VOLUME 50

JOURNAL OF THE BALINT SOCIETY

SEPTEMBER 2025

JOURNAL OF THE BALINT SOCIETY
VOLUME 50 2025

Soreanu, R. (2025). Editorial. *Journal of the Balint Society, 50: 1-3.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Editorial

Raluca Soreanu[1]

[1] Department of Psychosocial and Psychoanalytic Studies, University of Essex, UK: raluca.soreanu@essex.ac.uk

A plurality of formats and affective registers mark Volume 50 of the *Journal of the Balint Society*: from reflecting on sharp moments that change one's practice, to registering the loss of the Balint group space after retirement, to marking the transformative nature of working with patients with a mental health diagnosis, from creative writing that comes with a smile, to reflexive essays that ponder steadily on the continued relevance of Balint work, to writing that captures anxiety, ambiguity, or a sense of fluidity and even dissolution in clinical settings.

As Editor, I celebrate this plurality, and I would like to reach out to our community and invite submissions that innovate in both theme and format: shorter, longer or fragmentary pieces, in poetry, or essay style, or theoretical elaborations, or clinical vignettes. Fragmentary kinds of writing are, I believe, ever more relevant, not as a whim, or some kind of 'de-composition', but as a transformation of sensibility in the direction of questioning totalities and conclusive statements.

This volume is also marked by the presence of six prize essays, written by Ariana Axiaq, Will Brook, Elspeth Jamieson, Ava Koshnaghsh, Lianne Warr and Michael Zervos. The Balint Society UK essay competition – with its two sections, one open to all practitioners, and one reserved for student essays – has been an important call for elaborating on Balint group experiences. I hope many of our readers will feel stimulated to submit their pieces to the upcoming 2025 essay competition.

In these pages, you will find writings on the experience of seeing patients with psychiatric diagnoses (by Megan Coverdale and Katrin Fjeldsted); an article on grief and mourning in clinical practice by Henry Jablonski; a poem by Andrew Leggett; a reflexive essay by Alexsandr Supunov on the role of Balint groups for psychiatry trainees; a piece co-authored by Amelia Thompson and Vikram Luthra on the relevance of the 'drug doctor' in the NHS today; a playful (and probably the first!) Balint 'recipe', detailing the 'ingredients' of a successful Balint group by

Michael Zervos; and two historically important 'scenes' from the early days of Balint groups by John Salinsky and Suresh Pathak.

You will discover in the pages of the Journal several photos of Michael Balint and Enid Balint, which to my knowledge have not been published before. They are precious archival material: I am grateful to Susan Lawlor for the opportunity to share it with our community. The images originate from contact sheets produced in the 1967 by Edward H. Stein, M.D. (Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois). They have been digitalised with the support of the FREEPSY research project, based at the University of Essex.[1] I would like to thank Ewan O'Neill and Hugo Coria for preparing the photos for publication. We decided to maintain some of the markings present on the contact sheets, as this affords the viewer a way of being in some touch with the original material support. The cover image itself, designed by Hugo Coria, is cut and enlarged from one of the valued contact sheets I mentioned.

I would like to thank the Editorial Committee for their ideas and input: Shameel Khan (Deputy Editor), Katalin Barcza-McQueen, Jacqueline Bristow, Andrew Elder, and John Salinsky. I thank Agnes Meadows for her careful and dedicated copyediting work. I am sad to say that Andrew Elder is now stepping down from his role on the Editorial Committee, but his wisdom, generosity and insight will endure with all of us in our editorial work. It has been a privilege to be in conversation with him over almost a decade.

I would like to dedicate this issue to psychoanalyst, author and editor Judith Dupont, who in September 2025 is celebrating her one hundred years anniversary. She is an 'agent of memory' who contributed in important ways to the ways we are able to remember and access the work of Michael Balint and Sándor Ferenczi (and the work of the thinkers of the Budapest School of psychoanalysis more broadly).

---

[1] FREEPSY is an interdisciplinary research project ('Free Clinics and a Psychoanalysis for the People: Progressive Histories, Collective Practices, Implications for our Times') supported by a UKRI Frontier Research Grant [grant number EP/X022064/1]. See: https://freepsyproject.com.

Figure 1.
Michel Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu and Ewan O'Neill, with the support of the FREEPSY project. Montage by Hugo Coria.

Patterson, A. & Luthra, V. (2025). Presidents' Introduction. *Journal of the Balint Society, 50: 5-8.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Presidents' Introduction

Anne Patterson and Vikram Luthra[1]

[1] Joint Presidents of the Balint Society UK: president@balintsociety.org.uk

We are delighted to celebrate the third edition of the Balint Society Journal edited by Raluca Soreanu. The previous double edition of the Journal was launched after the pandemic, and at the beginning of our term as Joint Presidents. The current issue, volume 50, is published as we approach the end of term.

We have taken this point as an opportunity to reflect on how the Society has changed in the aftermath of the pandemic, on the notable developments we are working to achieve together as Council, and on the potential challenges.

Balint Society Website. This is now up and running, comprising a user-friendly interface with a variety of relevant resources (including previous copies of the Journal). We are grateful to Eamonn Marshall and Turtle Reality for all their work.

A relaunched Training and Education (T&E) Committee. We are grateful to Shake Siegel who was steadfast in maintaining T&E and in making links with Council and other engagement groups within the Society.

Accreditation Team. We are pleased that we have a robust team, chaired by Liz Lee and Chris Douglas, who are continuing to receive new applications for Balint leader accreditation. Council agreed new criteria which were introduced in June 2023. The criteria have undergone a further review by the accreditation team this year to ensure that we are getting the right balance to encourage growing numbers of effective leaders.

Supervisor Accreditation. Allied with the above, supervision criteria have been introduced and supervisor training days have now started.

Balint Society Members. We are attracting new members from new professions and a younger, more diverse demographic. This was reflected at the Leeds Study

Day (2024) with presentations about Balint groups for lawyers and gardeners as well as the more traditional groups for GPs, psychiatrists and therapists

New Council Members. We are pleased to see that there is plenty of enthusiasm from a younger generation to join Council and take on significant roles.

Financial State. We are pleased to be leaving the Society in a stable financial state, although we are mindful of the need to avoid complacency and ensure that we continue to break more or less even on events.

International Balint Federation. Chris Brown is the Council's new link person with the IBF, thereby strengthening our Society links internationally and feeding back any new developments. As Joint Presidents we continue to meet with the presidents of the international societies to represent and maintain the UK position on the global Balint stage.

Events. We have been reviewing the Balint Society events to ensure they are up to date and relevant for all those interested in Balint group work.

Challenges. Despite all the above, we have ongoing challenges which we hope Council and the Society will continue to take seriously: engaging GPs, retaining leaders who become accredited, and maintaining history and the experience of senior members. It is also of note that in psychiatry although case-based discussion remains mandatory, the majority of groups are not led by accredited leaders, even though they may be following the Balint model.

We are pleased to launch our September 2025 Balint Society Journal, which we hope will be thought-provoking for you all. We would like to take this opportunity

to once again thank Raluca Soreanu and the Editorial team – Katalin Barcza-McQueen, Jacqueline Bristow, Andrew Elder, Shameel Khan, and John Salinsky – for all their hard work putting together the journal.

Finally, we are thankful to Council and you, our members, for your ongoing support for the Society.

Coverdale, M. (2025). A Consultation that Changed My Practice. *Journal of the Balint Society, 50: 9-14.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

A Consultation that Changed My Practice

Megan Coverdale[1]

[1] Final year student at Hull York Medical School, UK: hymc24@hyms.ac.uk

This is a narrative of hope and humanity: a consultation which has enormously emphasised to me that we must redefine health and the way we consult with our patients who have complex intertwined physical and mental illnesses. We must acknowledge that it is a privilege to provide meaningful care to our vulnerable patients in the community who often find great courage to present in practice in an attempt to seek some solace.

During my medical school placement within a rural general practice, I met with a 72-year-old female, whom I will call Ms M., presenting with for a review of her chronic low mood. From what seemed at the start to be a routine appointment exploring the current status of her mental health according to the booking note, all was not so simple. Within minutes of the consultation starting, I was presented with a poem written by the patient that expressed her innermost thoughts and feelings about life.

An excerpt from the poem[1] reads:

What else is there left to say,
When you dread every new day.
If I could find peace,
Maybe my torment would cease.

All I want is to be normal, whatever that is.
I only know that it is not this.

Does anyone understand my fears, or do they feel my tears?
My trust in people has been broken.

[1] Permission gained from the patient, Ms M.

I was taken aback, struck by the ebony ink on the crimpled paper looking back at me. For a moment I embraced the silence within the room and paused to reflect. Ms M. sat still. Sombre. It seemed that today it was easier for her to communicate openly and freely with text than words, a first for me to experience. Although this was a heavy poem to read, having only been in the presence of this patient for mere minutes with minimal awareness of her background at that point, it undoubtedly highlighted to me the depths of her inner turmoil that she was willing to share. As a third-year medical student, it was an honour to have been privy to such a patient encounter. I was moved to have bonded and built trust so easily with Ms M. to the extent that she felt comfortable sharing this poem. It allowed me extraordinary insight into the cogwheels turning inside her mind at that moment in time.

After a frank, open, and honest discussion with Ms M. – alongside my supervising general practitioner who was also present – we started to depict the psychological distress she was experiencing and unravel why this was the case. I soon learned that she had recently experienced multiple dismissive consultations for her physical ailments with healthcare professionals. They had candidly stigmatised her and, unfortunately, undermined her capacity to engage in direct conversations as an adult after reading about her complex medical and psychiatric background. Relating to a past appointment for palpitations that she was experiencing, Ms M. recalled that

> *'when he [the doctor] found out I had mental health issues, he stopped talking to me and directly engaged with my daughter.'*

The crux of my consultation with Ms M. highlighted to me that during healthcare encounters, all Ms M. has ever wanted is to be viewed as a person. A real living human being, sharing the same air that you and I breathe: not an object,

nor patient identifier number, labelled as being a 'nervous wreck', judged by her history but not by her presence in the room. Yet, having faced these recent challenges within the medical community in achieving this, her faith in humankind had diminished. I was horrified to hear of how she felt so easily dismissed.

Ms M. confessed to me that in the past it has been '*actually nice to know that I really had something wrong with me and it wasn't just labelled as my anxiety…'.* Albeit paradoxically, this comment epitomised to me just how important holistic practice is to the individual. Thinking outside of the box when considering causative factors for health concerns is essential: mental and physical illness can coexist simultaneously. As doctors, we must not have preconceived ideas that a physical illness is always a result of pre-existing psychopathology and be biased in our judgements.

Having heard directly that morning from Ms M. that she appreciated having a medical condition (bradycardia) diagnosed independently, and not connected to her psychiatric issues, it reaffirmed to me the grave need to be proactive and inquisitive when consulting to ensure that all plausible possibilities are considered for the cause of the presentation. I gained a heightened awareness of the absolute need to consult as a generalist within practice: a physician forearmed with the expertise to craft uniquely tailored illness narratives for their patient, and reduce uncertainty in their diagnoses, which, in turn, can help to empower Ms M. and restore her optimistic outlook on life (Reeve, 2015; Reeve, 2018).

Upon peer discussion and personal reflection, this exemplar patient experience emphasised to me that we must not overlook the fact that the health needs of individuals are often multifaceted. A patient with complex mental health issues can also have physical illnesses. We must be mindful to not dismiss this finding by avoiding a 'one-size-fits-all' approach to the consultation, and in turn

escape the rabbit hole whereby the presenting medical complaint is attributed to psychological unrest, rather than thinking more wholly and systematically.

I quickly understood that implicit bias within consultations can impinge on the patient's ability to confidently express their thoughts and feelings about their health. In turn, this prevents them from feeling satisfied with a quality standard of care delivered. In this consultation, I realised that Ms M. would likely not have felt the need to write a poem explaining her disdain for life and poor mental health if we, as medics, had previously taken the time to get to know and understand her as a person, not just a patient. A listening ear bearing no judgement, clinical unease, nor bias, was imperative for Ms M. to explain her story, and share the depths of her physical and mental frustrations with me and convey her unhappiness with life.

As acknowledged by Ronen et al. (2020, p.1280), we must readdress the culture of medicine that Hippocrates underpinned: '*cure sometimes, treat often, comfort always*'. It is imperative that we observe how extremely powerful and important the patient-doctor partnership is in upholding strong foundations within medicine. It is fundamental for creating a meaningful two-way dialogue, incorporating the patients' ideas, concerns, and expectations, and acknowledging that the patient is often the expert regarding their health. This epitomises the ethos of Osler, reiterated by Centor (2007, p.59), whereby '*the good physician treats the disease; the great physician treats the person with the disease*'.

Ms M. left the practice that morning having shared her woes. I felt that we had succeeded in reducing the burden she was carrying that day and started to rebuild her faith in the healthcare system by allowing her the space and time to talk in a safe, open, and humane environment. We addressed the totality of her health and wellbeing and encouraged her to think and act positively, and proactively, in addition to safety netting and arranging a timely follow-up appointment, as appropriate. As highlighted by this case of Ms M., we must

advocate for marginalised and vulnerable individuals within the community through compassionate acts of humanity to those in need of expert support. I truly believe that this consultation with Ms M. was a significant illustration of the colossal philosophy of whole person medicine that is essential for the twenty-first century.

References

Centor, R.M. (2007). To Be a Great Physician, You Must Understand the Whole Story. *Medscape General Medicine*, 9(1): 59.

Reeve, J. (2015). Supporting expert generalist practice: the SAGE consultation model. *British Journal of General Practice*, 65(633): 207-208.

Reeve, J. (2018). Unlocking the Creative Capacity of the Self. In Dowrick, C. (ed) *Person- centred primary care: searching for the self.* Oxon: Routledge, pp. 141-166.

Ronen, G.M., Kraus de Camargo, O., and Rosenbaum, P.L. (2020). How can we create Osler's "Great Physician"? Fundamentals for physicians' competency in the twenty- first century. *Medical Science Educator*, 30: 1279-1284.

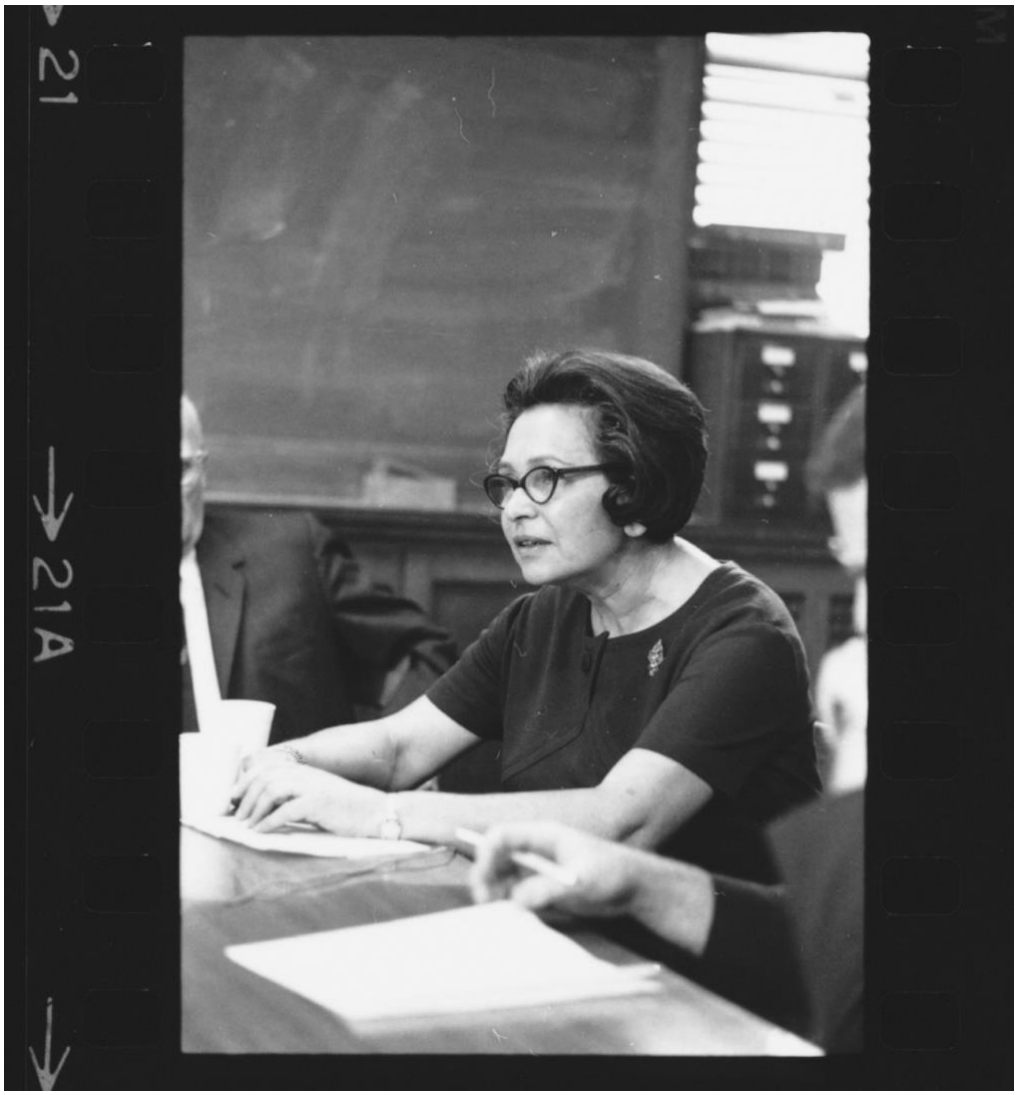

Figure 2.
Enid Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Warr, L. (2025). The Container. *Journal of the Balint Society, 50: 16-23.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

The Container

Balint Society Essay Prize 2022 Winner

Lianne Warr[1]

[1] SpR/ST4, Specialist Registrar in Psychiatry, North-East London NHS Foundation Trust: lianne.warr@gmail.com

My baptism into Balint coincided with my return from maternity leave and the looming threat of global pandemic on the horizon. The first wave would hit one month later, tumultuous and turbulent, with the things we had always been so sure of dissolving like sea foam. Small islands of solace in cherry blossom and kitchen discos – eerie calms while the storm clouds gathered in preparation for another torrent. We were cast adrift from each other, some drowning in ICU, others battered and shipwrecked by grief. Someone writes this in a poem, or something like it*: 'same storm, different boats'*.

