no good up-to-date introduction to Balint work for people to recommend. Well, here it is, lament no more! Congratulations to all the authors.

The parts are strengthened by the whole. I suspect that this is due to two highly literate editors working closely together and adopting a convincing overall concept which has enabled them to produce a coherent book. So often, similar books end up as a shopping list of related but separate approaches. If you are mainly familiar with a particular approach, it is instructive to read about others alongside, and see similarities

as well as differences. In addition to its two Balint chapters, the book covers Narrative–based Supervision, Practice Inquiry (the single non-Balint American approach), Practice-based small group learning in Canada and Scotland, Case-based learning in Swedish Primary Health Care and an excellent chapter describing the long tradition of peer supervision groups in Denmark.

The editors (and the volume!) are well served by two particularly strong opening chapters on Uncertainty: one by Trishia Greenhalgh (who never fails to be good value), in which she moves towards developing a taxonomy of Clinical Uncertainty through discussion of illustrative cases. And the second is by educationalist, Colin Coles who looks at what underpins 'professional judgement' and how this can be understood, how it develops and can be fostered educationally. He opens his chapter with what has become my favourite recent quotation from Kathryn Hunter, the distinguished American English Literature academic who has written extensively about her work on the narrative structure of medical knowledge: 'Despite its own emphatic claims to the contrary, medicine is not a science at all - and nor, incidentally, is it an art. Medicine is a practice.'

John Launer ties things together very skilfully in his Afterword. He emphasises a point made by Greenhalgh that 'the commonalities between the approaches described in this book are more noteworthy than their differences', and endorses Kjeldmand's call for collaborative research across the different approaches. It is too easy to remain cellular in our endeavours; a more organic approach is called for. I was particularly struck by his point that the scale and nature of peer supervision seems connected to the political and social context in which it is practiced, being more successfully established in the north European social democracies where there is a tradition of public welfare provision. Finally, John Launer points to an area of further research which has also been the subject of recent attention within our own Society (Balint Memorial Lecture, 2013). He refers to 'the wider systemic relationship between the case discussion groups and the practice or locality setting'. How do improved relationships within a team, nurtured by shared group learning, affect quality of care? How does a regular case discussion group affect the degree to which the professionals themselves feel secure and able to attend to their patients' needs? Good questions and exactly the sort of research questions that could be pursued profitably by a collaborative approach in the spirit of this excellent book.

Andrew Elder

Secretary's report 2013/4

This has felt like quite a busy year for the Balint Society. There has been a mixture of positive developments, blind alleys and tantalising opportunities. Character strengths needed by those of us involved in keeping the Society afloat and sailing include persistence, patience, vigilance and resilience! The focus on leadership training, so that where new opportunities arise, the Society has a resource to offer, continues to be a key part of the Society's work.

Membership
We are growing slowly but steadily, with new members from General Practice, Psychiatry, Psychotherapy and Psychology, and a Dentist has joined. We still offer a year of free membership to members of groups led by an accredited Balint leader and we encourage accredited leaders to promote the opportunity.

Events
Reports of many events are included in regional news and are not repeated here in any detail.

The Annual Dinner in February 2014 was again preceded by a Study Day, this year about Supervision for Balint leaders in training. The meeting and dinner were held at the Medical Society of London, which proved to be a popular venue. After dinner, John Salinsky shared some thoughts about his work and Balint and stimulated lively participation from other guests.

Weekends are now established at four per year, through welcome linkage with Belfast and Sligo. Leadership workshops are part of every weekend and we want to encourage medical student attendance through an expansion of subsidised places to all four weekends.

There have also been a number of one day events, as we try to increase opportunities in more venues to sample Balint work and access leadership training. If you would like to have a day in your area, do contact us.

Several of us attended the launch of a book in early May, edited by Balint Society member Peter Shoenberg and his colleague Jessica Yakeley, titled 'Learning about Emotions in Illness: Integrating psychotherapeutic teaching into medical education'. This describes the Medical Student Psychotherapy Schemes, which include Balint groups, operating in London and Bristol. See the book review elsewhere in this Journal for more details. The two student participants who spoke at the event were an inspiration to continue to support work of this nature.