We do everything we can to keep things normal for the kids. We read them stories, pick flowers on walks, we try yoga. Somehow, we do this and manage to work a bit in between too (I don't remember how). One day, we build a cardboard pirate ship from all those delivery packages, now arriving with embarrassing frequency (a chess set, weights, a disco ball). It is flimsy, but we all fit inside. We sing shanties, because – like banana bread – shanties have gone viral. Indulge me here for a brief diversion on shanties. Some say their origin is almost that of a marching song, to synchronise sailor's efforts for periods of hard manual labour on an already long and brutal slog of a journey ('Heave! Ho!'). But they're more than that. Mourning and melancholy, nostalgia and hope, stories and magic pour from them by the bucketload. They change on the wind as they are blown back towards land, travelling on the tongues of those they encounter, back towards the mothers they miss: a communication across the waves, the sea, as the distance but also as the medium. Some of the songs are deep as the sea and exquisitely painful as a jellyfish sting.

We have sung a version of the shanty 'Spanish Ladies' to our children at night since they were born, and a line springs to mind now: '*Let us be jolly and*

At the time of writing this piece the author was a Psychiatric Core Trainee Doctor, CT2, North-East London NHS Foundation Trust.

drown melancholy'. But, of course, this is not what the sailors were doing: they were using the time-old tradition of processing something painful through song. '*This is faux jolly to process our melancholy*', perhaps? Ahem. Back, for now, to our living room floor, to the cardboard pirate ship: our son is painting it green. We have found various hats and made flags; we are googling semaphore. We all fit inside. There's something here too about shanties and the pandemic: it is something you sing together, and for those two minutes and fifteen seconds of 'The Wellerman' we are all in the same boat, weathering the same storm. Nonetheless, I think of holes in the hull, using a bucket to stop us sinking. Maintaining this not-quite-normal is utterly exhausting. I read a tweet: '*ever spill a bit of your coffee and realise the thread you are hanging on by is actually quite thin?'*

And so. Back to our beginning. I go back to work. I have a baby and a toddler at home. There is a pandemic. Am I sinking? Am I one coffee spill away from annihilation? In any case, I feel lucky compared to many. Ready or not, here we go anyway. Patients. Laundry. MMSEs. Shanties. Amazon packages. The on-call rota. P.E. with Joe Wicks. Zoom lectures. More Amazon packages. Zoom pub quizzes. Mental State Examinations. Zoom memorials. A&E in PPE. The Maudsley Prescribing Guidelines. Banana bread. Balint (also on Zoom).

Balint. I have no idea what to expect but I dive in. We are invited to swim in the unconscious of our patients, those close to them, and the presenting doctor. I am reminded of Gabor Maté (2007): '*Children swim in their parents' unconscious like fish swim in the sea*'. (He goes on to say, '*It is good to make sure the water stays clear*', but at this period in time the best I can muster is a paddling pool). I am invited to bathe in the minds of old women with dementia, racist inpatients, self-harming teenagers and their mothers who scream 'Do more'. Sometimes we 'lose' the patient, or the doctor, or both, caught in our own fantasy; we are guided gently back to them. Sometimes I submerge myself, and sometimes it's painful to dip a

toe in. Sometimes it is just too close and sometimes too far removed. I try to remember that '*every separation is a link*' (Weil, 1947), but it is easy to forget.

One session, our facilitator tells us about Bion's 'container'. We are holding something for someone that they are unable to hold themselves. 'My hull is leaking. My bucket is full. I'm leaky right now and I need a bigger bucket. SOS.' In acting as container for the infant, the mother carries the infant's rage and sadness, the big, messy things that can't help but spill over. The mother scoops it up, repackages it and hands it back in a child-friendly form: 'Here, I've put a handle on your bucket. It's still heavy, but you can hold it with one hand now.'

This is a moment of realisation for me. I am newly a container for not just one but two small humans, and I'm feeling the surface tension at my edges. I realise this is what I have been doing through the meltdowns, fevers, broken bones: holding them, murmuring to them, making up bedtime shanties – 'Baby, please give me some of this. You don't know what to do with it yet.' I remember the feeling of my skin stretching to its limit toward the end of pregnancy, the ache of a body barely able to contain. And then, suddenly, at the moment of birth, the sensation of a wet fish sliding out of a carrier bag, a sudden emptiness and distance.

As doctors, we like to think of ourselves as strong, sturdy, opaque containers. And maybe we are, some of the time. But in these pandemic years, we cannot avoid the image of our colleagues and friends collapsed in corridors, teary eyes just visible above a mask and behind a steamed-up visor. It is too much to contain. And so here in Balint, we could begin to contain each other: just a little, newly, as containers yielding and flexible and forgiving. Yes, a carrier bag comes to mind again.

It is weird now to remember that I once thought being a doctor might make me a better mother (rather grandiose actually, on reflection). But I do think that being a mother has made me a better doctor, and maybe this has something to do

with my experience in Balint, and the timing of all of it. I am not angry at that mother screaming, 'Do more' at the A&E doctor, and I think I might have been before. I am there with her (I am her) the night my son had a high temperature and I argued with the paediatrician about antibiotics. Not my best moment, I'll give you that. But when your child is sick, even your flimsy carrier bag-like containment starts disintegrating and I can almost hear that unconscious communication now: 'SOS BIGGER BUCKET PLEASE'. And for the patients 'acting out' and saying abusive things to the doctor, I hear it too: 'I AM SPILLING OVER AND I DON'T KNOW WHAT TO DO ABOUT IT, I have never been shown how.' And for the doctor in front of us in Balint, overwhelmed with anxiety or even barely concealed hatred for those patients, I hear it: 'I am supposed to be a big, shiny, tough bucket. What is going on, please?' Balint is one of the things that have helped me to see that people have different ways of telling me their boat is leaking and their bucket is not enough to stop them sinking. It might be coded in semaphore – indecipherable to me – but I will see that they are waving their arms frantically and with time I could learn their red flags from their yellow. They might do something totally mind-boggling, like poking more holes in their ship so that I will help them faster. They might have never had another bucket offered and fearing what it is, throw it back at me, handle and all. The doctor might not yet realise he has a bucket to offer in the first place.

Last year a container ship got stuck in the Suez Canal, and the image that sticks in my mind is that of a tiny digger scraping furiously at the side, totally dwarfed by the task at hand. I realised that I had somehow never thought about how this giant and mysterious industry supplies 90% of the things I wear and eat and do, from bananas to disco balls. I learned that even the captains know less than 5% of what their actual cargo is (could be anything from yoga mats to nuclear waste). A rather shocking number of shipping containers just fall off into the sea, unopened, buried and forgotten.[3] I suppose Balint and parenthood remind us that,

even when we present ourselves as huge and reliable containers, some parts are still unknowable to us as captains of our vessels. Some compartments will fall into the sea, remaining sealed and unopened. Perhaps, though, by allowing others to scratch the surface, some parts may become more knowable to us. Moreover, we cannot know if or when we may become 'stuck' ourselves, and not only block our own progress, but that of the containers around us, who rely on us to navigate and move smoothly through a difficult passage. Come little baby ships, follow your mother ship to the sea!

The sea, the sea. Perhaps we should think of the container as fluid itself. During the pandemic, I felt myself drawn towards bodies of water for that fleeting serenity peculiar to floating. I wasn't alone here. In the UK, we flocked in droves to wild swimming spots, drinking up greedy gulps of nature and weightlessness, parched and bone-weary from this inescapable and menacing viral cloud hovering over land. But what else was here? A yearning for a return to the fluid containment of the womb? Like shanties, water is a balm for melancholy: '*For whatever we lose (like a you or a me)/ it's always ourselves we find in the sea*': an E.E Cummings poem I rediscovered at the Turner Gallery in Margate, half-forgotten from my first poetry book given to me by my mother. Margate, also home to the first 'sea bathing hospital' for the treatment of non-pulmonary tuberculosis. A disease then untreatable, uncontainable; how terrifying it must have been, for patients, for their mothers, for their doctors. How much of the benefit derived from this 'treatment' was actually a sort of fluid containment? Is this what the doctors unconsciously offered their patients? No solid container would hold that much mourning, I think. Here in Balint too we can all pour into a collective unconscious and swim together, go fishing and see what bites. Fluid thinking, fluid containment. Maybe we can invite our patients to swim here, too.

Turbulent waters do not reflect. Perhaps we are moving too fast, churning up the waters around us; a wake that would capsize little ships. In Balint, perhaps

we can slow things down, steady our ship enough to give the sea time to still itself and catch a glimpse of ourselves on the surface.

Maggie and milly and molly and may

maggie and milly and molly and may
went down to the beach (to play one day)

and maggie discovered a shell that sang
so sweetly she couldn't remember her troubles, and

milly befriended a stranded star
whose rays five languid fingers were;

and molly was chased by a horrible thing
which raced sideways while blowing bubbles: and

may came home with a smooth round stone
as small as a world and as large as alone.

For whatever we lose (like a you or a me)
it's always ourselves we find in the sea

(E.E. Cummings, 1956)

References

Barr, D. (2020). '*We are not all in the same boat*'. Widely quoted.

George, R. (2014). *Deep Sea and Foreign Going: Inside Shipping, the Industry that Brings You 90% of Everything*. London: Granta.

Maté, G. (2007). *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. London: Ebury.

Weil, S. (1947). *Gravity and Grace*, trans. Crawford, E. & von der Ruhr, M. New York: Routledge, 2004.

Zervos, M. (2025). A Spoonful of Balint (A Recipe).
Journal of the Balint Society, 50: 24-30.

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

A Spoonful of Balint (A Recipe)

Balint Society Essay Prize 2024 Winner

Michael Zervos[1]

[1] Specialist Registrar in Child and Adolescent Psychiatry, London, UK: michael.zervos@nhs.net

Prep Time: 20 minutes

Cooking Time: 60 minutes

Serves: 4-10

I love making Balint. I tend to make it once a week, on a Wednesday afternoon, just as I'm starting to become weary of the working week, and the weekend still seems so far away. I have often pondered it as so unusual to make something like this at work. Hospitals don't tend to evoke that 'warm, fuzzy' feeling, so it's a welcome change to put on my chef's hat and forget how to 'fix' or 'do' and instead sit and listen to the clock tick. I am delighted to be able to share this recipe with you today and hope that more of us will see Balint made more widely, by chefs still yet to be discovered.

I suppose that anyone reading this is at the very least curious about Balint (in reality, dear reader, you're likely to be a seasoned professional Balinter with more years making it than me). Sometimes, though, a fresh approach can work, so I hope reading this recipe will stimulate a change in how you Balint or prompt you to write in with your top tips.

I often find pure Balint to be tricky but, like with any dish, the more I have made Balint the easier it has become. Now, two years into the Balint way, I feel honoured to make it quite well, hopefully, although I'm not holding out for a Michelin Star just yet.

I make Balint for a general group at the moment, a crop of young doctors fresh out of medical school, spread across our region with sparse autonomy and many electronic notes to write. Balint for them can be a bitter tonic. My handy hack in this recipe is to dilute it just enough that it's palatable yet still retains that distinctive flavour that leaves them wanting more.

This is a fine balance, and I confess I don't always get it right. Sometimes they curl their nose at the idea that there is 'no right answer' or scoff at an off-the-wall interpretation I offer. Recently, I made Balint with someone who walked out the room! I couldn't tell if it reeked, reminded him too much of a dearly departed loved one, or perhaps he needed the toilet. More likely is that I'll never know as he's not yet returned (it's been over a month).

Conversely, I have also recently had Participants take to it like the proverbial duck, gliding through their four months in our pond, writing at the end that it was the highlight of their week. I suppose this reflects that the success of Balint does depend on the Participants with whom you make it. Those less mature or experienced might curdle the batch, spoiling the taste for others, but they may also have the pep and zing needed for a truly excellent Balint. Diluting the Balint cordial can be a kindness, making something quite abstract and intimidating softer and more appealing to the biomedical empiricists that our universities train up.

The more I make, the more I realise I don't really know what will happen each week. It's an acquired taste, but that's part of the fun.

You'll be wondering why I use 'I' so much here when we all know that making Balint takes two. I am happy to say my co-chef is the best I could wish for. We have worked together for a year and no longer need to communicate about such frippery like timekeeping. We dance around our Balint kitchen with implicit trust and ease, satisfied that if one of us invites the presenter back into the circle, now is the right time for it. I do think however that we have a different Balint genealogy (stretching back generations) that means we make it differently. We use slightly different tools and flavouring conventions, and I recall it required some adjustments when we started a year ago so as not to step on each other's toes or trip over ourselves. He approaches Balint as though the patient is there making it with you – what a revolutionary idea this was when I heard it?! A patient… making Balint?! Whatever next. But this approach has started to wend its way into my

Balinting, much like how I may pull the presenter back in with, 'feel free to re-join the conversation when you're ready'.

I wouldn't put words in his mouth, but maybe he'll share his recipe with you in due course, as different as it may be to mine.

While they do say that curiosity killed the cat, I can't write about making Balint without commenting on it and am sorry to endanger all our lives like this. At the core of every Balint I make is a kernel of curiosity, and without it the Balint simply won't rise. I think of it like the symbiotic culture of bacteria and yeast (a reference for all the Kombucha brewers reading this), the liquid gold that allows the primary and secondary fermentations to occur with some intangible quality that adds sourness and acidity but also sweetness and depth. Some Participants simply don't have curiosity, and I wonder if they were once the cat, wounded by caring too deeply for someone or something else. I cannot ever know this answer, but I feel grateful to have had my own curiosity nurtured by Balinters before me and now with the chance to pay it forward. I mourn the loss of this curiosity in others and hope for its spark to reignite over their career.

Can you write about Balint without a brief word on silence? Everyone who makes Balint has a different tolerance for silence, and there is no universally agreed right amount. I like to think about it as a proportion; am I adding enough silence for the other flavours to shine? Is there enough silence for the Group to breathe? Is there too much silence now, suffocating the Group? I have seen Balints thrive with the right amount but know it must be titrated exactly. Managing this titration is hard while concentrating on the faces around the circle and flurries of conversation, and I recall finding a recent silence intolerable. I simply had to burst the bubble, effervescent in my chair with something to say, frustrated that no one else would. But I did restrain myself and beheld a Participant pipe up two heartbeats later, offering up a thought that must have flitted through my mind directly into hers. The silence works: have faith.

Without further ado, here is my tried and tested Balint Recipe:

Ingredients

- 1 (but preferably 2) Balint Leaders
- 4-10 Participants – the more you use, the more you might need to stir the pot
- 1 'Does anybody have a case?'
- 1 doctor-patient relationship
- 1 ladleful of curiosity
- Several healthy sprinklings of silence
- 1 jar of Questions of Fact

Steps

1. Create a safe and welcoming space for the Balint to rise. Set the scene with some confidentiality, introductions, and warmth. Make sure the Group is in a circle and can all see each other.
2. Time to add the 'Does anybody have a case?'
3. Allow the silence to settle until someone is so uncomfortable they crack like an egg, spilling a viscous story that could hold anything from raving madness and sombre death to raucous joy or mind-boggling boredom.
4. At the end of the story, make a judgement as to whether Questions of Fact will add or take away from the Balint experience. There is no right or wrong here – some suggest a maximum of 3 questions, while others might give 10 minutes.
5. Push back the Presenter and allow that safe space you created earlier to heat up.
6. Allow another liberal sprinkling of silence.

7. You should start to see some bubbles at the point, hopefully from a range of points around the room. Try to resist stirring as much as possible.
8. Despite your resistance, a stir may be needed. Be judicious, don't use too much force, and try to follow the flow of the conversation.
9. Season with curiosity as needed, and make sure you taste as you go, looking for the bouquet of the doctor, the patient, and (most importantly) the relationship.
10. At the right moment, bring the Presenter back in. Fold them back into the Group, infusing with flavour and reflection, but take care not to over mix.
11. Take off the boil 60 minutes after starting, certainly no more. Thank the Group and bottle up that warm Balinty goodness until your next batch.

Some Cautions!

A. Sometimes you might have a very lively Balint, with Participants fighting over which case to bring, or certain people demanding more attention during discussion. Trust your gut instinct in these cases: if someone is obnoxiously hogging the room, it's likely others will have noticed and be resentful. Nurturing the Group can sometimes require you to dispense some tough love.
B. You may worry about your Balint being too large or too small. It can lose its wow factor with too many Participants and might also be too uncertain and volatile to handle. Conversely, fewer people mean you'll struggle to get it to rise whatsoever, having to stir and steer the Balint far more than you'd want and losing the authenticity of the Participants' contributions. These issues are sometimes inevitable, and you must persevere through to the next week,

perhaps with a kind but firmly worded reminder that attendance is expected.

Summary

My Balinting journey has been a great privilege, and I feel fortunate to know I have many years left to do it, and many more Balints to try (I recently found out how good Oxford Balint tastes – I highly recommend).

Even after writing up this recipe, I still don't quite know what Balint is. Is it a juice or cordial, readily diluted to one's palate? Is it a carefully crafted pie, decorated and baked in a roasting oven? Is it a collaborative fermentation, a hearty stew, a bread that you watch rise? Is it all these things and more?

I think it must be, because Balint's unknowability is its attraction, and I'm glad that I still find myself compelled so many years in. I shall continue to peak and trough for as long as I make Balint – it's never the same twice, and therein lies the beauty.

Good luck!

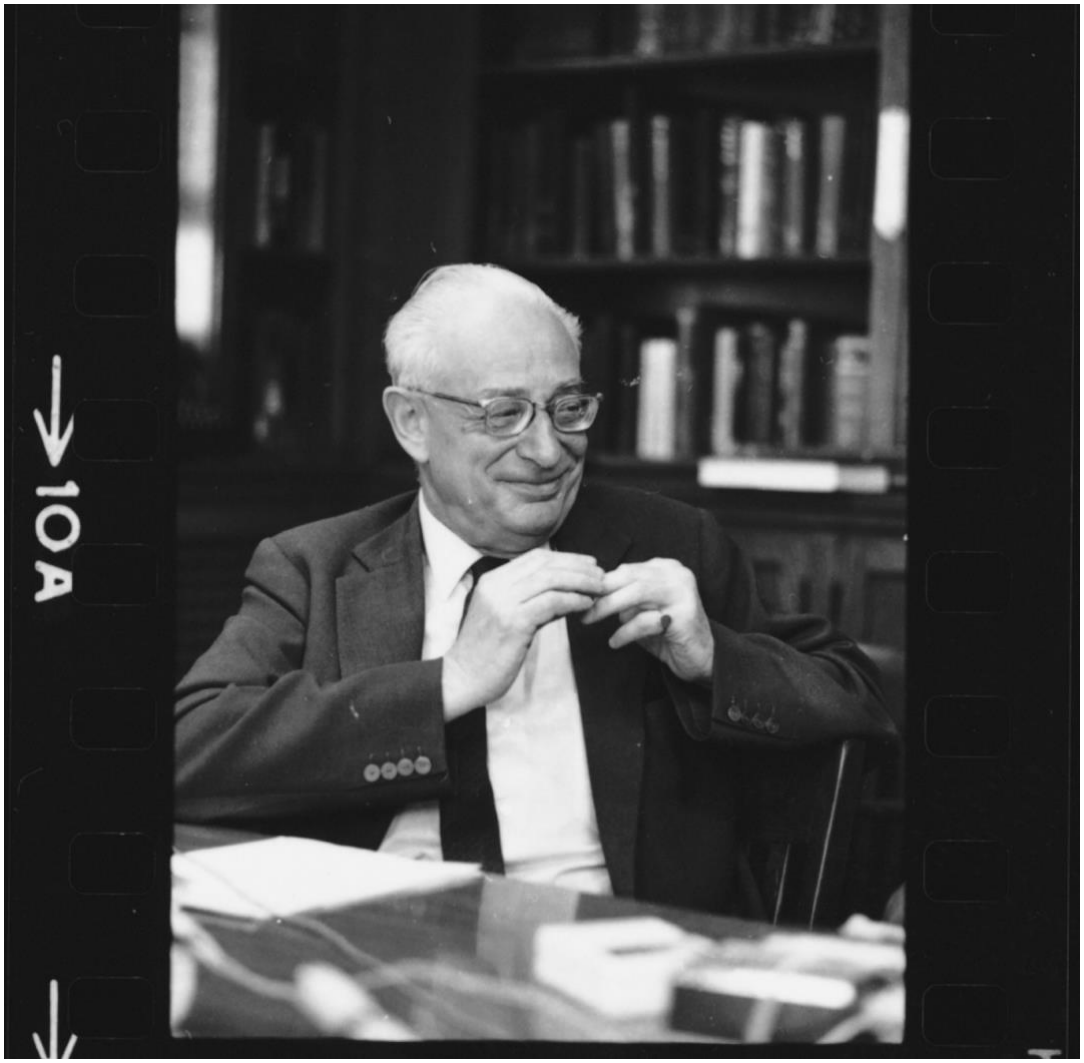

Figure 3.
Michael Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Jablonski, H. (2025). On Grief and Mourning in Clinical Practice. *Journal of the Balint Society, 50: 32-49.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

On Grief and Mourning in Clinical Practice

Henry Jablonski[1]

[1] MD, MSc, Sweden: drhj@jablonski.se.

Before I started to work on this paper,[1] I asked a good friend, an experienced paediatrician who has devoted the larger part of his clinical life to children with chronic intestinal diseases, 'What do you think about mourning in everyday clinical work?'

'That is a difficult issue', he answered thoughtfully. 'It´s not only about mourning when patients die, but patients and their families also mourn the remaining disabilities.'

'Indeed,' I said. 'Now, what I had in mind is rather the mourning in you, in us, as doctors. How do we deal with it? How does it affect our libido economy?' – an odd phrase that slipped out of me, but he is used to my idiosyncrasies, but to make sure I added, 'How does it affect our lives as human beings both inside and outside of our surgeries? Which are the triggers for mourning reactions in us as clinicians?'

His gaze turned inwards. He obviously needed to rethink my question from quite a different angle. But would you not agree that his response is typical for many good clinicians? Their focus is on the patients and their families.

There is very little space in clinical everyday life for the doctor´s own sadness, grief and mourning. Authors on this subject refer to 'disenfranchised' reactions, i.e., unrecognised phenomena – often repressed or else manifested in a variety of ways. Our professional and personal psychological defence mechanisms prevent us in varying degrees from dealing thoroughly with impending strong emotional reactions. This is generally adequate, as we cannot compete with our

[1] This text is based on the opening speech for the Swedish Annual Balint Conference at the Östrabo Bishop´s Farm in Växjö in September, 2021, on the theme of grief and mourning in clinical practice. A minor part of this text appears in an earlier paper, 'The Human Glue in Medical Practice and Balint Group Work: Coping with the Unavoidable Illusions and Seductions in the Doctor-Patient Relationship', included in the *Proceedings of The International Balint Congress* in Heidelberg, 2013. Inspiration for writing earlier versions of this paper is owed to Andrew Elder's (2009) discussion of the GP practice as a secure place for both patients and doctors.

patients and their families for the emotional space in the clinical encounter. Yet, when we are affected, how do we deal with it?

An array of questions come to my mind. How does the cumulative experience of grief and mourning in clinical practice – be it recognised or repressed – affect the inner life of the doctor? How do we defend ourselves against the experience of grief and mourning? When are our defences adequate? When will the repressed affects constitute a potentially traumatising process? How does the personality of the individual doctor and his/her personal life experiences play out in the clinical meetings? And how do these issues show and play out in Balint group work?

Before we go into these issues, a general observation: Doctors, to a varying degree, have a need to underpin their daily practice with recognition and appreciation from their patients, colleagues, and staff. Nothing strange about that. Mutual recognition is usually an important part of most work relations. But I think it is worthwhile to look at this aspect as a mix-up of professionally adequate *and* personal (neurotic) intentions. Lack of recognition may be a source of mourning, depression, and frustration in doctors. Also, you can hardly talk about mourning and bereavement without talking about attachment, relation, and love.

Writing the draft for this paper,[2] many experiences came to my mind, mainly

[2] This presentation was originally planned as a joint venture with Stefan Bálint (1945-2019) from Malmö. Stefan was a Swedish psychologist and psychoanalyst, member of both the Danish and Swedish societies, and former chairman of the Danish. He was introduced to Balint work in the '70s by Professor Lennart Kaij, who had adopted the method after visiting the Tavistock that year. Stefan led groups for almost 40 years and trained leaders. At the time of his death, he was a full-time practising psychoanalyst making plans to retire in 2021. In July 2019, he had a bike accident that left him tetraplegic and confined to a respirator. He was mentally intact till his last breath five weeks later. We never found the time to coordinate our contributions. But you would have heard Stefan´s thoughtful reflections, so well grounded in his personality, in psychoanalytical theory and practice, and in his Balint work. Stefan, as an analyst, supervisor, teacher and Balint leader, was highly reputed, almost iconic, for his profound and useful take on matters. It is a pity that he had such a resistance to writing. But I see many of his partners and Balint disciples in this gathering today – carriers of an even more important oral tradition. So, for us who had the privilege to work with Stefan, our joint project goes on.

from the Balint groups I have been leading but also from my own clinical work. But why should I waste your time with them? You will all have innumerable examples of your own. I will present a couple of examples though after my attempt to discuss relatedness, grief, and mourning from a psychoanalytic perspective and my take on recurrent themes in clinical everyday life.

I will begin by touching on some psychoanalytic ideas. Firstly, I discuss the Balint vantage point on the practice of psychoanalysis and his thoughts on human psychic development. Secondly, I look at Freud's ideas of mourning, depression, and early psychic trauma. Thirdly, I bring in Winnicott on the transitional area. Drawing on these authors, I explore the traumatising potential of grief and mourning on 'both sides of the aisle' in clinical work.

Balint's formulations are not self-evident at all, even if they may seem so – neither in psychoanalytic nor in medical practice. He insisted on the value of treating patients in an informed, interactive, and benevolent way. Even in his English writings he used the German *arglos.* It is often translated as *non-intrusive,* which does not by far cover *arglos.*

The benevolence is missing and, in my view, so is the most important aspect – sincerity and honesty – which contain a double commitment for the doctor: to betray *neither* his patients *nor* his own professionality.

Sigmund Freud described psychoanalysis as a love cure. That cure would only be possible if there is a repressed love in the patient behind the suffering, behind the psychic and psychosomatic symptoms, the despair, helplessness, mourning and fury. It is important to recognize that this is the most common reason for people looking for psychotherapeutic help – but not always. Love is also crucial for the psychoanalyst/psychotherapist: his/her professionality, intuition, and psychological knowledge should be steeped in a loving – *arglos* – intention, a constrained passion, which will facilitate a non-intrusive examination of the patient in cooperation with the patient. This is what Balint called *a mutual investment*

company. Correspondingly, would you not agree, that love, the *arglos* benevolence, is necessary for good enough doctoring?

Such personal qualities and professional motives should not be taken for granted in clinical practice. They may lack, or more often be blurred by, other motives and psychological and social restrictions. Correspondingly, we should not assume that the motive of patients seeking therapeutic or medical help is *always* benign. As a Balint group leader, I have been struck by how many hard-working doctors in various somatic specialities *do* have these qualities and professional motivation. Many of them are psychologically resourceful – a gift often not recognised by themselves until they discover it through Balint work. Then they can make better use of it in their clinical work. It is easy to understand why Balint wanted to work with such colleagues. They certainly must have widened his perspectives, just as Balint group work opened new areas for applied psychoanalysis. A mutual investment company, indeed! Michael´s namesake Stefan felt the same (see footnote 1).

Balint (1952) coined the concept 'primary love', describing the early mother-child relation – the harmonious mother-child mix-up – an area characterized by a powerful mutual illusion, out of which the individual will gradually emerge.[3] From here the child will discover the world, its own creativity. The impact of the mother-child mix-up experiences – to most people deeply embedded in their childhood amnesia – will have a considerable impact on our adult lives.[4]

---

[3] Reading Balint´s books and essays, you can really sense his vitality as a psychoanalyst. Yet, as Harold Stewart (1992) pointed out, Balint did little to link his ideas to other contemporary psychoanalytical theories. Balint himself wrote that it was due to his lack of courage. I could not possibly know but I have an impulse to disagree. I think he had good reasons, like avoiding involvement in the Melanie Klein-Anna Freud controversies. However his thinking and concepts, particularly on ochnophilia and philobatism (Balint 1959), and also on more accessible ideas like primary love, creative area (Balint 1952), basic fault, etc., were never quite integrated into the psychoanalytical mainstream, despite their obvious connection with Hermann, Mahler, Ferenczi, Winnicott, Freud, Little, Bion and Fonagy.

[4] Balint tended to see traumatic experiences as affecting the primary-love state of the baby – threatening to damage the development of the child's budding loving capacities – rather than focusing on primary rage and hate in a baby who is experiencing external 'normal' frustrations. His

My reading of Balint is that he saw traumatic experiences as something that was threatening to the primary love state, the creative area. Traumatic experiences, mainly in the preverbal stages, could prevent the development of the creative and loving potential of the infant. The harmonious mother-child mix-up would be a reasonably safe harbour, a container, for the painful, overwhelming, and terrifying experiences of the world into which the baby so recently had entered. Primary love in the mother-child mix-up would help the child to gradually incorporate, assimilate, and integrate the world and thus develop increasing independence.

Internalisation – the incorporation of impressions, experiences, relations – is a process which starts very early in life, presumably in utero. The differentiation between self and object emerges gradually. A prerequisite to mourn someone/something is that it must be represented in the inner world of the mourner. Our ongoing everyday lives are played out in parallel spaces of our souls. In most of us, fortunately, there are some leaks between the universes of fantasy and reality; between obsessions and passionate ideas on the one hand, and reflective thoughts and calmer states of mind on the other. Balint (1952) spoke of the *creative area*. We could see these parallel states of mind as the living heritage from our childhood fantasies, which become more or less integrated and more or less repressed in the adult ego.

D. W. Winnicott (1971) developed a similar concept, *the intermediate area*. Similar to how a child enters into relation with a stuffed animal, or a snuff blanket, or various forms of imaginary or interactive playing, the grown-up enters into relation with the drama, worship, and nature. And to his fellow human being. This

---

thinking is concordant with Winnicott´s 'good enough mothering' and Bion's transformations of indigestible psychic elements into digestible ones. The harmonious mother-child mix-up setting will contain frustrating and traumatizing experiences and, in the end, promote separation, individuation, and growth. Balint stated explicitly that every psychoanalytical theory – including his own – contains a basic-fault bias, urging us to spot it when judging the essence and clinical relevance of a psychological idea. What I am missing in Balint´s discourse is a discussion about the possibility of a mother-child disharmonious mix-up and the constitutional potential of the baby itself, i.e. its ability to cope with disharmonies in early-symbiotic relations.

is what Martin Buber (1937) named the *I-Thou* relation. These concepts embody a psychic reality, which may help us to deepen our understanding of our clinical practice by looking at the surgery *also* as an intermediate area.

Would it be fruitful to consider that we offer our surgeries to our patients not only as a clinical meeting place but also as a personal playground – a place where we are playing, but also are played on and played with? The meetings with some patients, some situations, for better or worse, tend to touch early strings, increase the permeability between our parallel inner worlds. How do the inner perceptions/images, which doctors and patients have of each other, match with actual psychic realities? From a strictly medical perspective, I think it is important to recognise that these more or less conscious biases do at times affect clinical judgement significantly. Balint´s (1971) concept of *the apostolic function* links directly to this transference by the doctor onto his patients.

How do we affect each other in more or less harmonious ways? How protected, or unprotected, are we as doctors in those meetings? Where does mourning enter, and what is its place? The practice of any somatic doctor differs from that of the psychoanalyst. But still, personal basic faults projected on patients do affect the treatment situation. Doctors live in a 'harmonious and dis-harmonious adult mix-up' consisting of an uncritical obedience to the local subculture of the clinic, to EBM and other guidelines, and to the influence of the pharmaceutical industry, leading to over-medicalization, which exerts a strong influence on the doctor-patient relationship.

Depression and Mourning

Freud (1917) emphasized in his essay on 'Mourning and Melancholia' that mourning consists of psychic work on an object loss. Depression is similar but

different. Mourning is painful and exhausting, but, Freud stated, it does not significantly affect the self-esteem of the mourner. The purpose of mourning is to liberate the love of the mourner from the lost object. Let us say that someone we love *is* dead. The full implication of this sentence is a psychic contradiction as the immediate reaction tells us that someone we love *cannot be* dead. Reality tells us that we cannot be where the deceased loved one is, but the bonds of love oppose it, by spontaneously refusing to accept reality. Sometimes the mourner has a strong urge to join the deceased loved one. In the *work of mourning* (this Swenglish expression with its association to labour is more expressive than the *process of mourning*) the presence and the memories of the lost loved one are intensely reactivated. Thus, gradually, the bonds can be eased. The mourner can move on. The deceased loved one does not exert such strong pain inside the mourner any longer. The dead is not part of a shared life any longer, yet is alive, incorporated, in a different way. In Swedish there is a saying about a person full of zest and vitality: 'He/she is full of the bones of the dead'.

The most significant difference between mourning and depression consists of the 'inner right' to liberate oneself from the lost object. A depressed person constantly lives in the shadow of the lost object, Freud said. The depressed person is often clueless about the feelings and thoughts that are dynamically active in the depressive process. The affective life is dominated by hopelessness and meaninglessness. The sense of coherence is fragile or lost.

As doctors it is unavoidable that we meet with patients and relatives and are thrown into situations that affect us. Most doctors are committed to deal with them one way or other. (Some are not). Doctors who do not have the space to reflect and work on painful clinical experiences are under oppression and run a risk for secondary traumatization. The cumulative *unresolved* experiences – recognized or not – tend to lead to chronic unease, personality deformities (detachment, cynicism, hyperactivity, obsessiveness, etc.) – and/or depression. The consequences, neither

for patients of such doctors nor for the doctors themselves, are not difficult to imagine, if we allow imagination a minimum of space.

Repressed Mourning

Over the years as a Balint leader, I have often wondered how many doctors there are out there who are clinically or sub-clinically depressed from harbouring introjected clinical experiences chaffing in them. 'Where on the VAS-scale is your case?' That is a frequent question when setting the agenda for a Balint session. The doctors themselves usually underestimate the pain and the urgency of their cases, whereas in a well-functioning group the other members can hear the pain and distress of the presenter already in the first sentence.

The situation for a colleague presenting a distressing case often reverberates with a state of inner loneliness where doubt, self-reproaches, and self-devaluation dominate. Working through your case in a Balint group is greatly facilitated by the other group members making themselves available as living and present objects, as temporary auxiliary egos for the presenter. Indeed, the entire group can be seen as a good-enough mix-up. By being immersed in in it, the presenters may recover and develop a more distinct, and a better integrated, professional ego. They will be able to reflect on the doctor-relationship in a more realistic way and have a clearer view of its intricacies. The patients will gain a more available doctor. It is similar to adult patients who successfully work through a depression in therapy or analysis, and whose children will gain more present and adequate parents.

There is another parallel between Balint group work and psychodynamic therapy or psychoanalysis. It happens more or less often that you as a therapist become aware of your own unresponsiveness to your patients. Such deficiencies and defects in the therapeutic relation can often be repaired and turned into

something useful that will help the patient come closer to himself. It may well be that the therapist was absent-minded or insensitive 'on his own merits'. But it may also be that something in the patient´s inner life was subtly enacted in the room, affecting the therapist in the therapeutic mixed-up relation. This process would then be understood as a return, in the here and now, of a traumatizing process in the life of the patient.