Seminars for group leaders to present and discuss their work continue to be offered in London and the North East, with the North West hoping to follow.

Council
Council has met on four occasions during the year, including one telephone conference. Doris Blass stepped down as Honorary Treasurer after many years of hard work for the

Society and Christina Blackwell has now taken her role. We recognised that the work of the Society is becoming more complex, with much more leadership training, and increased outreach aided by electronic mail and use of the website to communicate. We now have in place appropriate insurance cover and an email policy to keep us in line with data requirements. The main piece of work has been a development plan. This is work in progress, but has helped Council to review activity and spending, and consider how the Society should be moving forward.

Links with other organisations

We have tried to strengthen our link with the International Balint Federation by co-option of the IBF Secretary, Paul Sackin, onto Council. Newcastle hosted an IBF Council meeting in June as part of the Balint weekend (see elsewhere).

The UK Society was well represented at the IBF Congress in Heidelberg in September 2013 and this planted the seed of an idea that maybe it was time for us to consider hosting the Congress in 2017. This offer has now been made to the IBF and acceptance is anticipated. The UK Balint Society has been active in supporting development of Balint work in Greece, with leadership supervision from Gearoid Fitzgerald and attendance at a Balint weekend in Athens by Sotiris Zalidis. Lida Bitrou, who has led the work in Athens, has attended several of our weekend meetings and gained leadership accreditation. To see what she has achieved see
http://www.balintgroupgreece.com

We are working increasingly with the Psychotherapy Faculty of the Royal College of Psychiatrists, which is a welcome development. A number of Medical Psychotherapy Specialist Trainees are working towards, or have achieved, Balint leadership accreditation. A talk and demonstration Balint group were included in the Scottish division conference in Perth in November 2013. More recently, we were invited to join a working group at the RCPsych which hopes to develop Psychotherapy Schemes for medical students across the UK (see previous reference to Peter Shoenberg and Jessica Yakeley's book). This opens up another 'branch' for our leadership training programme. Several Balint Society members are already involved with medical schools, but we hope this will increase.

Group Analysis North included a seminar on Balint as part of their training programme, which was attended by Andrew Elder and Caroline Palmer. Antony Froggett, who organises the training programme, is also an accredited Balint Society leader.

Links with the Royal College of General Practice are less well established overall. We are part of the Alliance of Primary Care Societies and receive their circulations, but this has not led to closer association as yet. There are locally arranged relationships with GP training, with taster or on-going Balint groups in some areas, though these are being lost in others. We continue to look for opportunities and would be pleased to hear about any involvement that you have or are aware of. The RCGP First Five initiative for recently qualified GPs may offer opportunities.

Website, Facebook and Twitter

The website is a key part of our communication about Balint work and events and continues to be developed. The Journal archive has been digitalised, so should be available on the website in the next few months.

The Facebook page has gained some 'likes' and we are building a Twitter following. The Secretary will shortly be seeking some help from members more familiar with social media, so if you are one of these people, do let me know on ceri.dornan@gamil.com.

Ceri Dornan, Honorary Secretary.

Report on Balint Society Whalley Abbey Weekend Workshop

March 21st-23rd 2014

Once again, on the cusp of Spring, twenty of us met at the tranquil and alluring Whalley Abbey conference house for a weekend workshop offering both a Balint leadership intensive, or a Balint Group. People had travelled from as far as Vienna, London, Leicester and Wales, as well as from nearer - Liverpool, the Peak District and West Yorkshire. There was also a wide diversity of professions represented, from Consultant Psychiatrists and Psychotherapists to GPs and medical students, with a range of Balint experience from those with plenty, to those with none, while a few had returned after a first experience the previous year, which is gratifying.