In a Balint group, when a colleague is presenting a case that profoundly affects him or her, we are facing a parallel situation if we are not responsive enough. Presenters may even be unable to grasp the insufficiencies of the group. This is a situation resembling work on the basic fault level (Balint 1968). Usually, presenters withdraw into polite numbness. Even if they are vaguely aware of the discussion being misdirected, it is difficult to criticise well-intentioned colleagues when you are at a loss yourself. But, if group members become aware of their failure and the effect it has on the presenter, we may address it. Compared to the setting of individual psychotherapy, there is the advantage that, in a well-functioning Balint group, there are more persons who have the potential of adequately addressing a tormented colleague. Someone will be able to see through the mist. In the end, it is the responsibility of the leader.

Freud (1915) wrote in his paper 'The Unconscious' that a (traumatizing) external stimulus could be internalized, 'i.e., by eating into and destroying an internal organ' – a challenging proposal for psychosomatic medicine. I suggest, in analogy, that undigested clinical experiences are a kind of external stimuli that may be introjected or internalized in the doctor and stay undigested as a painful, shameful, guilt-ridden memory, or a symptom – depression, anxious tensions, and psychosomatic symptoms.[5] Introjection implies that the experience is insufficiently

[5] Such an internalised stimulus will act like an instinctual impulse: it creates a state of tension, discomfort, and pain. Freud (1917) returns to the theme of pain again in 'Mourning and Melancholia'. He views the depression that consumes the melancholic person's self-esteem as a process functioning like an instinctual drive. In psychoanalytic work we can, in favorable cases,

contained mentally. It is analogous to the traumatic experience of the child, when the harmonious mother-child mix-up has failed to contain and protect.

Clinical Application

In many doctors, professional maturation can also be seen as a mourning process – conscious or not – the lost object being their youthful ideals and visions about the profession. Clinical reality is 'naked'. Meeting with dying and seriously ill patients and their relatives, and facing self-destructiveness and social misery may wear heavily on doctors. So does their meeting insensitivity, cynicism and brutality in colleagues and staff members. Even very experienced doctors can be taken off guard. As discussed above, the burden of guilt is an important dividing line between mourning and depression. Not having lived up to one´s own standards, whether real or fantasied, and particularly when the outcome is fatal for the patient, may precipitate a depression. Balint work can transform such states into sadness.

I think it is important to keep Martin Buber´s (1937) distinction in mind between existential guilt on the one hand and feelings of guilt on the other. Guilt for one's actions that have affected others can never be 'treated away'. They must be acknowledged with the guilt and sorrow that they entail and with those reparative actions that may be possible. One particularly important aspect inherent in Balint work is that you can learn from mistakes by not denying or trivializing them. But, as Buber said, feelings of guilt do not necessarily imply existential guilt. In Balint discussions we also discover that conscientious doctors have internalized

---

revive, rediscover, and reconstruct traumatizing object-relations. The ideas and processes underpinning the depressive state can thus be differentiated from a person´s instinctual life. Indeed, psychotherapeutic work with depressed persons is similar to labour, the therapist acting like the mid-wife.

the imperfections and shortcomings of their clinical environment, thus becoming its victim, following the pattern that 'The shadow of the object falls on the ego' (Freud, 1917). (One should add that doctors who become the active accomplices of a flawed clinical environment are often unfit for Balint work as reflection precipitates too much conflict, guilt, or shame.)

Relief and catharsis are a vital part of Balint group work. Presenters may say that a heavy – and sometimes long-standing – burden has been lifted off their shoulders. But exploring deeply rooted personal idiosyncrasies that affect clinical work (apostolic functioning) is a much longer process. In my view that is a more important and challenging aspect of Balint group work (see Courtenay, 1977, 1992; Salinsky, 2018). Grief and depression may also be reminders of irreplaceable losses – sometimes manageable, sometimes not. To what extent have we chosen the medical profession with the intent to repair something that cannot be repaired inside of us? If so, how does that affect our apostolic mission?

Clinical and Balint Group Examples

A respected and somewhat feared anesthetist, with a few years left until his retirement, breaks down in tears while talking about how he lost a middle-aged patient whom he failed to intubate 35-40 years ago. As he talks about the meeting with the patient and the relatives, and his own vulnerability and loneliness, there is a feeling that it has recently happened. His boss, a benevolent, non-judgmental man, had been unable to meet him in a deeper collegial sense. He had come down to the room with the young doctor and the dead man, taken the laryngoscope, noted how difficult it was to find the lumen, and then with a slanted laryngoscope, kindly and educationally: 'Come, look, this is how you could have come in.' The rest was silence. Our devastated colleague had not been able to go to the clinic for a week and had to take a very long professional detour to be able to return to the specialty he was

so passionate about. He brought the case both for his own sake and because he wanted to give something to his younger colleagues in the group.

I thought that he was brave. Considering his position at the clinic, he took a risk with his younger colleagues by exposing himself. But the Balint framework – equality and freedom of expression – was obviously safe enough.

The emotional extremes in clinical everyday life can sometimes become too much and create conflicts, i.e., if the doctor´s own spontaneous zest for life threatens to break into in the clinical work.

This is exemplified by a presentation by a colleague at a G&O clinic – an unrecognized emotional roller-coaster experience until it was brought to mind in the late afternoon Balint session.

In the morning:
A number of outpatient abortions
Then a visit to the maternity ward
Lunch
In the afternoon at the outpatient surgery
Neonatal death follow-up with a couple
Then a couple consulting on involuntary childlessness
Then a couple wishing abortion, quite late, appr. 16th week. With an ultrasound, I examine the couple wishing for an abortion and I have a spontaneous urge to exclaim, 'You have twins!' I have to bite my tongue. I am at a loss. What is this about? I have nothing to do with them. They are requesting abortion and my duty is to comply. Do I sense ambivalence? In her, in him? Or is this an after-effect with me from the previous visits? Or being tossed dealing with fertility and infertility the whole day? It is helpful to have a Balint group to sort things out to avoid stress and confusion.

This final example illustrates Balint´s thoughts on the vicissitudes of human psychological development and early attachment reflected in a Balint group case. I believe that in some Balint group presentations I can hear the doctor making him/herself available to his patients with something resembling the harmonious mother-child mix-up.

The connection between early attachment and clinical presence is rarely explicitly thought of, but I often find that there is an echo of it in the good clinical encounter. (There is a saying in Swedish 'Health remains silent', yet psychoanalysts insist on bringing those states out of their silence by giving them names). In Balint work, we focus on the clinical here and now – we do not put our group members on the psychoanalytic couch and ask them what associations they have to their childhood and other personal experiences when they meet with their patients. This means that the link between the acute strain and grief reaction of the doctor in a particular clinical event and its connection to the private sphere is usually unspoken of and only implied. Yet it can be seen and confirmed in the group. Though it is not in focus for our work, it happens that personal experiences spontaneously are told.

The presenting doctor in a mixed specialty university hospital Balint group has been treating a severely chronically ill patient, in his forties just as herself. He tries to keep up his family life and work despite his disease with impending organ failure which requires frequent hospitalization. That is when they meet. His state is gradually deteriorating. There is a silent rapport between the doctor and her patient, the doctor explains: 'I cannot say what it is. But there is something special about the character of this man, and yet there are so many things about him that I do not know anything about.'

It is winter. The doctor is off to the Canary Islands for two weeks of well-deserved holidays with her husband and children. She enjoys it thoroughly and sleeps like a log. In the second week of her vacation, she suddenly wakes up in the middle of the night thinking,

'He is dying right now'. Back to work the week after, she finds out that the patient had died in the very hour of her awakening.

There was a long silence in the group after our colleague had unburdened herself of this experience. Gradually thoughts were shared. Her awakening that night and her uncanny feeling seemed to some group members as a natural consequence of what she had told. Some recognized the situation and feelings of the presenter and were reminded of having similar experiences of their own. Others were moved as if a new landscape had been opened. The wordless sharing was an important part of group work. The presenter had both created and found the place to mourn and re-experience what her patient and his dying had meant to her.

On an unconscious level it would seem as if the doctor and her patient were connected in an early mix-up, a sharing within joint boundaries. The group in silence also seemed sufficiently able to share and work on that level. On a *conscious level* there was no manifest mix-up, just a good, friendly, respectful relation between individuals for doctor and patient, and as a parallel process as the discussion evolved in the group after the silence.

Many doctors tend to disregard sensitivities like these as they may be perceived as uncanny (or *unheimlich*), irrational, and certainly at times very tiring particularly with severely ill, deteriorating, and dying patients. The Balint group is a unique place where you may discuss and reflect on such aspects of clinical work and turn such personal qualities of the doctor into a clinical tool.

I think it might be helpful to recognize that human exchange is affected by such undifferentiated, 'primal mix-up relations'.[6] The impact on the doctor-patient relationship varies of course but may be considerable.

[6] For instance, those psychoanalysts who are not aware of how their own basic faults affect the analysis and refuse to address this problem (for narcissistic reasons, or to avoid personal pain or guilt), use their patients and the psychoanalytical body of knowledge to reinforce their own narcissism and to avoid a real life. Both Ferenczi and Winnicott recognized the desperate need of

Some six months later, this colleague presents another case. She told us that she rarely got involved in the treatment of children, but now it had happened.

I don't remember the details, and it's immaterial, but her pediatric colleagues needed her specialist expertise. They had first involved her by phone but eventually she had seen the patient, a seriously ill child, a couple of years old. She had given important advice and instructions to the pediatricians but was completely devastated. In a low voice, she says something like this:

'I had intended to become a pediatrician myself, but my first child died. I was a young doctor. I knew there was something seriously wrong. I searched, I inquired, I tried to explain. The doctors didn't listen. I have tried to tell myself that it was difficult, but I´ve had a hard time getting past the fact that it took them such a long time. And then it was too late. It might have been too late anyway, but I've always thought that, if they had listened, she would have stood a much better chance. I chose this line of service so that I would never again have to face a seriously ill child.'

To me, the atmosphere in the group that shared the experience of our colleague was like being present at the funeral service of her child. In hindsight, I was thinking that the sensitivity she had towards her dying child was transferred to her patients, such as the man with the liver disease. But these patients did not give her an immediate reminder of her own dying child.

Concluding Remarks

Many colleagues suffer from not receiving a positive or negative response from their patients. This tends to affect the self-assessment of their professional contribution in a negative way. The absence of emotional reciprocity – the illusion

---

the patient to cure the psychoanalyst – to create a mature and useful helper. This reflects how a baby plays an active role in establishing the mother-child mix-up from early on.

in the mix-up sense described above – is a pathway to depression. Being structured and 'moderately shielded' can be part of a professional adjustment strategy. But shielding and blind obedience to standardized procedures might prevent doctors from being clinically present and from finding appropriate solutions in an interaction with their patients, which will affect both patients and doctors.

Let us not idealize the medical corps. Some colleagues lack the inner resources to deal with this kind of professional stress. Some defenses are therefore just as rigid as they are necessary for the individual doctor. But I guess that at least half of the members of the medical profession can cope with the pressures inherent in Balint work – i.e. critically and benevolently reviewing one's own clinical practice. The longer you delay such a process, the more difficult it becomes. Because whatever the doctor is made of, too many unprocessed impressions in clinical everyday life risk numbness and dullness. In the clinical meeting there is the seed of a mature professional attitude, but also the seed of destructive action. The doctor can direct this towards his patients as well as towards himself. Declining professional self-esteem, alienation, confusion, poor judgement, burnout, cynicism, and withdrawal are not only symptoms in their own right. They may also be seen as expressions of defenses against anxiety, sadness, and fury with regard to our shortcomings incorporating and internalizing the conditions and fates that we encounter in clinical everyday life.

In a focus group interview that Elsa-Lena Ryding (2023) did with Balint group participants, an experienced colleague said: 'I don't know about the rest of you, but I think it's good for doctors to air their concerns. In the 19th century it was said: "Doctors and priests bury their dead together". Pretty good! Today we also need to bury our sorrows and difficulties… together!'

References

Balint, M. (1952). *Primary Love and Psycho-Analytic Technique*. London: Hogarth Press.

Balint, M. (1959). *Thrills and Regressions*. London: Hogarth Press.

Buber, M. (1937). *I and Thou.* Edinburgh: T&T Clark.

Buber, M. (1957). *Guilt and Guilt Feeling*. Taylor and Francis.

Courtenay, M. (1977). The Leaders, the Doctors and their Patients. *Journal of the Balint Society*, 6: 18-24.

Courtenay, M. (1992). A plain Doctor´s Guide to Balint-Work. *Journal of Balint Society,* 20:20-2.

Elder, A. (2009). The GP surgery as a secure base? Patterns of attachment in primary care. *Psychodynamic Practice*, 15(1): 6.

Freud, S. (1917). The Unconscious. *Freud Standard Edition Vol XII,* London: Vintage Publishing.

Freud, S. (1917). Mourning and Melancholia. *Freud Standard Edition Vol XIV*, London: Vintage Publishing.

Jablonski, H. (2013). The human glue in medical practice and Balint group work – coping with the unavoidable illusions and seductions in the doctor-patient relationship. Unpublished proceedings of The International Balint Congress in Heidelberg.

Ryding, E.L., Birr, A. (2023). Becoming the kind of doctor that you want to be. A qualitative study about participation in Balint group work. The International Journal of Psychiatry in Medicine, 57(4). doi:10.1177/00912174211042972

Salinsky, J. (2018). What is so special about Balint groups? *Journal of the Balint Society*, 46: 103-110.

Stewart, H. (1992). Unpublished lecture at the Swedish Psychoanalytical Society.

Winnicott, D.W. (1971). *Playing and reality*, London: Penguin

Brook, W. (2025). Remoteness and Liveness: Thoughts on the Consultation in Current Primary Care Practice. *Journal of the Balint Society, 50: 50-61.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Remoteness and Liveness: Thoughts on the Consultation in Current Primary Care Practice

Balint Society Essay Prize 2023 Winner

Will Brook[1]

[1] GP Partner, East London, UK: william.brook@nhs.net

Six years ago, I took a break from my GP work in the UK to arrange a work placement in Japan, where I would observe primary care clinics. I offered to give a presentation by way of giving something back and I decided to speak on the photographic archive of primary care (I have an interest in photography). The subject had a logic to it given that English is not widely spoken in Japan, and I hoped to use visual material by way of a peg to hang some ideas upon.

I tried to pose the question of why it might be useful for us to look at this archive. After all, one might take the view that family medicine/general practice is not inherently very photogenic. In the wider culture, the 'spectacle' of medicine more often gets located in operating theatres, resuscitation rooms; perhaps jars with grim specimens in pathology museums. Two or three people talking together in a nondescript room? Not so much.

Nevertheless: the pictures are there – how could we make use of them, I wondered. I drew on the 'longue durée' as a phrase: the view of history that concentrates on slowly evolving structures. I put to the audience of doctors that self-evidently we were part of a long lineage; that doctors from earlier eras may well have shared many of the satisfactions of practice as well as the challenges, the agonies.[1] There is a risk that new doctors coming into the profession may feel part of only a recent temporal landscape – the last few years of NHS turbulence dominate the frame. Lasch (1979) describes an idea of 'the evaporation of history', a certain ebbing away of any identification with historical continuity in the culture. In Japan and elsewhere, giving this talk, I've invited people to survey a longer vista of time.

Fast forward to this year. I gave the same presentation to local GP trainees – doctors right at the end of the postgraduate training, five years post medical school.

[1] While my first audience was Japanese, for the sake of brevity one thing I have to forgo here is a transcultural narrative within these ideas.

At its latest 2023 iteration, a different theme seemed to dominate the discussion afterwards. If the pictures I showed hinted at a set of 'frames' for thinking about practice, then an important one related to ‘liveness’: the photograph as a residue of a live face-to-face encounter. How could we think about the live encounter? Leaving aside for a moment practicalities like physical examination, could medicine be (largely) practiced remotely? What was the added factor X in the face-to-face consultation? There was a view in the room that the post-pandemic reconfiguration in GP work, with less of an emphasis on seeing patients in person, was perhaps a useful residue.

It's hard to avoid the Covid pandemic at this juncture. There is no question that the reconfiguration of primary care work in March 2020 was huge. Around that time, it was commented that a process of reform that might otherwise have taken four years happened in about five days. The majority of GP surgeries adopted a triage-first model, with the emphasis on conducting as much of the business of medicine as possible without having to meet face-to-face. The reasons were obvious. Nobody reading this essay will have been untouched by the gigantic upheaval of the pandemic. One could argue that over three years later we remain in a pandemic, and that there is a public health case for sticking with this new modus operandi. Clearly, I'm not here to unpack these arguments from a public health point of view. But I make the observation that while most of public life has returned to something closer to ‘normality,' the pendulum swing that took place in medicine has not been reset. A default setting for telephone and video consultation as part of everyday life has become accepted and indeed embedded within normal medical practice. It is as though a tacit revolution has taken place.

Considering our work (pre-Covid) one might take the view that the basic building block of medical work was to sit in a room for an increment of time, talking to a patient, on occasion examining their body, and coming up with some kind of agreement or plan. This has changed.

And I want to say, has no one else noticed? Is anyone else shocked by these developments? Is this not a tectonic shift?

A search of the BMJ archive on this subject since Covid yields one single item: a letter written by London GPs with a brief though impassioned defence of face-to-face consulting as the gold standard. This in turn got precisely one positive response – not exactly a cacophony of voices. There will be countless arguments to bring to bear on this subject: the value, or otherwise, of this change from a systems point of view, from a position that acknowledges the scant resources in the NHS, the need to maximise efficiency. These bring in useful perspectives, and indeed many of those I share. I'm a partner in a busy inner-city practice and we have to make it run. Those arguments are for a discourse elsewhere.

It will be no surprise then that I'm for maintaining a practice based around face-to-face clinical work, a position I imagine is shared by most who are reading this piece. I may be wrong. I may also be pushing at an open door, and the purpose of writing this piece is not really to put forward a manifesto for it. But it does make me ask two questions. What is it about the live encounter that contributes so much? What is the factor X? The other question is, why might it be that our profession has settled so readily for this different way of seeing patients?

Both are complicated to answer. In the spirit of a Balint discussion, I make a start, as though a shot in the dark. Balint himself would likely have had much to say in this discussion, one which will wander in and out of the space of the group. And as with much in medicine, and the wider domain of caregiving, or therapeutic work, you scratch the surface with questions like these and their complexity is laid bare. One binary to start with, which one can think about in relation to medical practice, is that it incorporates elements that are *transactional*, and others that are *relational*. To frame it in a different way, the dilemma of the doctor is whether they are principally to *do something* and or to *be something*. This starts to lay bare the odd

hybrid nature of General Practice: it foregrounds medicine as a relational practice, and the biomedical recedes.