After a buffet supper in the cellar refectory, the weekend's proceedings began with a talk by Linda-Mary Edwards, a psychotherapist from Wales, on 'Silence'. This included a short guided meditation, which helped us feel relaxed, rested and in the moment, after the pressures for many of a week at work, the problems of getting away from it and on time, travel and traffic problems, etc. People seemed to find it very refreshing and helpful.

I was quite suddenly aware that I had a growing concern that after the talk on 'Silence' that our groups could be engulfed and enmired by it! I need not have worried, as the groups quickly got under way with stimulating and animated cases. During the weekend we met four times in our groups as well as running a demonstration 'fishbowl' group session, which therefore included everyone.

The leaders' group spent half of each session thinking about and discussing a case, while the second half was spent in looking at the way in which the leaders worked with the group, and at their interventions. The leadership of the group rotated with each session, giving everyone the opportunity to lead, including the fishbowl group. The cases discussed by the leadership group almost all seemed to have boundary problems as their over-riding theme. Talking of over-stepping or over-turning boundaries, we also decided in some of the cases, not to allow any clarifying questions at all, in the hope that people would retain their immediate emotional response to the case, without the filtering and distancing barrier of questioning. It was felt that it did enable more fresh and vivid speculation and fantasy about those cases, though some found it frustrating not to have the 'full information' to work from!

The more typical Balint group, dealt with a variety of cases, which were often visceral and emotional, but in which there seemed to be themes of denial, (sometimes

bilateral), manipulation, guilt, as well as often anger and frustration. The participants said that it felt a very open and trusting group, which they felt was remarkable, given the variety and difference of participants' experience and background, and that it had been an intensely useful and creative experience.

All said that they had enjoyed the weekend, especially the restful, attractive venue, the wholesome tasty food, the comfortable accommodation, with a roaring log fire in the grate in the drawing room, and the opportunity to get out on the Saturday afternoon into the countryside, or for retail therapy in the village!

If you've never been to Whalley Abbey, you've missed a treat, but there's another opportunity next year, from Friday March 20th to 22nd 2015, so we hope to welcome you there then!

Reports from the regions - Balint Society related work in the UK and Ireland 2013 – 14

Introduction

Looking back over my term as President for the last three years I see a crisis which has developed in the NHS alongside the recession in the economy. While some would have us believe the economy is on the upturn, many ordinary people say they fail to experience any improvement, welfare reforms are leaving people including many of our children and young people almost destitute, and funding for primary care has fallen dramatically in real terms. Morale in General Practice has probably never been so low, with recruitment of young doctors into general practice falling dramatically and GPs feeling every more tied up with tedious administrative procedures and enormous pressures on the time available for their patients. Primary care is expected to shoulder an increasing burden of the workload without the necessary additional resources. Resources for Mental Health services have also been cut, both in the NHS and by local councils while increasing numbers of people seek help for psychological problems and depression. Professor Sue Bailey, the outgoing President of the Royal College of Psychiatrists recently told BBC news that mental health services are in crisis, 'its a car crash and we need people to listen'.

Amidst all this chaos many practitioners are looking for ways to sustain themselves and their colleagues, and we have noticed an increasing interest in Balint work as well as other forms of support. This is an opportunity for the Society and we have been developing work in training and accrediting Balint leaders, forging more links with all those who are doing or interested in Balint work through contacts and our website, supporting new groups, and networking with interested organisations and the international Balint community. This is hard work as, despite interest, many practitioners find it difficult to create time and space for themselves. A little bit of Balint can go a long way in helping people to feel more supported and understood in their work – a monthly group can be a lifesaver, but the downside to this is that organisations and individuals may show interest in 'taster sessions' without wanting to commit the resources required for longer term groups.

It is also hard work because the issues are hard – our patients bring illness, disability, death, psychological distress and mental illness, loss, family breakdown, poverty and disadvantage to us on a daily basis. The thought of creating a reflective space to really explore what we think and feel in the face of the work we do, may seem overwhelming.

Not only do we need to train more Balint group leaders but we also need to support them in this work. We are now able to offer supervision to those who want to become accredited, and we would like to establish more peer supervision groups for Balint group leaders around the country.