A first foray: what do the photographs give us on this? Perhaps in seeking out this archive, I wanted to get closer to the fine grain experiential side of being a doctor, being a patient. What does it actually feel like, to be ill, to be a patient? While we can see it, it doesn't take us right inside. In truth, the pictures themselves only take us so far. For a start, the photographic record is biased. Photographs privilege certain aspects of medical care at the expense of others: we do see encounters, we see affect, relationship; different qualities of attention, of listening. We see some of the transactional 'business' of medicine. What they don't say very much about is the *method* of medicine, about cure, or diagnosis. (One might say these don't necessarily figure prominently in the primary care space either.) We don't see 'good' or 'poor' practice. The photographic record skews things in other ways, too. The space of the consultation is a private one and taking a camera and photographer into the space, to come away with pictures that can enter the public domain, is fraught with ethical complexity. The view is only ever partial, fragments from a vastly bigger unrecorded body of practice.

Where else to turn in unpacking this binary between the transactional and the relational in medicine? Framing it in this way creates a point of contact between the practice of medicine and psychotherapy. And a nodal point in that terrain is, of course, one we have touched on – the tradition and practice of Balint groups. No doubt a similar live-versus-remote debate goes on with regard to group work. I confess I feel less strongly on this issue of live practice in relation to groups. Let's be pragmatic: like most engaged with Balint work, my own group went online during the pandemic; it worked well enough, and the sessions were a blessing and a solace during that difficult time. And one cannot ignore other practicalities: if remote/online groups are the only way that colleagues in far-flung places can meet,

then the case for that is unassailable. So in expressing that opinion there is a voice which is unavoidable – the pragmatist.

Back to the first question again, about the nature and value of 'liveness'.

There's one psychoanalytic body of work I want to try and use: the Kleinian mother-baby dynamic. It has been suggested that healthcare encounters can be thought about through the lens of Klein's (1970) mother-baby dyad. It's an idea that, once explained, has stuck with me. The link is how illness and distress engender primitive behaviours around fear and a kind of regressing in age: regressing on the part of the patient, and at times the health professional as well. So, by this logic, the person who is ill, vulnerable, may present as though a baby. Their illness evokes and revisits early primitive behaviours: fear, terror, splitting, idealisation. The doctor as devil, the doctor as angel. This baby's world is binary: food/no food, happiness/catastrophe, breast/no breast. So: very split, with good objects, damaged objects. The skilled mother has a sense of how intuitively to facilitate the shift from this primitive position (the 'paranoid-schizoid') to one that is more digested and resolved (the depressive position). If there's a theory of mind here, then it is the sense that the baby feels 'held in mind': a reparative quality conveyed by the skilled mother to the baby. But there has to be something lived and experienced in the live moment for this to take place – disturbance and a back-and-forth in both parties, things communicated both subtle and at the same time powerful.

There's a risk of eliding these two settings too easily (mother/infant, doctor/patient) and oversimplifying. But if there's a kernel of truth here, it's this comparison: what does the baby want, what does the patient want? What has happened when the doctor feels that a correct and helpful moment of communication has taken place in the consultation? It may be that the patient wants to feel they are held in someone else's mind, that their words and communications don't just disappear into the ether, they land on fertile ground, they're held onto, and thought about, digested. If the doctor can do that holding, and then convey it

to the patient, it is very therapeutic, powerful. This Kleinian baby felt very familiar to me in the consulting room. We can take it into the group as well. I wonder if something of the same shift (paranoid-schizoid to depressive) comes up in our sessions. Where is the 'held-in-mind' located there? In a group, the leader has a different role to the rest and may embody this most strongly. But that quality also gets passed around the participants and perhaps at times sits collectively in the group as a whole (I take this idea back into the GP practice, the doctor group, the wider staff group, even the building itself as a version of 'brick mother').

The mother and baby duo is the reminder (one of many) that the space of the consultation has two active subjectivities at play, two actors affecting each other reciprocally. Let's not idealise this process: the two-way conduit that happens in consulting allows doctor and patient to not only take benefit, but also to enact and interrogate suffering. This live space is one of strong colours, both light and dark. Psychiatrist David Bell (2001) brings into focus this dynamic in the clinician's inner world:

> We all enter the field of mental health for complex reasons, but probably coming to us all is a wish to repair our own Damaged inner objects. In order to be able to work effectively, we need to be able to tolerate the patients' attacks on these reparative wishes, our most vulnerable point. We need to be able to stand failure so that the patient can improve for himself, rather than experience the need for progress as a demand from those caring for him. […] more than anything else staff morale is the vital therapeutic ingredient; morale that needs to be robust and not dependent on any individual patient getting better. (Bell, 2001)

These commentators evoke a space in the consultation that is charged, and dynamic, full of reciprocal processes and intersubjectivity. At its most vivid, this happens in physical proximity, lived and experienced from moment to moment.

I turn for a moment to the other question: why might it be that our profession has settled so readily for this different way of seeing patients? I put this question to psychologically minded colleagues and the answer invariably comes back: surely it's a defence. Psychiatrist Tom Main (1989) is useful to recruit here. In an address to the Balint Society, he uses Balint's 'pedagogic breakthrough' (group work) to point up with compassion the ways in which doctors limit what they take on: 'Like all of us the conscientious doctor shies away from lifting more than he can carry, and if he is in danger of feeling more than he can cope with he takes avoiding measures'. For Main, recruiting defences so as to work with patients is inevitable; the key is to do this with some understanding, to avoid those defences that are 'thoughtless, rigid and automatic'. This concentration on defences is easy to relate to in clinical work. Main's paper describes phenomena close to my day-to-day life at work. Indeed, as one starts to think around this, defences appear pervasive. Starting work again after a break, there is a case in point. Casting my eye down the list, certain names resonate and start to fill my consciousness. A certain 'pre-defence' starts to take its place. (A defence against what? Collectively the sense is of The World about to re-enter the room, with its perennial problems). To start the surgery is to take a deep breath, with a hardening resolve, and re-enter the fray. In truth, many of the defences involved are very concrete, embedded: in the scheduling of our time, the architecture, the means available for our patients to communicate with us. Usually, they are experienced by patients as barriers to getting in touch. Reception colleagues act to restrict access to us, to maintain barriers, to ensure the rationing of our time. We can only survive on this basis.

The literature on social defences is extensive. Menzies' (1960) celebrated study looked at how defences became embedded in professional practices so as to

cope with the anxiety that comes with care of patients. Defence mechanisms among the nurse group that she studied fell into certain categories: behaviours to prevent intimacy between patients and staff, others to diminish the individuality of both. Overall, these entailed a stepping away from responsibility; stepping away as well from the anxiety involved in care work. Main's point is key here: it behoves us to use defences in ways that are self-aware and insightful. Thus – if there is something avoidant in the way that GP care is offered principally as a remote contact, then at least have some self-knowledge of that. But he holds firm to a view of clinicians that is compassionate in spite of these manoeuvres; of clinicians doing their best in less-than-ideal conditions.

A change of tack: what is the value and the nature of the live encounter for me? I return to the scene of seeing younger training colleagues at the lecture, conveying to me that they had no problem with this current 'even-handed' approach to the consultation. No-one wants to appear a luddite, or a stick-in-the-mud. As a trainer, I accept we are duty bound to coach our trainees substantially for the world we inhabit now, for the years ahead. For these doctors in their late 20s, and it must be said for patients too, new tech is ubiquitous and inevitable, and modes of care consistent with modern service industries are not going away anytime soon. Nevertheless – the longue durée. What will endure? Or perhaps: what must we teach such that it will endure? So the last data I turn to around 'liveness' is my own. The group would say: well then, bring a case. In fact, I sidestep that; my thoughts turn to fragments, sense impressions that try and get close to what's happening on my side of the desk.

I'm in clinic. Time and again, when starting work in an irritable, skittish, distracted state of mind, it dissipates and I become focused simply by starting to see patients. The work becomes integrating, calming. The role I take on has its effect on the particular cognitive state needed. Along with, of course, the patients themselves. In ways that are hard to understand, these encounters repair me, and

I'm fit for purpose again. There's a more specific and heightened version of this. If the talk is of defended states, this is something more like a sudden letting go of a defended self. It is something somatically experienced, a powerful example of patients having an overt effect on me, as well as some notion of the reciprocity involved. This is during clinic, when a serious matter, part of the history that has a self-evident gravity, as though able to break free from the subjectivity of the patient, comes into the consultation. It may be a symptom, or a physical sign, or indeed something about a mental state that is immediately striking and of concern. This is a moment when everything turns on its head, and what may have been a scattered state in me – boredom, or irritation, or being at a loss – suddenly becomes integrated and focused, and the room becomes a place of exchange, alertness, and great meaning. It is as though epistemologically the air clears, the tension goes out of the situation, and with it there comes a clarity of bodily experience, that is prior to, or separate from, anything mentalised.[2] The power of this instantaneous process is striking and consoling. It is indelibly a thing of the live encounter alone. It is a hard thing to describe, or indeed to understand, and it were as though I am content to stay in a state of 'non-knowledge' about it. (Or perhaps not entirely. David Bell's [2001] description of the clinicians 'reparative wishes' may shine some light here – a sense that that reparative quest is indeed two-way. The urge to be reparative to the other, consistent with one's vocation, is echoed in some way in this process of self-repair I'm trying to describe.)

These phenomena link with another subjective element that, for me, is essential to stay in touch with in clinical work: the sense of privilege in doing it. This sudden 'embodied clarity' that I describe above leaves a residue of feeling

[2] I have wondered about a link with Enid Balint's idea of the 'Flash' moment in a patient encounter, though the mapping is not exact, when reading of how she meant that term. Likewise, a useful phrase used in discussion by a tutor, Zoe Playdon: the *compassionate realisation of possibility beyond oneself.*

grateful, of feeling privileged to be in a position to do it. *The Fortunate Man*, indeed (Berger, 1967).

This might seem idealising and sentimental. GP work can be hard, draining, thankless. But the word feels to me accurate, sound. Not a fantasy or some kind of virtue signalling. A GP friend abroad says how burnt out he feels, and one point I want to convey, one of many, is the critical necessity to keep alive this sense of privilege in the doing of it. Again, in ways I do not fully understand, this also feels important in Balint work. A good, alert, discursive session in the group gives back that quite primitive feeling that we are fortunate to do this work – to be given this work. It is echoed and magnified: feelings of fraternity, recognition, comradeship are additional powerful elements in the group setting. Even if there is less necessity for the group discussion to be face-to-face, nevertheless, such a successful exchange seems closely bound in with managing to find, articulate, and use the power, the vivid colours of the live doctor-patient encounter. When this quality is made clear again, in our sessions, as though a window rubbed clean, I am reminded that it is a state in which there is no place for narcissistic pleasure, for the ego-trip.

Where can we get to with all this, for now? In the spirit of a group session, my two questions have been thought about – and passed round, a few flags placed in the sand, even if they elude 'open and shut' answers. The discussion probably needed some material on touch and examination – things corporeal, complex subjects deserving of their own discursive space. And I can still hear the pragmatic, rationalising voice within me, trying to accommodate all the caveats around this. Thus:

Remote consulting is here to stay.

Let's not be precious: much of the work is simple. Much of the work IS transactional.

These modes of working clearly suit some doctors, and very often they suit patients.

And so on.

In trying to tie off the two questions posed, I return a last time to the trainees in the seminar room. The issue of how to use the historical archive was answered with one further observation: that our profession is one in crisis. A crisis of morale, of motivation; chronic problems with recruitment and retention. An emerging workforce less willing to embody vocation as a professional raison d'être. At the end of the session, feeling something of a lone voice, I looked out at the group and thought there was more at stake than the quality of their clinical work going forward: that it was the very future of these young colleagues, their wellbeing, their ability to sustain their work, that was on the line. I put to them bluntly: consider the longue durée. Leave aside appraisal, revalidation, the timescale of MRCGP; the 'launch phase' of your career. How will you stay engaged and interested, and emotionally available, in this work for 20, 25, 30 years?

This was probably the motive to write this essay. It's not an academic piece; neither, as I've said, is it a manifesto. I have no qualms about saying these things publicly, but it won't be printed on a poster to take to the barricades. The pragmatist again: the work goes on, we keep going. We do the best we can, in as thoughtful a way as possible. For my trainees, I think of modelling in different ways a style of practice that has sustained me for this time, that has deepened my own engagement. But the piece is also a cri de coeur. As I stood facing my young audience at the seminar in January, I accepted that these colleagues would come through and effectively take the profession forward, but there was an elegiac feeling as well. I fear for what may be lost amid the current melee of our time, and the underlying powerful forces of change.

References

Lasch, C. (1979). *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*. New York: Norton.

Klein, M. (1932). The Significance of Early Anxiety-Situations in the Development of the Ego. *The Psycho-analysis of Children,* London: Vintage.

Bell, D. (2001). Who is killing what or whom? *Psychoanalytic Psychotherapy*, 15(1): 21-37.

Main, T. (1989). Some Medical Defences against Involvement with Patients, *The Ailment and other Psychoanalytic Essays.* London: Free Association.

Menzies, I. (1960). A case-study in the functioning of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. *Human Relations*, 13: 95-121.

Berger, J., Mohr, J. (1967). *A Fortunate Man: The Story of a Country Doctor*. London: Penguin.

Figure 4.
Enid Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Fjeldsted, K. (2025). The Tip of the Iceberg. *Journal of the Balint Society, 50: 63-65.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

The Tip of the Iceberg

Katrin Fjeldsted[1]

[1] Retired GP, Reykjavík, Iceland: katrinf@simnet.is

Like so many who have dealt with the mental health of patients, I have never been a psychiatrist but all those years ago decided to choose general practice as my path. Even if I am not a psychiatrist, nevertheless a great deal of a family doctor's work must take into account not only physical symptoms and signs but also the patient‘s background, mental state, and life events. When dealing with patients, it is useful to think of the iceberg where only 1/10th visible and the rest does not meet the eye.

Having been involved with the Balint movement since my GP training in London in the seventies, it has been my pleasure and privilege to lead Balint groups for GP trainees for over twenty years in Iceland. Having gone through medical school, the medical model is obviously at the core of young doctors‘ thinking but adding Balint at that stage is in my opinion paramount to be able to move outside the box and see and deal with the patient as a person. This may be a difficult path to follow for many reasons.

As a medical student I spent at least a month in the psychiatric hospital Kleppur in Reykjavík. The building was old, the wards mainly based in common rooms, adding a few private rooms for isolation, and medicines quite crude with numerous side effects. Some patients had electroconvulsive therapy (ECT) which probably was almost experimental but by this time the old method of ice cold baths alternating with hot water was outdated. Later, when I had in mind to specialise in anaesthetics, I attended the above mentioned ECTs, watching the convulsions with awe.

As a medical student one of my duties was clerking patients, which meant that a friendly connection was often made. I especially remember a young woman, more or less my age, whose life history and background were obviously to blame for her mental difficulties at the time. I spent a lot of time listening to her.

Another youngish woman walked up and down her ward in a sexual manner, swinging hips and moving her thighs in a way that mirrored her disturbed

thinking. There was a tendency to copy her gait on the way to have a coffee break – a bit sad and shameful when I think of it now.

Most surprising for me was to enter a ward with chronic patients, most of whom had been hospitalized for years and years. The forgotten people. One woman was hardly in any touch with her surroundings except the electric switches. These switches were on the middle of the walls, approximately at the height of her face and she spent her days wandering from one to the other, kissing each one as they were her boyfriends.

I worked as the assistant city medical officer in Reykjavík for a year, attending the scene of suicides and murders and attending arrested people in cells. One prisoner had been caught and imprisoned after throwing a large stone through the window of a doctor's sleeping accommodation in Kleppur. They had had a disagreement. I was sent to meet this guy, who paced up and down the interview room, the door ajar as a policeman was to sit outside which he alas did not. I was pregnant at the time and must say not at ease trying to assess this prisoner-patient.

So, as a GP dealing with my patients for almost forty years, sharing their sorrows and joys, is that psychiatry? I have often found psychiatric diagnoses like depression overused, especially when sorrow is the real reason and therefore antidepressants make no difference. Would you turn to psychotherapy or a GP who knows you?

One middle-aged lady in my practice, married with children, repeatedly presented with obscure physical complaints – 'a difficult patient' – but finally confided in me about an abusive father who had sexually molested her for years. She had never been able to reveal the fact to anyone before. After school she would sit on the steps outside the house in all kinds of weather waiting for her mother to come home rather than venture inside to dad. Stories like this one appear in literature again and again. A recent one I read is called *My Absolute Darling* by Gabriel Tallent. Make sure you read it.

Khoshnaghsh, A. (2025). The Power of Reflection in Developing Cultural Competency and Compassionate Care for Refugee Patients. *Journal of the Balint Society, 50: 66-77.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

The Power of Reflection in Developing Cultural Competency and Compassionate Care for Refugee Patients

Balint Society Essay Prize 2024 Winner – Student

Ava Khoshnaghsh[1]

[1] Medical Student, GKT School of Medical Education, King's College London, UK: ava.khoshnaghsh@kcl.ac.uk

Introduction

This year, the introduction of the mental health block in our medical school curriculum marked a pivotal moment in my understanding of patient care. The block provided a comprehensive exploration of mental health issues, emphasising that clinical practice extends far beyond the application of NICE guidelines. For the first time, I encountered patients from a variety of backgrounds, each presenting unique and complex situations. This experience was particularly eye-opening in understanding the challenges faced by refugee patients.

The mental health block compelled me to recognise the limitations of relying solely on a guidelines-based approach to patient care. While guidelines offer a valuable framework, they often fall short in addressing the realities of individual patients, especially those from marginalised or complex backgrounds. Refugee patients, in particular, present challenges that cannot be neatly categorised by standard protocols. According to the United Nations Refugee Agency, 65.6 million people have been forcibly displaced worldwide (Müller et al., 2018). As doctors, we will inevitably encounter some of these individuals and must be prepared to provide appropriate care for them. These challenges are deeply rooted in the intersection of cultural competency, medical care and empathy.