The following reports from around the regions offer a snapshot of some of the work on the ground which is supported by the Society. I am well aware that there is a lot of other Balint, or Balint-type activity going on around the country which we are not linked into, be it in Psychiatry and GP training schemes or ordinary Balint groups for qualified professionals. We would very much like to hear from any of you who are involved in this

work and we are interested in your ideas about how we can support and promote future developments.

Jane Dammers President

Reports from the regions

Flying the Balint Banner in Wales!
New Balint groups
After attending a number of Balint weekend workshops and realising that there were no Balint groups for GPs in Wales, we decided to test the water and see if there was enough interest to form a Balint group in North Wales. A Balint Taster session was held last June in Wrexham, with support from the Balint Society via Dr Ceri Dornan, who led the session with an enthusiastic member of her own group. We were very encouraged to have seventeen people there and everyone seemed to find the session interesting.

Following on from this, last autumn Dr. Arthur Niesser, GP and Jungian Analyst and Linda Mary Edwards, Group Analyst, started a group in North West Wales. However, after the three sessions, although group members found the sessions useful, there was insufficient interest to form an ongoing group, partly due to the travelling distances involved.

Linda Mary and I have now established a Balint Group for North-East Wales, based in Wrexham. We meet monthly on a Wednesday evening and have attracted five group members so far, mostly GPs with one Consultant Psychiatrist. The group has worked very well with interesting Balint-type cases being presented. After three sessions the feedback was positive and we are now hopeful that the group will continue. With this in mind, we are keen to attract new members, including those from other disciplines.

GP vocational training
Over the last eighteen months I have also been co-leading a Balint group for a GP Vocational Training Scheme, initially with Dr. Tony Downes, a GPwSI in Psychological Trauma, and now with Linda Mary Edwards.

Dr Ann Evans, GP Llangollen

'Sharpening the Saw'
attending to essential reflective practice using the Balint method as the sharpener. The journey in Ireland over the past two years

There are approximately 2500 General Practitioners in the Republic of Ireland. In addition there are thirteen GP Vocational training schemes. Both my colleague Clive Garland and I have been aware of the value of the Balint process historically but also of its absence as an essential tool of reflective practice for doctors and related professions.

The Sligo Balint Symposium
With this in mind we hosted The Sligo Balint Symposium in association with the Northern Ireland Balint team & the Balint Society UK in November 2013. This was a hugely beneficial event, which attracted GPs, Psychiatrists, Psychotherapists and other related

professions from north and south of the border as well as the UK. We remain indebted to the encouragement and support of our colleagues in Northern Ireland and especially the team from Balint UK who travelled and lent their full support to the gathering. We have agreed with our Belfast opposites, that we will now host a Balint Symposium bi-annually in an effort to promote and service the development of Balint in the whole of Ireland. Furthermore, the notion of an All Ireland Balint society affiliated to the U.K. society will be further explored in time.

Encouraging Balint groups and Balint in GP training

As a consequence of the Symposium, which we hosted in Sligo, we became aware of a burst of energy and enthusiasm of some participants in their need to proceed to setting up Balint groups in their areas. We know from experience that the work of setting up a successful group is fraught with technical considerations. With this in mind, we hosted a further one-day training event in Athlone in May of this year where we helped participants to begin to explore the hidden complexities and issues that require addressing to ensure that a successful Balint group can develop and thrive. We realise that there is a need for more of this type of foundational work to be developed and we intend to pursue this in the coming year.

The Balint approach continues to slowly gain purchase within the south of Ireland. I ran a workshop at the National Association of Programme Directors (NAPD) of GP training schemes earlier this year where the technique was demonstrated and staff of GP training schemes were encouraged to build this approach into their GP training schemes. As a follow up I co-hosted a Balint workshop with Dr Tony Cox, then president elect of the Irish College of General practitioners at the national GP trainers meeting in April 2014. Resultant of the success of this Tony, who is now president of the ICGP and I were invited to present a Balint workshop at the ICGP summer school in June 2014.