As a medical student, it became increasingly clear that cultural competency is not merely an academic concept but a crucial component of effective clinical practice. It requires a profound understanding of how cultural factors influence health beliefs, practices, and patient provider interactions. For refugees, this understanding extends to recognising the significant impact of their experiences of displacement, trauma and adaptation to a new and often unfamiliar healthcare system (Khanom et al., 2021). The complexities of their situations, including psychological scars from violence, the challenges of resettlement, and barriers to

accessing healthcare, cannot be fully addressed through standardised guidelines alone.

The refugee crisis exacerbates these challenges, highlighting the need for a more comprehensive approach to care. The scale and urgency of the crisis often stretch the capacities of healthcare systems, leading to significant gaps in services and support. Refugee patients frequently face systemic barriers, such as language difficulties, limited access to culturally competent care, and financial constraints (Kiselev et al., 2020). These factors contribute to increased vulnerability that cannot be addressed by guidelines alone. Providing effective care for refugees requires not only adherence to clinical standards but also cultural sensitivity, trauma-informed approaches and genuine empathy (Stubbe, 2020). The limitations of guidelines become evident when faced with the real-life complexities of refugee patients, where a one-size-fits-all approach is insufficient. Instead, healthcare providers need to adopt a more individualised and contextually aware approach that considers each patient's unique background and experiences.

This realisation has reinforced the importance of integrating cultural competency into medical education and practice. It calls for medical students and professionals to engage in continuous learning about the diverse needs of refugee populations, to advocate for systemic changes that address these needs, and to develop a compassionate approach that transcends mere adherence to protocols. By doing so, we can provide care that is not only technically proficient but also deeply respectful of the patient's cultural and personal context, ultimately leading to more effective and humane healthcare.

The Unique Healthcare Challenges for Refugees

Refugee patients often face a multitude of challenges that compound their medical needs. One of the most significant barriers is trauma. Many refugees have experienced severe psychological stress, including exposure to violence, loss and persecution. Addressing these issues requires not only a robust understanding of trauma-informed care but also the ability to create a safe and supportive environment where patients feel comfortable sharing their experiences.

Language barriers are another critical issue. Effective communication is foundational to medical care, yet many refugees may not speak the dominant language of their host country fluently. This can lead to misunderstandings, reduced adherence to treatment plans and a general sense of disconnection from the healthcare system. Navigating these barriers often requires the use of interpreters, culturally sensitive communication strategies, and an awareness of non-verbal cues that may carry different meanings in various cultures.

Access to services is also a significant concern. Refugees may face logistical challenges, such as navigating a new healthcare system, financial constraints and limited availability of culturally appropriate services. This can result in delays in care, difficulties in managing chronic conditions, and overall disparities in health outcomes. Addressing these issues requires a proactive approach, including advocacy for policy changes and the development of community resources that cater specifically to the needs of refugee populations.

Personal Reflection

As the daughter of immigrants and the first person in my family to pursue a career in medicine, meeting refugee patients felt like more than just a professional

challenge – it was a transformative experience. I was struck by an emotion that is difficult to put into words, a realisation that the difference between me and a refugee is a matter of luck. The differences between us were not the result of personal choice but shaped by circumstances beyond anyone's control. This has strengthened my commitment to addressing their specific needs and providing care that is compassionate, dignified and respectful.

Growing up, I often heard stories about the hardships of moving to a new country and starting life over from scratch. These stories shaped my understanding of the resilience required to survive such a journey but also the emotional toll it takes. It also enhanced my appreciation for the importance of empathy and cultural sensitivity in medical practice. When speaking with refugee patients, I was often reminded of the common threads in their journeys – shared themes of seeking safety, opportunity and a better life. This recognition highlighted the importance of approaching each patient with an open mind and heart. I came to realise that being a good doctor requires more than just medical knowledge; it involves connecting with patients on a human level, acknowledging their individual stories and the unique challenges they face.

Integrating such personal insight into my patient care has reinforced the importance of seeing patients as individuals rather than just a collection of symptoms. It emphasises the need for a holistic approach that considers the broader context of a patient's life, including their cultural background, personal experiences, and emotional wellbeing. This perspective is crucial in delivering care that is not only clinically effective but also emotionally supportive and respectful. Becoming a good doctor involves continuously striving to understand and address the multifaceted needs of patients. For refugee patients, this means integrating cultural competency into care, being sensitive to their trauma and advocating for resources that support their health and wellbeing. My experience working with this patient group has driven me to seek out opportunities for further education and

advocacy in these areas, aiming to bridge gaps in care and contribute to more equitable and compassionate healthcare practices.

A Story That Stayed with Me

One particular patient from this block has stayed with me in my thoughts long after our encounter. I shared her story with my Balint group, vowing to remember her throughout my career. This young woman, having fled her war-torn homeland, had endured unimaginable violence, including torture and sexual abuse, which left her with profound psychological trauma. She had escaped her country with her siblings by boat but, due to adverse weather conditions and darkness, two of her siblings tragically drowned. The loss of her siblings, compounded by the trauma she had endured, led to severe emotional distress. She frequently experienced hallucinations of her lost siblings and was overwhelmed by guilt and a sense of responsibility for their deaths. This intense sorrow manifested in self-harming behaviours as she struggled to cope with her pain. Her initial presentation included symptoms of severe anxiety and depression, which are common among refugees who have experienced such extreme stressors (Mclean Hospital, 2024). Her case highlighted the importance of considering a patient's history and current circumstances sensitively. It became clear that her struggles were not merely symptoms of mental health issues but were deeply rooted in her traumatic experiences and social context.

When it was my turn in the Balint group, I knew this was the case I had to share. The weight of her story had been heavy on me and sharing it with my peers offered a much-needed outlet for my emotions. It was comforting to hear that others had faced similar challenges, and their experiences helped validate my own feelings of concern and compassion. In that shared space, we were able to

collectively reflect on the complexities of working with such a vulnerable population. Listening to my peers recount their encounters made it clear how widespread these issues are. It became evident that the struggles faced by this patient were not isolated but part of a broader pattern affecting many individuals in similar situations. This shared realisation provided valuable perspective.

The discussions within the Balint group emphasised the need for a more comprehensive approach to supporting refugee patients. There is no formal module in medical education that fully equips us to address the challenges of providing trauma-informed care to refugee populations. The emotional and practical challenges we discussed pointed to a clear need for greater awareness, sensitivity, and resourcefulness in addressing the unique needs of refugees. The mental health section of the Migrant Health Guide highlights the importance of investigating such cases with care (Office for Health Improvement and Disparities, 2017). The guide provides resources, including patient information in various languages, to support clinicians in addressing these complex situations. For this patient, understanding the impact of her trauma on her mental health was crucial in providing the right care. Additionally, I learned about the importance of considering factors like dialect, culture and gender when selecting a language interpreter, ensuring that communication is not only effective but also sensitive. Linking patients with support organisations that specialise in aiding refugees and asylum seekers can offer invaluable assistance, providing both practical help and emotional support.

One of the aspects I valued most about participating in the Balint group was the opportunity to share my thoughts with peers who, while undergoing the same training, brought a range of diverse perspectives. This exchange not only enhanced my own learning but also provided insights that could be valuable to them in future practice, particularly when working with refugee patients. Reflecting on these shared experiences, I believe that we will be better equipped to approach such cases

with greater empathy and understanding. While reflective writing is an important part of medical education, the collaborative discussions during Balint offer a unique depth, allowing us to explore and articulate our reflections together, enriching the learning process beyond what written accounts can offer.

The Balint group experience emphasised the need for continued dialogue and education about these issues. It reinforced the importance of maintaining empathy and being proactive in seeking resources and support systems for our patients. As medical professionals, we must advocate for and work to create a more inclusive and responsive healthcare environment for refugees and other marginalised groups.

Integrating Compassion into Patient Care

Compassion is a fundamental element in the care of refugee patients. It involves recognising their vulnerabilities and responding to their needs with sensitivity and respect. Compassionate care goes beyond clinical skills – it requires a willingness to listen, validate patients' experiences, and to advocate for their needs within the healthcare system. In practice, this means taking the time to build trust, understanding that patients may have had negative experiences with healthcare systems in the past, and providing support that acknowledges their trauma and current challenges. It also involves working collaboratively with multidisciplinary teams to ensure that all aspects of a refugee patient's needs are addressed comprehensively.

We can begin working on these goals during medical school through initiatives like Balint groups. These groups provide a safe, non-judgmental space where difficult emotions, complex cases and challenging interactions can be openly discussed. By sharing and reflecting on real patient experiences in a structured

format, participants gain valuable insights into the emotional and psychological aspects of care, while also becoming more aware of their own responses and biases. This reflective practice develops our understanding of the doctor-patient relationship, particularly in the context of refugee care, where trust and empathy are essential. Balint groups also promote a sense of shared responsibility among healthcare professionals, encouraging a collaborative approach to problem solving that can be applied directly in clinical practice.

Future Goals

Looking towards the future, I am committed to advancing my understanding in refugee healthcare and mental health, recognising that becoming a good doctor requires more than just medical knowledge. It involves the ability to connect with patients on a deeper level, addressing both their physical and emotional wellbeing. This includes having a trauma-sensitive approach, advocating for resources that support holistic wellbeing, and actively working towards more inclusive healthcare practices.

Insights from the mental health block and my reflections on refugee care have highlighted the importance of cultural competency and empathy in patient interactions (Stubbe, 2020). This involves the need for continuous self-reflection, ongoing education and skill development to address the diverse needs of patients. Incorporating these lessons into my practice means remaining attentive to the challenges faced by refugee patients and creating a more supportive, inclusive environment for all patients.

One key goal is to continue my involvement with Balint groups, both as a participant and as a future mentor. These groups offer an invaluable space for healthcare professionals to reflect on the emotional and relational aspects of patient

care. By engaging in and leading these discussions, I hope to cultivate a culture of empathy and self-awareness among medical students and fellow practitioners. Reflection is critical to developing compassionate care and improving our ability to respond to complex cases, such as those involving refugees, where the emotional dimensions of care are particularly significant.

In addressing the refugee crisis, I am committed to advocating for systemic changes that improve access to care, especially mental health resources. This includes promoting policies that enhance the availability of culturally competent services and securing funding for mental health initiatives. Building stronger collaborations between healthcare providers, community organisations and policy makers will be essential in creating a more integrated approach to addressing the needs of refugee populations.

To progress towards solutions, we must also focus on education and training for healthcare professionals, ensuring that they are well equipped to work with marginalised groups. This involves incorporating cultural competency and trauma-informed care into medical curriculums as well as providing ongoing professional development opportunities.

Conclusion

Exploring cultural competency, medical care and empathy in the context of refugee healthcare has been a transformative experience. It has developed my understanding of the complexities of providing care to this vulnerable population and highlighted the importance of integrating emotional and cultural awareness into patient care.

The Balint group has been an invaluable space for reflection and support throughout this journey. Sharing my experiences and challenges with my peers in

such a safe and empathetic environment allowed me to process the emotional weight of my cases. The group's feedback, coupled with the shared stories of others facing similar challenges, was both validating and enlightening. This reflection broadened my perspective, reaffirming the widespread nature of these issues and the importance of addressing them thoughtfully.

Balint groups provide a unique opportunity for medical professionals to explore the emotional dimensions of patient care, offering a deeper understanding of how personal experiences and emotions influence our practice. As I move forward in my medical career, these lessons learned – from direct interactions with patients to the reflections shared in the Balint group – will continue to shape my practice. I am committed to not only providing empathetic and culturally sensitive care but also to advocating for systemic changes that support marginalised populations, ensuring their voices are heard and their needs addressed.

References

Khanom, A.; Alanazy, W.; Couzens, L. et al. (2021). Asylum seekers' and refugees' experiences of accessing health care: a qualitative study. *BJGP Open*, 5(6). doi: https://doi.org/10.3399/BJGPO.2021.0059

Kiselev, N.; Pfaltz, M.; Haas, F. et al. (2020). Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland', *European Journal of Psychotraumatology*, 11(1): 1717825. doi: 10.1080/20008198.2020.1717825

Mclean Hospital. (2024). *Refugee mental health: What you need to know*. Available at: https://www.mcleanhospital.org/essential/refugee-mental-health.

Müller, M.; Khamis, D.; Srivastava, D.; Exadaktylos, A. and Pfortmueller, C. (2018). Understanding Refugees' Health. *Seminars in Neurology*, 38(02): 152-162. doi: https://doi.org/10.1055/s-0038-1649337

Office for Health Improvement and Disparities (2017). *Mental health: migrant health guide.* Available at: https://www.gov.uk/guidance/mental-health-migrant-health-guide.

Stubbe, D.E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus*, 18(1): 49–51. https://doi.org/10.1176/appi.focus.20190041

Figure 5.
Michael Balint and a group of colleagues in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Axiaq,, A. (2025). Transcending Babel: A Balint Exploration of Medical Encounters. *Journal of the Balint Society, 50: 79-94.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Transcending Babel: A Balint Exploration of Medical Encounters

Balint Society Essay Prize 2023 Winner – Student

Ariana Axiaq[1]

[1] Resident doctor, NHS Lothian, Edinburgh, UK: ariana.axiaq@nhs.scot

Every medical professional has experienced patient encounters that linger in their memory, leaving an indelible mark on their journey.[1] These encounters stand out not merely due to complex diagnoses or unique treatments but because they touch upon the essence of human personhood. They remind us that, amidst the intricate web of blood tests, scans, and procedures, the heart of medicine lies in understanding and relating to the person seeking care.

In this essay, I will reflect on my Balint experience, presenting a case with a patient called Ms Lennox.[2] Her case, reminiscent of the ancient parable of the Tower of Babel, has been salient in my appreciation of the paramount importance of effective communication and empathy in the doctor-patient relationships. Ms Lennox's consultation challenges the boundaries of understanding between patient and clinician, leading to a tangle of unspoken emotions. In this narrative I have recounted my Balint experience as a presenter sharing my perspective on the dynamics between consultant, nurse, patient, and presenter, and explore the importance of reflection in medical education.

The Tower of Babel: An Analogy for Communication Breakdown in Healthcare

In the biblical narrative of the Tower of Babel,[3] shared by both Jewish and Christian literature, the people of the city of Babylon aimed to construct a tower, wanting to reach the sky. As a divine response to this hubris and excessive ambition, God dispensed discord, mistrust, and alienation among the people by making them speak in different tongues. This fateful punishment parallels the complex misunderstandings and the erosion of rapport frequently observed in medical

[1] At the time of writing this piece, the author was a medical student at Queen's University Belfast, Northern Ireland, UK.
[2] Names have been altered to protect the identity of individuals involved in this case.
[3] *Genesis* 11:1-9 (New International Version).

consultations. The case of Ms. Lennox, which I presented during a Balint group session, mirrors the Tower of Babel allegory, where diverse languages led to an acute communication impasse. Both the patient and the clinician were deeply committed to the patient's well-being, yet they grappled with divergent perspectives on the path to achieving this goal. Failure to decode the patient's emotional nuances resulted in mounting frustration, disappointment, anxiety, and anger, overshadowing trust and respect in the consultation room.

On Presenting the Case

I have sought to experience Balint within different capacities, as a presenter and a participant, and both in groups focussing on medical students and others with more established clinicians. However, I always find myself grappling with the same question: am I more inclined towards being a case presenter, or do I experience a deeper sense of fulfilment when actively engaging in discussions around cases presented by others? For me, presenting evokes a sense of trepidation, characterized by lingering uncertainty about the significance of the cases I choose to present and a nagging curiosity about what compels me to select specific cases over others. Meanwhile, as a non-presenting participant, I enjoy contributing my perspective to the flow of discussion within the group. Like an orchestra co-producing a symphony of music, building on each other's thoughts and emotions with the opportunity of occasional challenge is highly satisfying to me. Nonetheless, when I do assume the role of a presenter, I find comfort in ceding control, allowing the rich tapestry of discussion to unfold. Therefore, during my first session in the National Medical Student Balint Group, to dispel the long silence had pervaded the group, I volunteered to present.

The Case: Meeting Ms Elizabeth Lennox

I started by setting the scene. It was a sunny spring morning in the geriatric outpatient clinic at a small rural hospital. The consultant, Dr Peter Murphy, and I had navigated our way through a list of 'straightforward' patients, such as individuals with query TIAs, Alzheimer's dementia, or early signs of Parkinson's disease. The clock had ticked its way to 11:40 am, and, with just one patient left to see before the anticipated early lunch break, a palpable sense of eagerness permeated the geriatric team.

As the consultant glanced over his screen, with a mixture of excitement and trepidation in his voice, he looked over and uttered, ‘You will want to watch this one.’ Intrigued, I sought clarification, yearning for a better understanding of what lay ahead. His response, however, only added to my perplexity. ‘She's a character,’ he remarked.

Confused and wanting to quell my curiosity and prepare myself for the impending consultation, I probed further. ‘What do you mean by 'a character'?’ I inquired. There was a tinge of irritation in his response, hinting at a certain level of exasperation as he repeated, ‘She's strange, she's just strange.’

Our dialogue was curtailed as we prepared to welcome the patient. With the aid of a walking stick, Ms. Lennox slowly made her way to the consultation room, dressed in black head to toe.

The memory of Dr Murphy’s words and his enigmatic grin haunted me. It brought to mind the image of a circus master, orchestrating the opening spectacle of a show. I was left to ponder not only the possible influence of knowing this information on my rapport with the patient but also how, if the patient had overhead us, it might affect her perception of the forthcoming consultation.

As Ms. Lennox settled between my consultant and me, she started to explain how, a few weeks prior, she had grappled with left-sided weakness, profound

fatigue, and numbness. These symptoms had propelled her into a hospital visit, marked by an exhaustive investigation for a suspected stroke. The thoroughness of these investigations and her night at the hospital had led her to firmly believe in the presence of a serious underlying cause.

The physician, charged with delivering the much-anticipated good news, sought to reassure her that the tests had yielded clear results, negating the suggestion of a stroke. However, each attempt to communicate this information was thwarted as Ms. Lennox fervently clung to her belief that a stroke remained the sole explanation for her symptoms.