So, it's slow but steady progress. When we 'get there' we will let you know!

Patsy Brady Psychotherapist and medical educator living in the West of Ireland.

Balint activities on the 'North East Coast Axis'

Tyneside, Teeside, Leeds and beyond

NE Balint co-ordinating group

Our co-ordinating group in Newcastle, Claire Appleton, Christina Blackwell, Chris Brogan, Jane Dammers, Dave Morgan, Jane Mulholland, Esti Rimmer and Gordon Shiells, meets regularly to plan and develop Balint activities in the NE. Over the last couple of years we have developed a productive collaboration with Gearoid Fitzgerald in Leeds – joining up on the East Coast Axis to run Balint leader training workshops together. Gearoid co-ordinates Balint work in and around Leeds, running groups for trainee psychiatrists and training and supervising psychiatrists and psychotherapists in Balint group leadership, many of whom are becoming accredited Balint group leaders.

Balint groups

We have four Balint groups in the North East for qualified health professionals. Two are for GPs and two are mixed groups including GPs, counsellors and psychiatrists. All our Balint groups are co-led by a GP and psychotherapist or clinical psychologist. There are also Balint groups for trainees in clinical psychology, trainees in psychiatry and some

foundation year doctors.

Leadership training
We ran a second successful leadership training day at Claremont House Newcastle with more than twenty participants, and a third is planned for November 2014. This year we have established a Balint leaders' peer supervision group group which meets every three months at Claremont house. Leaders are encouraged to present their groups and there is also time for discussion of more general issues.

Balint weekend - Longhirst June 2013 and County Hotel Newcastle June 2014
We hosted our usual Balint weekend at Longhirst in June 2013 but had to change at short notice to the County Hotel in Newcastle in June 2014 when Longhirst went out of business. We were also hosting the IBF board meeting in 2014 and thankfully the County worked out very well, being immediately opposite the central station, making it easy for all our international colleagues who attended. With seventy delegates we were able to run two leaders training workshops and three ordinary Balint groups and benefitted from being able to compare different styles and approaches to Balint work from around the world. There were many younger people at the conference which was very encouraging.

Work with the Northern Deanery and GP trainers
We continue to deliver workshops about Balint to GP trainers looking at both the doctor-patient relationship and trainer-trainee relationships. We would like to explore ways of doing more Balint work with registrars and foundation doctors, as well as medical students in the longer term.

Links with other professionals and organisations
We have good links with local psychiatrists and clinical psychologists who are leading Balint groups for trainees and with the Squiggle foundation through Dr Chris Brogan. We plan to run another Balint introductory day in November with the North of England RCGP faculty.

Jane Dammers GP

Balint activities in the North West

Balint groups
Balint groups for GPs continue to run in Manchester and Cumbria. Antony Froggett, a Group Analyst and accredited Balint leader, is involved in two Balint groups for GPs, one alone and one with Ceri Dornan. Sally Wraight and Ian Tod, a GP also trained in psychotherapy ran a Balint-type group in Penrith for experienced GPs from 2012 . It was a lively and thoughtful group with a core of very keen attenders. However the numbers dwindled and the group ended earlier this year. Helen Sheldon ran a Balint 'taster' session for a group of 'First Five' recently qualified GPs in Tameside and there is a wish to form a new on-going group. Caroline Palmer co-leads a group for Psychiatry trainees with Phil Brown in Preston, which is a welcome inclusion of a GP perspective. Helen Sheldon had been leading a multi-disciplinary Balint group in a psychiatry department, as well as a consultant group, before her retirement. Enquiries from nurses in local mental health

teams about a possible group, unfortunately did not lead to further activity, perhaps because of lack of managerial support.

Medical students and GP trainees
Caroline Palmer and Sally Wraight have established a link with Lancaster Medical School and run Balint workshops for medical students. It does seem that smaller medical schools may offer better opportunities than the very large. Ceri Dornan ran a seminar about Balint work for South Manchester VTS trainees, including two case discussions, which was a challenge for a lone leader and sixteen trainees.