The ensuing conversation spiralled into a self-perpetuating cycle, with both the patient and the geriatrician becoming increasingly entrenched in their disparate perspectives. Tensions mounted as Ms. Lennox castigated the doctor as rude, and he, in turn, pointed out her aggressive tone.

After a prolonged and increasingly heated deliberation, Dr Murphy reached a breaking point and decided to summon a nurse, Mary, to the scene. This intervention, however, initially exacerbated the situation.

As Ms. Lennox turned to Mary and me, her expression bore the weight of a plea for validation and understanding. Yet, in that moment, my ability to respond was limited to nodding and tending to the pieces of paper she wished to share as evidence of her stroke diagnosis. Ms. Lennox embarked on a final attempt to substantiate her concerns, focusing on a previous suspected myocardial infarction (MI) that had occurred months ago. However, the doctor swiftly pointed out the normal troponin levels on the electrocardiogram (ECG), bringing this thread of the discussion to a close.

Silence finally descended upon the room, and the doctor seized this opportune moment to convey the conclusive test results and the subsequent management plan. Given she was already on anti-coagulants, he explained that whether or not a stroke had occurred, her treatment regimen would remain

unaltered. As the doctor conveyed the news of her discharge, Ms. Lennox offered a brisk nod of acknowledgment and gruffly thanked everyone before making her way out of the clinic with the nurse. It was a moment that brought an unmistakable sense of relief to both the physician and the patient. I, on the other hand, was devastated by the consultation's abrupt and bitter ending.

On the Inquiry

Upon concluding my presentation of this case, I was surprised by how exhausted I felt, reminiscent of the day when I had witnessed this protracted and seemingly fruitless encounter. Despite the length and depth of my presentation, I found myself harbouring an arsenal of unspoken thoughts and insights, parallel to how the patient must have felt during the consultation. Moving on to the inquiry phase of the session, I offered some clarification in response to my group members' questions before muting my microphone.

Prompted by one of the facilitators, the two other medical students initiated their line of inquiry. As I answered these questions, I wondered how my answers would influence the course of discussion; how knowledge or lack of knowledge of the circumstances around the patient's presentation could have affected our perception of her. (Soon afterwards, I wondered whether I was possibly thinking about these questions too much).

'Was she with someone?' 'No, she came alone.'

'Was she visibly ill?' 'No, but due to her frailty, she walked slowly.'

'Do you know anything of her previous encounters with the geriatrician?'

'No, I wish I did.'

I often find that, in Balint groups, it seems like there is not enough time for these factual questions. This limitation mirrors how time constraints and

psychological resistance from patients do not allow clinicians to obtain all their answers in a consultation. I have come to appreciate that the plot holes in the story are breeding ground for creative imagery, speculation, and free association. Questions brought up during discussion around the duration of the consultation, what happened after the consultation, and the geriatrician's usual demeanour, had to wait until the end.

On Discussing the Case

The Patient

As I muted my microphone, simulating the 'push-back', my fellow medical students immediately fixated on Ms. Lennox's striking all-black attire. To me, that choice of clothing symbolised mourning, suggesting the possibility of significant losses in her life. The group delved deeper into this imagery, contemplating how it might be a prelude to dealing with the grief that comes with a diagnosis.

Questions began to emerge about her family, her children, or grandchildren. Why did she come to the clinic alone, especially given her apparent frailty? Did she push people away, or was it a case of bravely facing her struggles independently? These were questions left unanswered by the consultation, leaving us with only speculation. As I watched Ms. Lennox slowly exit the clinic and vanish into the hospital corridor, she seemed almost mythical, like a fleeting apparition. We could only speculate about what happened when she left the hospital, what her life was outside of being a patient, and who was close to her.

Our discussion revolved around deciphering the patient's feelings and motivations. We pondered whether her diagnosis served as an explanation for the emotions she struggled to articulate. Despite her unwavering reluctance to allowing the geriatrician time to speak, we empathised with the patient's sense of

disempowerment, considering how the geriatrician's withdrawal of her diagnosis could be perceived as invalidation. We felt how helpless she was at the face of the consultant and then the nurse. As the presenter, I had shared some of this helplessness during the consultation but was too scared to speak up in front of the clinician, given his authority. As the group members wondered about how difficult it already was for the patient to come into hospital on her own, we also fantasised about how she might have felt embarrassed by her frailty and her slow stride. This led us back to her choice of black attire, a possible attempt to blend into the background and avoid drawing attention to herself, further explaining why perhaps she presented alone.

The Presenter

As the facilitator guided us to reflect on my role as the presenter during that consultation, a rush of emotions from that day flooded back. In memory, they had been overshadowed by the plot as I had remembered more of what happened but less of how I had felt. The group empathised with how constrained I felt during the consultation, however it was divided on how much I could have done to influence the patient's experience. While one member recognized the challenge of intervening due to the power dynamics and the heated nature of the consultation, another suggested that more questions about her background, perhaps during or after the session, might have provided insight into her family and life circumstances. This comment resonated with me the most, and I appreciated that the group members had felt safe enough to provide this constructive feedback.

Prior to this discussion, my sense of helplessness and my desire to stay on good terms with the clinical supervisor had hindered me from taking more initiative. I had believed there was little more I could do, and I couldn't afford to challenge the geriatrician's authority. Even after the consultation concluded, I failed to approach the patient when I saw her in the hospital reception hall. I needed time

to process the encounter. However, the guilt and slight embarrassment I felt due to my inaction during the session motivated me to strive for better next time.

As a medical student, I have the privilege of spending more time with patients and having fewer clinical work constraints. I can communicate with patients and rebuild their trust in the medical profession in a way that clinicians focused on ordering and interpreting lab results and x-rays cannot. This is why Balint is indispensable for medical students. Without the opportunity to reflect on our roles as medical students, we risk accepting a passive role within the clinical environment without realising the potential for more significant impact.

The Consultant

Most of the discussion centred on the patient's feelings and then on those of the presenter. While the patient's anger seemed more justifiable, the members of the group, myself included, found it challenging to consider the consultant's perspective. This was an essential aspect raised by the facilitator, given that the group found it relatively easy to comment on the patient's viewpoint instead. By forcing ourselves to reflect more deeply about the consultant, the session proved to be a transformative experience of empathy, especially when a person's behaviour is harder to decipher.

The consultant's introduction of the patient, resembling a circus performance, was a perplexing image that lingered through the discussion. It contradicted the empathetic interactions I had previously witnessed when he dealt with upset families or spoke to patients on ward rounds and in clinics. This inconsistency left me bewildered.

We questioned the consultant's previous encounters with this patient and whether his preconceptions led to a self-fulfilling prophecy, where the boundaries he erected to shield himself from discomfort contributed to the session's discord. Through observing the discussion between the other medical students, I was able

to speculate on how his initial sarcastic remark about the patient might have served as a defence mechanism, concealing his anxiety.

Was the consultant threatened by the patient's unwillingness to heed his clinical judgment? We speculated about how the presence of a medical student might have exacerbated the situation, making the consultant reluctant to shed the persona of the 'all-knowing' clinician. In medicine, medical students not only acquire hard skills but also internalize the values, norms, and perceptions of the clinicians they work with. Dr. X's inability to connect with Ms. Lennox might have left him feeling embarrassed, as if he had failed as a teacher.

When I revealed that the consultation had lasted for an hour and fifteen minutes, we realized that the duration was a crucial factor in understanding the consultant's behaviour. In hindsight, this prolonged consultation illustrated the futility of the consultant's approach. Like the people featured in the story of the Tower of Babel, the patient and the consultant seemed to be speaking entirely different languages, and no amount of time would bridge that gap. Was the consultant better off accepting this as a challenging consultation he just had to get through?

Understanding the constraints within an under-resourced healthcare system, with overbooked clinics and long waiting lists, made us more empathetic toward the consultant's position. Possibly, he felt constrained by his lack of the time and skill required to handle Ms. Lennox effectively.

The Nurse

The introduction of the nurse, though mentioned late in our discussion, offered another opportunity to consider Dr X's perspective by considering his intentions for his decision to involve her. Beyond potential legal concerns, the consultant might have turned to the nurse to compensate for his communication

shortcomings. However, the patient might have misinterpreted this introduction as a collusion against her, further fuelling her anger.

As the nurse's body language began to mirror that of the patient, Ms. Lennox gradually relaxed in her presence, allowing the consultation to conclude. Being in her 50s, we considered whether the nurse represented a daughter-like figure for the patient. With the other two students, I explored how the nurse's presence might have bridged the power imbalance between the patient and the consultant. After the session, I pondered on the role medical students could assume in advocating for patients to address this gap.

The presence of the nurse was only discussed after I re-joined the group at the end. It struck me as ironic that, just as nurses are often overshadowed in ward rounds and multidisciplinary team discussions, our group had initially failed to recognise the nurse's significance in this interaction.

Post-session

As the facilitator brought our meeting to a close, we bid our goodbyes, unsure if this would be a one-time encounter. Exiting the Zoom meeting, I felt relief. Knowing that other medical students shared my passion for delving into the intricacies of medical interactions was reassuring. In the days that followed, I held onto the knowledge that I wasn't alone, and I couldn't help but wonder if other medical students I knew had similar feelings and apprehensions about medicine's complexities.

Yet, alongside relief, a sense of confusion lingered. This consultation was just one isolated episode in Ms. Lennox's care. I never got to experience what came before or after. What had happened as Ms Lennox exited that hospital door? How did she get home and where did she live? Did she live alone? It left me without closure. Presenting the case had helped me come to terms with it, but I still had

unanswered questions. I became more appreciative of the enigmatic beauty of the relationships between patients and healthcare professionals—there's often no clear right or wrong, no clear hero or villain. Balint encourages me to embrace dialectical thinking, allowing for the critique of actions without assigning blame.

Medical Students and Reflective Practice

Among the many facets of medical education, reflective practice often stands as an overlooked, ambiguous pursuit for medical students. Similar to patients receiving prescriptions from their doctors, we receive learning outcome lists for various clinical competencies, from history-taking to diagnostic procedures – but the role of reflective practice remains a nebulous entity (Gathu, 2022). Unlike the clear objectives of mastering clinical skills, reflection tends to be relegated to a checkbox exercise, lacking clear modelling and structured guidance from experienced mentors (Gathu, 2022). This absence of a framework can lead medical students to perceive reflective practice as peripheral and less important, a skill that appears detached from the immediate demands of the clinical environment.

In recent years, there has been a growing body of research highlighting the challenges medical students face, including declining mental well-being (Peng et al., 2023). However, without clear evidence and direction on how to teach reflection, few academic institutions have posited reflective practice as a solution for fostering sustained performance and self-care (Uygur et al., 2019).

Why Balint Is Important for Medical Students

The case described in this essay underscores the persistent existence of complex and perplexing interactions for medical students. Our unique vantage point as passive observers rather than active participants in patient cases provides us with rich exposure to the emotional tapestry of healthcare. However, this role is often unstructured, leaving students without formal outlets to express the emotions we encounter. Moreover, as students continuously transition between various specialties, we often lack opportunities for involvement in the continuum of care, leaving us on the periphery of the patient's journey. Balint group discussions, however, offer a pathway to better closure and a forum for medical students to share challenging experiences with seasoned healthcare professionals. These conversations transcend the common practice of peer support, fostering an environment where personal narratives are examined critically, assumptions are challenged, and multiple perspectives are considered.

Furthermore, the Balint approach introduces medical students to a world that extends beyond binary thinking and problem solving, which can become ingrained during our training. In the clinical realm, we are frequently presented with scenarios that demand definitive, right-or-wrong answers. Balint encourages a more nuanced consideration of multiple viewpoints, recognizing that a host of variables and complexities shape doctor-patient relationships. This perspective equips students with tools to grapple with uncertainty skilfully, promoting self-compassion in difficult clinical situations and enhancing our ability to empathize with both patients and colleagues. It serves as a profound reminder that doctors, regardless of their experience, share common insecurities, fears, joys, and the full spectrum of complex emotions.

The unique environment fostered by Balint transcends the traditional hierarchies of medicine, welcoming professionals from various disciplines and

career stages to convene as equals. In this counter-cultural setting, medical students find the confidence to express their thoughts and emotions more openly with non-peers. While Balint may still be relatively unknown among medical students, its potential to encourage emotional vulnerability is crucial for open, effective communication with patients and colleagues. It opens the door to more meaningful and genuine connections, ultimately shaping the next generation of doctors into practitioners who are at ease with their own emotions, adept at engaging with patients and peers, and well-prepared for the intricacies of medical practice.

Medical Student Balint Groups or Balint Groups with Medical Students?

The depth and richness of the case presented in this essay underscores the value of Balint group discussions that involve medical students exclusively. In the described case, a Balint group consisting of three medical students and two facilitators provided a platform for vibrant and insightful discussions. Despite our relative unfamiliarity with one another, as participants, we found common ground in our shared concerns, fears, and contemplations. Our interpretations varied, creating an atmosphere of constructive challenge, broadening each participant's perspective.
By focusing on experiences common to medical students, these specialised Balint groups foster camaraderie that may not be as pronounced in groups with a minority of medical students. However, the contributions of more senior professionals offer a blend of clinical expertise and Balint experience that enriches the discussions. Hearing experienced practitioners openly share their own challenging experiences serves as a wellspring of inspiration for medical students, who are at the beginning of our journeys in healthcare. Furthermore, when Balint group members have backgrounds in psychotherapy, they bring a valuable

knowledge base that bolsters the depth of reflection and enriches the learning experience for medical students.

Conclusion

Drawing on the poignant allegory of the Tower of Babel, miscommunication can lead to erosion of trust and a sense of alienation between people. In much the same way, the breakdown of effective communication between a doctor and patient can lead to a breakdown of patient rapport and poorer quality of care.

In revisiting Ms. Lennox's consultation, I find myself immersed in the profound intricacies of doctor-patient relationships. This narrative underscores the indispensable role of Balint groups in my medical education. With Balint, I strive to become more self-aware, empathetic towards colleagues and patients, and considerate of other perspectives.

In a healthcare landscape fraught with resource constraints and overburdened staff, I have come to realise that reflection plays an important role, enriching communication and nurturing compassion, while simultaneously guarding against burnout and compassion fatigue. These experiences in Balint have granted me profound insights into the human side of medicine, reaffirming the notion that doctors are not just purveyors of clinical knowledge but, in fact, serve as integral proponents of the healing process, akin to a drug itself.

References

The Holy Bible. Genesis. 11:1-9, New International Version (1979), London: Hodder & Stoughton.

Gathu, C. (2022). Facilitators and Barriers of Reflective Learning in Postgraduate Medical Education: A Narrative Review. *J Med Educ Curric Dev*, 3(9): 23821205221096106. doi: 10.1177/23821205221096106

Peng, P; Hao, Y; Liu, Y; Chen, S; Wang, Y et al. (2023). The prevalence and risk factors of mental problems in medical students during COVID-19 pandemic: A systematic review and meta-analysis. *J Affect Disord*, 321: 167-181. doi: 10.1016/j.jad.2022.10.040

Uygur, J; Stuart, E; De Paor, M; Wallace, E; Duffy, S; et al. (2019). A Best Evidence in Medical Education systematic review to determine the most effective teaching methods that develop reflection in medical students: BEME Guide No. 51. *Med Teach*, 41(1): 3-16. doi: 10.1080/0142159X.2018.1505037

Jamieson, E. (2025). Unspoken Valency and Showing Emotion. *Journal of the Balint Society, 50: 95-105.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Unspoken Valency and Showing Emotion

Balint Society Essay Prize 2022 Winner – Student

Elspeth Jamieson[1]

[1] Foundation Doctor, London, UK: e.jamieson4@nhs.net

'Communication is the heart and art of medicine' (Ha and Longnecker, 2010). It is also a skill that requires honest self-reflection to hone and understand. Although I had never heard of the Balint Society before, I selected the Balint group project because of its focus on reflective learning. I was interested in the possibility of exploring the medical student–patient relationship and reflecting honestly on the various dynamics and driving forces that steer such interactions. Reflection is necessary for any medical practitioner to develop and improve professionally. It is thus of paramount importance to succeeding in all aspects of medical practice.

In medical school, my teaching regarding empathy has been focused on how to offer verbal empathy to a patient, and not how to feel it oneself, nor on how to reflect upon feelings of empathy. This difference is important. Empathy is integral in effective patient–doctor interactions – however, without reflection upon how the doctor feels, the empathy can degrade and become disingenuous. Reflection improves the quality of the empathy the patient receives and in turn improves the ability of the doctor to cope with their emotions, consequently enhancing the doctor's mental health.

This essay will begin by briefly outlining the Balint process. My discussion will be divided into two themes: unspoken valency and the appropriateness of showing emotions. Finally, I will reflect upon my experiences in this Balint Group and comment on Balint's overall usefulness for my future career.

The Balint Process

In this section, I touch on five aspects of the Balint process. To begin, I offer a summary of the process. I then consider my role while listening to cases and while presenting. I touch on the dynamics of my role and finally review my reflective journey.

My Balint group had eight members and two leaders. We sat in a circle every Thursday evening for 12 weeks. Each week, one presenter volunteered to speak from memory about a significant interaction they had experienced with a patient. The interactions had remained with them, often because they were emotive experiences, or they felt unable to process the interaction. After the presenter finished their case summary, the leaders invited a limited number of questions, generally no more than five from the group. The presenter was then required to remove themselves from the group discussion, whilst the group discussed the case and its nuances. When each aspect of the case had been explored, the leaders invited the presenter to return to the group. The group then had an opportunity to reflect on what they had heard and offer feedback if the presenter felt that would be helpful.

In the early stages of the process, there was a palpable reluctance in the group to disregard the clinical facts of the case and to examine the emotional responses of the subjects in the case study. Indeed, I felt this approach was contrary to much of my academic teaching, and I found it unsettling to think about medical situations from a more subjective, rather than a factual scientific, perspective. It took time for me to give myself over to the process.

A few weeks into the project the leaders encouraged the group to fantasise, to go with initial thoughts and run with our imagination. It felt wrong initially to speculate about others and the motives which may have driven their actions. Over time, I found exploring these fantasies helped greatly. It was a way of allowing my emotional imagination to drive my thought process, and it enabled me to verbalise these thoughts back to the group.