Leadership training and support
We are aware of a need to increase the number of accredited leaders in the North West. Established leaders and those leading psychiatry groups in have expressed interest in meeting to discuss leadership issues, in line with the London and North East seminars. Hopefully the first meeting will take place in early Autumn.

Whalley Abbey weekend reported on elsewhere by Caroline Palmer

Links with other organisations
Helen Sheldon and Ceri Dornan went up to Perth in November 2013 to offer input about Balint to the Scottish Division of the Psychotherapy Faculty of the RCPsych Annual Conference. This included a talk about the value of psychodynamic thinking to work in General Practice and a fishbowl group. Those attending showed a lot of interest in both understanding the challenges faced by GPs and in the Balint model.

As part of the development plan undertaken by the Balint Society Council, funds obtained from another charity in the North West have now been designated as a Research and Innovation Fund. Further details of how this will operate are still to be decided.

Ceri Dornan GP

Balint Work in London and the South East

Balint weekend and leadership training
The Balint Society hosted two events this year in the Southeast, the Oxford Balint weekend in September 2013 with 75 delegates, and the London Study Day and Annual Dinner in February 2014. The Study day focussed on leader development and included a Group Leaders' workshop, a Supervision Group for Balint group leaders who brought their groups to discuss, and an ordinary Balint group for people also interested in the leadership process.

David Watt led a Balint group for the Course Organisers from South East London at Cumberland Lodge in March 2014. David Watt and Mary Burd presented a Group Leaders workshop at the Medical Psychotherapy Faculty of the RC Psych annual conference in April 2014.

Balint groups for GPs, GP trainees,
medical students and care home staff
There are many ongoing Balint groups of various types in the South East. Ordinary GP

groups are in Brent led by John Salinsky and Tessa Dresser, in Lewisham led by Paul Julian and Eamonn Mitchell and a new one in Newham led by David Watt and Maria Eyres. There are two in Oxfordshire led by Val Parker, and one in Brighton led by Anne Tyndale and Fiona Bernard. Paul Julian and David Watt both run groups in the practices from which they retired. Andrew Elder and Anne Tyndale run a group for the Physicians Health Partnership, a multidisciplinary group.

In GP Vocational training schemes there are groups in Tower Hamlets, Northwick Park, UCH, Royal Free, Whittington and the Homerton. Also some work is starting on the Lewisham scheme and the Canterbury scheme (Medway). There are Balint groups in the FY2 year at Newham University Hospital run by David Watt and Paul Julian.

Many of the Balint Society leaders in London also participate in the UCLH Student Balint Group Scheme which is the subject of a new book 'Learning about Emotions in Illness' edited by Peter Shoenberg and Jessica Yakeley. A most interesting departure is a group run by Suni Perera in Brent, where she has obtained research money to pilot Balint Groups for carers in care homes.

Tavistock Balint Group Leaders Workshop.
Finally, there is the ongoing Balint Group Leaders Workshop, meeting three times a year at the Tavistock Clinic, which is now attracting a smattering of psychiatrists running groups in psychiatry training, and attended by 8-16 people each session.

David Watt GP

Balint in the Midlands - new developments

Balint groups
There are a few known groups currently meeting in the West Midlands, and signs are emerging of rising interest in forming new Balint groups which is very encouraging.

Existing groups include:

A group that has been meeting in East Staffordshire for the past 30 years. This is based on the Burton-on- Trent, Lichfield, Tamworth axis. This is largely a GP group and meets in the homes of participants on a rotating basis. Over time it has inevitably evolved into a support group, and as it meets at night includes food and refreshment as part of the programme. The group meets monthly. Members include trained Balint leaders and some aspiring future leaders. Participants are approaching retirement and new recruits are welcome.

A GP group south of Birmingham which describes itself as 'a dinner club with Balint cases'. This is also a peer support group, which draws inspiration and direction from the Balint process. Some members are looking to become accredited as Balint leaders. This group has met over the last decade or so.

A group for Specialist Trainees in Palliative Care from across the region meet monthly. This group has been running for 2 years. It is co-led by an accredited leader and

an experienced facilitator in the process of acquiring Balint Society accreditation.

Balint inspired activity in vocational training, mentoring and the medical undergraduate curriculum.
Balint-inspired activity also occurs in the region to varying degrees:

On the Vocational Training Schemes for General Practice (GP VTS). This depends on the experience and interest of the Training Programme Directors. The region's director of GP Education is very supportive and keen to promote more Balint experience within GP VTS.

Within the mentoring programme for doctors in difficulty. This is supported by the Professional Support Unit (PSU) of the former deanery, now known as Health Education West Midlands (HEWM). The Balint process is applied to deepening understanding of the Mentor: Mentee relationship. This group meets approximately every 2-3 months.

There has been some interest from medical schools in Birmingham and Derby and activity has been sporadic over the past decade or so. No established programme or group exists presently.

New initiatives, new groups in the region
A successful study day/workshop was run in Edgbaston by Drs Jane Dammers and Shake Seigel in April. Interest exceeded capacity. Outcomes of the meeting were several new applicants interested in leadership accreditation and a new group has formed which is due to start in the summer of 2014. A follow-up event is planned for 2015.

A young practitioner group is being planned in East Staffordshire and sufficient interest has already been expressed. It is hoped that this group will start meeting in the summer of 2014.

Enquiries from the west of the region in Shropshire and Staffordshire have been received and an introductory/ exploratory meeting is planned for later in 2014.

Shake Seigel GP and freelance medical educator

Pictured are the delegates who attended the 2014 Beijing International Balint Conference and Group Leader Training.

Fourth Beijing International Balint Conference and Group Leader Training

Peking Union Medical College Hospital
June 2014

We were persuaded by Heide Otten (past president of the International Balint Federation) to join her and others in taking a group and participating in the Fourth Beijing Balint Conference in June 2014. I felt unsure about this when invited but now look back on the experience with warm and positive feelings.

The Conference was organised and hosted by Wei Jing (Professor of Psychology) and held at the Peking Union Hospital. It was attended by 100 Chinese doctors, psychiatrists and psychologists over three days. The staff team consisted of eight members, three Germans (Kurt Fritzsche, professor of psychosomatic medicine at Freiberg, Dankwart Metke, psychiatrist and psychoanalyst from Munich, and Heide Otten, family doctor and psychotherapist from near Hanover); two Australians (Leonie Sullivan, psychoanalyst and Laurie Lovel-Simon, psychotherapist, both from Sydney); an Israeli (Martine Granek-Catarivas, GP trainer and teacher); an American (Don Nease, President of the International Balint Federation); and myself.

The Conference started with talks on 'The Working Method of Balint Groups', 'The Experience of Practice of Balint Groups in a General Hospital in Shanghai' and another on 'Systemic Family Dynamics'. Of course, everything had to be translated by interpreters. We all had well-informed interpreters (often senior medical students) in all the small

groups which tended to slow things down but was very necessary as most of the participants knew no English. Whenever any speaker, or indeed anybody, walked up to the rostrum on the stage they were accompanied by a blast of loud music, sounding like 'Sports Personality of the Year'. Very hyped up – hilarious! The format was familiar – some lectures but mainly small group work (five sessions) and a daily fishbowl demonstration group with discussion.

We realised right from the beginning of the conference that doctors in China have a hard time, experiencing a lot of aggression from patients, quite a number of physical fights and some are even murdered. They are not well-paid (about £10,000 p.a) but get additional payment 'on the side' by pharmaceutical companies, and, apparently people feel that because of this they often do unnecessary tests which engenders mistrust. Mistrust seemed widespread. Their workload is heavy (60 plus patients a day) and there are often difficulties between doctors and the administration which also causes problems. Sound familiar? We heard that the drop-out rate for medical students is high – not surprising! Patients in China receive very basic medical care, having to pay themselves if they need better or more effective medicines or treatment. If they are poor this means borrowing money from friends or family members and not seeking help until symptoms are advanced. Then, if the treatment fails and, for example, their aged parent dies when they have spent all their life savings to get help for them, anger is vented on the medics.

In the small groups we noticed attitudes in modern society in China reflected in the cases presented. Patients' angry behaviour often caused anger in the doctors themselves; issues of certain patients being given preferential treatment because of some connection to a member of The Party; or cases of daughters suffering anorexic-type symptoms perhaps due to the huge pressure and expectations on them by two sets of grandparents and their own parents. With the 'one child' policy only children could feel affected in this way, and some cases illustrated the difficulty of separation between parents and their one child. There are many manifestations of what we learned to describe as the 4:2:1 syndrome! Children's school days are extremely long, with extra classes every evening on top of school homework, paid for by their parents, and then the extra pressure of parents having to find the money somehow to pay for their university education.

The staff team were a delightful group, very open in their discussions at the end of each day, analysing problems or difficulties in the groups and how to encourage expression of feelings from the participants. Expressing feelings openly is not the norm in China. One thing that was clear was the enthusiasm among members for Balint work, and generally there is now the start of psychoanalytical training and understanding developing there, although in its infancy. Ninety-two per cent of mental health cases in China receive no treatment at all, and of the remaining eight per cent most are treated pharmaceutically rather than with therapy, so it felt good to be part of a new venture to introduce this approach. It was also a pleasure to be entertained one evening to dinner by a psychiatrist and systemic family therapist in Shanghai who has started various projects to open up training and research – a real pioneer.

There were other papers given during the conference. One was a talk on 'The Doctor-Patient Relationship in the View of Medical Students' which had a lot in common with medical students in this country, and there was another talk on 'Systemic Balint Work and Sculpture'. There was an emphasis from some team members on the use of

sculpting in Balint groups to help participants express feelings more easily, but attitudes varied among the staff team of group leaders about this, and I myself wondered whether participants were being given too much to think about, with two methods portrayed in the papers when most had never had previous experience of Balint work before. At the end of the conference I was asked to lead a Fishbowl which was quite an arduous task with interpreters who were not always easy to understand and a group (along with an associated case) determined to 'break rules'. Perhaps a breakthrough of sorts – but an uncomfortable ride for my co-leader (Laurie Lovel-Simon) and I! Feedback seemed very positive about the whole conference with enthusiasm about continuing it again next year.

Fortunately we were able to get in some sightseeing in Beijing, a walk along part of the Great Wall, a Chinese foot massage, and a tour of the Forbidden City. After the conference, we made a five hour (only) train journey – by bullet! - to Shanghai (stations like airports, meticulously clean and shiny) and enjoyed a few days being a tourist in an amazing modern sky-scraper city with a population of 25 million. So our Chinese experience turned out to be a very positive one, full of interest, opening our minds to a very different but changing society - and a truly global perspective on Balint work! China remains a deeply authoritarian and repressive society and we can only speculate what will become of something open, collaborative, and liberating, such as Balint work.

Andrew and Penny Elder

The Balint Society Essay Prize 2015

The Council of the Balint Society awards a prize of £500 each year for the best essay on the Balint Group and the Doctor-patient relationship.
Essays should be based on the writer's personal experience and should not have been published previously.
Essays should be typed on one side only with three copies, preferably on A4 size paper with double spacing and with margins of at least 25mm.
Length of essay is not critical.
Entry is open to all except for members of the Balint Society Council.
Where clinical histories are included the identity of the patients should be suitably concealed.
All references should conform to the usual practice in medical journals.
Essays should be signed with a nom de plume and should be accompanied by a sealed envelope containing the writer's identity.
The judges will consist of the Balint Society Council and decision is final.
The entries will be considered for publication in the Journal of the Balint Society.
The prize-winner will be announced at the Annual General Meeting.
Entries must be received by 1st May 2014 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr Tom McAnea by email as an attached word file. The address is *tomcmc@doctors.org.uk*

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