While listening to cases toward the end of the process, I realised that thinking about patients as human beings, as people outside the consultation room, was very important in allowing me to relate and empathise with them. When I could paint a clear visual picture of the patients, I was then able to relate to them

on a deeper level and thus be more empathetic. I found that when the presenter was able to share additional aspects of the patient's lives (such as their profession or social circumstances) it enabled me to understand and resonate with them more. I found throughout the project that when I presented a case, I not only shared my memories, but I shared myself: the principles by which I conduct both my professional and my personal life. This very personal, open contemplation was only made possible by the safe, non-judgemental space created by the two leaders. An important part of fostering such an environment was the mutual recognition of the need to maintain the confidentiality of the meetings.

My role in the group varied week by week. Sometimes, I felt a synergy with the case and very connected to the patient. On these occasions, the process flowed easily, as did my contributions. However, on other weeks, I found visualising the patient difficult, and relating to the case was consequently challenging. During these weeks, I found myself in awe of the others' contributions and their ability to grasp the case. I also found it comforting to hear others depict cases where I had experienced a similar interaction. They were able to verbalise emotions that I had not yet considered or thought to reflect upon. I felt a bond between us as medical students during these shared experiences. It was reassuring to hear the others' struggles and concerns because it meant I was not alone on this journey, in the challenging environment that is medicine.

Finally, I'd like to comment on my reflective journey and how it formed my now more holistic viewpoint. Through Balint I have been encouraged to and become familiar with seeking a wider breadth of insight into situations. I was comforted at the beginning of the process by hearing the others' points of view that aligned with my own. However, with time, the opposite became true. The varied contributions of the group members, especially those which made me reconsider my preconceptions, taught me much more about my own perspective than the contributions that echoed my own thoughts. The Balint group allowed me to foster

a more balanced and reflective outlook. The opposing opinions were vital, enabling me to reflect more deeply. The Balint group facilitated an approach that incorporated multiple perspectives, whilst giving me the space to visualise and collate ideas for improved interactions in the future. I believe learning and continuing this type of rounded reflection will make me a more balanced, well-informed clinician in the future.

The Unspoken Valency

Unspoken valency was a concept introduced to the group by the facilitators. It is the unrecognisable pull between a patient and a medical student, a synergy that would not have been the same between two different individuals in the same consultation. Unspoken valency is a notion I had never considered in the context of a doctor–patient relationship prior to my time in the Balint group. Upon reflection, while presenting the following case to the Balint group, I truly understood its importance and how much valency alone can drive a consultation.

During my General Practice rotation, I met a man in his forties who had migrated to the UK from Bangladesh. I was asked by the GP to take a history and consider a management plan. After less than a minute of us talking, I realised his mood and demeanour was very subdued. His eyes darted around the floor, he was slumped in his chair, and he was speaking very softly. Without thinking I put my book down, where I had been taking notes, and closed it. I no longer required my lists of signs, symptoms, and differential diagnosis, to feedback eventually to the GP. This case was dissimilar to others I had encountered, and I intuitively began to operate differently.

My change in behaviour was picked up on during the groups reflections and this subtle action was described as a symbol of presence. By closing my book, I gave

myself over to the patient and was actively present in the consultation. This behaviour gave me presence and allowed me to see the patient as a whole, as a human being, someone with a life outside of the room. This patient was not suffering from an organic medical cause which could be neatly categorised but was rather an anxious and depressed individual. To help this patient effectively, I needed to learn more about his life and his social background and to discover what had led him to visit the GP that day.

It transpired that the patient had migrated to England due to being persecuted in Bangladesh for his sexuality. He was seeking a new life, one where he could be himself without fear. However, he had been finding things difficult and freely admitted to feeling suicidal regularly. Before this consultation I had not had a one-to-one talk with a patient about suicidal thoughts. Nevertheless, I was settled by his ease in opening up to me and I felt very comfortable talking to this patient, despite my lack of experience. Much of the group's discussion revolved around valency. The group considered the unrecognised pull between the patient and myself. The group commented on a palpable connection between the two of us – something I had not considered before.

I am part of the LGBTQ+ community. On further reflection, I think this played an important role in the consultation's dynamics. Neither the patient nor the Balint group knew this about me, yet still the group noticed a synergy between us. I felt a deep sadness for the man's situation and could not help but imagine the hardships he had suffered. I felt a strange sensation during the consultation, almost like an unconscious pull towards him. Unspoken valency is an intangible, but very powerful force, which can drive interactions with patients. This force is what I believe allowed the patient that morning to feel listened to and it allowed me to be non-judgmental and sympathetic. I now have a better grasp of myself and how my everyday life will impact my future consultations, unconsciously pulling me towards patients, or potential pulling me away from them.

After this interaction, I reflected on the support in place for GPs after they have cared for suicidal patients. Most patients that commit suicide consult their GP at some point before their death (Rotar Pavlič et al., 2018). This is rarely spoken about, perhaps due to a level of guilt or deep shame that GPs may be burdened with. I think many GPs rely on informal self-help strategies from family, friends, and colleagues to cope. Balint groups, however, can act as a different type of professional support.

The group's discussion surrounding this case did delve into the worrying emotions students or doctors are left with after seeing a suicidal patient. The group posed questions about what medicine really is and whether the mere presence of a compassionate doctor may act as a therapeutic benefit to the patient. It is very hard to accept that sometimes sitting and listening is the best therapy for patients. I found it valuable to hear from the group that it is sometimes all one can offer, and that I am not always going to be able to resolve every problem I encounter. Accepting that 'the doctor is the medicine' is challenging because of the weight of responsibility this carries, but in many cases such as this one, it feels applicable and comforting to know the support this can bring (Balint, 1955).

Is Showing Emotion a Sign of Weakness?

Since starting medical school, I have learnt that a career in medicine comes with an emotional burden. However, before participating in this group I had not considered the tools needed to cope with that emotional stress. In what follows, I explore coping after an emotionally demanding patient consultation through a discussion of a case review. I then discuss grief and burnout.

One highly emotive case was discussed a few weeks into the process. The student had met this patient, a woman in her fifties, whilst on a GP rotation and

was tasked with taking what seemed like a relatively straightforward pain history. However, one week prior to the consultation the patient had survived a catastrophic house fire, leaving the family homeless and her son hospitalised. The presenter became visibly upset whilst recalling the events and reliving the story. The student mentioned she had not been this upset when reflecting on it before. She was shocked and apologetic about her emotions. The group was supportive and attempted to reassure her that it was natural to feel emotional.

This case expanded my insight into unconscious parameters that can increase emotions and make it harder to cope with patient interactions. When the presenter re-entered the discussion at the end, they recounted a time their mother's dress had caught light whilst cooking. They had not thought about the significance of this near miss in relation to the patient before the Balint group. The 'what if' scenario that may have unintentionally been playing in their head about their own personal experience perhaps made this patient's grief more meaningful and tangible for this student.

The Balint environment is a unique space where one can bring traumatic stories and reflect on them free of guilt, without the worry of burdening friends and family. It is an environment that reveals the truth of the cliché that 'a problem shared is a problem halved'. This reaction from the student presenting illustrates the benefits that may arise from reflecting on one's emotions. I suspect that if the student had not had the opportunity to speak about their feelings, they may have found them harder to come to terms with.

As to the emotion of grief, it was a feeling that was touched upon in many of the twelve cases presented to the group. For many weeks I danced around the topic, not wanting to highlight its presence, through a fear of then having to discuss it. Grief is very personal and effects everyone in different ways. However, it does inevitably affect everyone. A leader commented one week on the group's hesitancy of the topic and queried why. The silence was broken by an admission from

someone that they had a preconception that doctors should be strong. This then led the group to consider the appropriateness of crying whilst at work. I found it hard to accept that doctors could listen to patients relaying trauma and stressful events whilst remaining entirely unaffected themselves. I commented during the group that while it is acknowledged that patients may require counselling to address their trauma, there remains a feeling of discomfort in the medical profession around accepting that we may require therapy. I have accepted that I cannot always be strong, and I may cry at work. Indeed, it is sometimes acceptable – and even helpful – to do so (Robinson, 2019).

One role of Balint groups, described in *The Australian Family Physician* journal, is their potential protection against burnout and compassion fatigue (Benson and Magraith, 2005). 'Burnout' is defined aptly by Figley as 'physical, emotional and mental exhaustion' caused by being involved in an emotionally demanding environment over a long period (Figley, 1995). In contrast, compassion fatigue can come on suddenly and is a result of dealing with patients who are experiencing or have experienced stressful events. Compassion fatigue, if addressed in the primary stages, can be reversed and the professional can make a full recovery. Both can lead to feeling overwhelmed and helpless. Burnout, if not tackled, can lead to depression (Benson and Magraith, 2005).

In one of the cases presented, a doctor was described as treating a patient with contempt and disregarding a safeguarding concern. The presenter had raised this matter with the doctor and had also been dismissed. I found myself judging this doctor and I wished I would never adopt their demeanour in years to come. This fear of losing passion and drive for the occupation was echoed by the group. Now I think the doctor's concerning behaviours were signs of compassion fatigue. I wonder if the doctor in question is feeling the strains of their role more than most. So, their empathy and inner purpose has diminished. I feel this doctor, like many, could reap the benefits of a Balint group. Balint provides a safe environment where

viewpoints can be challenged, and positive encouragement given. Having access to this environment and being a part of Balint, I believe, can protect health professionals from compassion fatigue and burnout.

Conclusions

Overall, my experience in this Balint group has been very positive. I can see the many benefits this supportive group learning environment can bring. It gave me the opportunity to reflect upon my own challenging experiences and learn from others as well. I found it particularly helpful in consolidating my feelings about, and uncovering the driving forces behind, patient interactions. The group setting allowed for healthy debate and the varied viewpoints left me with a newfound appreciation for the value of holistic reflection. The environment created by the two leaders felt safe and secure, allowing me to express my emotions freely. I found it difficult at times to find the right words to explain how I was feeling. However, through attempting to verbalise and structure my thoughts, I was able to gain a deeper understanding of my emotions. I now feel more confident in trusting my instinctive feelings, accessing my own emotions, and engaging with them.

It is a privilege to be entrusted with information about patients' lives and guide them through their most challenging times. The role of a doctor is a daunting one because there are unavoidable trade-offs that will occur: with these gains there will be inevitable losses. I think such challenges are easier to come to terms with if they are foreseeable and reflected upon. The process has reminded me of the reasons why I chose this career and the phenomenal difference doctors can make to their patients.

References

Balint, M. (1955). The doctor, his patient, and the illness. *The Lancet*, *265*(6866): 683-688.

Benson, J. and Magraith, K. (2005). Compassion fatigue and burnout: the role of Balint groups. *Australian family physician*, *34*(6): 497-8.

Figley, C.R. ed. (1995). *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized*. New York: Routledge.

Ha, J.F. and Longnecker, N. (2010). Doctor-patient communication: a review. *Ochsner Journal*, *10*(1):38-43.

Robinson, F. (2019) Should doctors cry at work? *BMJ,* 364: 1690.

Rotar Pavlič, D.; Treven, M.; Maksuti, A.; Švab, I. and Grad, O. (2018). General practitioners' needs for support after the suicide of patient: A qualitative study. *European journal of general practice*, *24*(1): 177-182.

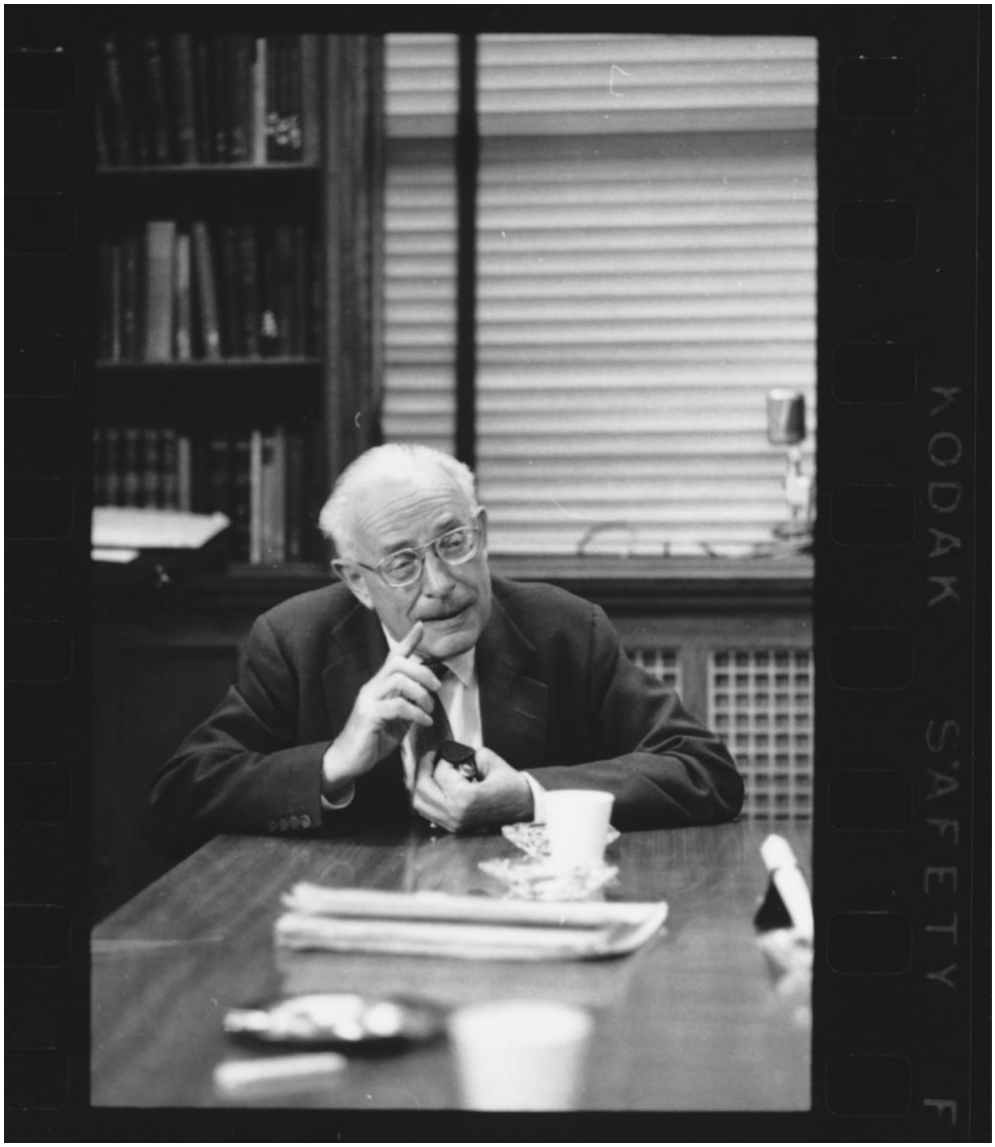

Figure 6.
Michael Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Coverdale, M. (2025). A Consultation that Changed My Practice. *Journal of the Balint Society, 50: 107-109.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

How Can I Help You?

Andrew Leggett[1]

[1] Specialist Consultation Liaison Psychiatrist and Accredited Psychotherapy Supervisor, Townsville University Hospital, Australia; Associate Professor James Cook University College of Medicine and Dentistry: Andrew.Leggett@health.qld.gov.au

How Can I Help You?

'How can I help you?'

'I don't know if you can, unless you've got a cigarette.'

'What's the trouble? What's brought you here?'

'The police brought me in.'

'Sorry to hear that. What's happened?'

'The neighbours must've complained again.'

'What would the neighbours be complaining about?'

'I've no idea. Maybe you should ask the police. Haven't you read what they wrote?'

'I'm more interested in hearing your story.'

'Are you really a doctor?'

'Yes, I am.'

'Then why should I tell you my story if you're not competent enough to read what the police wrote about me?'

'Would you like me to do that, then come back and ask you what's happened?'

'While you're gone, I'll head out front to find a roach to smoke.'

'You can't do that!'

'So while you muck around, I'm stuck here in emergency against my will?'

'That must be very difficult.'

'Don't patronise me! I'm here to be assessed, not patronised.'

'You really don't want to be here.'

'I'm not fucking suicidal! Who told you that?'

'I just mean to say that it must be very difficult for you.'

'I want a second opinion. I want a different doctor!'

*

While this dialogue fragment is a work of fiction, it is a compound of many experiences encountered by the author as an Australian psychiatrist, who values the relational aspects of his work, while conducting assessment consultations with patients in hospital emergency departments.

Sapunov, A. (2025). The Role of Balint Groups in Enhancing Reflective Practice for Psychiatry Trainees. *Journal of the Balint Society, 50: 110-116.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

The Role of Balint Groups in Enhancing Reflective Practice for Psychiatry Trainees

Aleksandr Sapunov[1]

[1] Consultant psychiatrist at Barnet Complex Emotional Needs Pathway and Barnet Psychotherapy Tutor, North London NHS Foundation Trust, UK: aleksandr.sapunov@nhs.net

Psychiatry is a field that demands both intellectual rigor and deep emotional engagement as practitioners grapple with the psychological complexities and emotional weight of their patients' experiences. For psychiatry trainees, this balancing act can be particularly challenging as they navigate the demands of clinical training alongside the emotional toll of patient care. Balint groups, which are structured peer groups focused on discussing the emotional and relational aspects of the doctor-patient relationship, offer psychiatry trainees a vital space to reflect on their experiences. These groups enhance reflective practice by fostering emotional resilience, providing a deeper understanding of the therapeutic relationship, and improving patient care by cultivating empathy and emotional insight (Balint, 1957; Otten, 2017).

Emotional Support and Reflective Practice

One of the key roles Balint groups play for psychiatry trainees is offering emotional support in a field that can feel overwhelming. Trainees often experience feelings of isolation when dealing with challenging cases, leading to emotional burnout (Katzman et al. 2016). The emotionally charged nature of psychiatric care, where clinicians engage with patients suffering from profound mental and emotional distress, can leave trainees feeling unsupported. Balint groups create a safe, confidential environment where trainees can share their emotional experiences and recognise that others face similar challenges, reducing feelings of isolation and fostering solidarity.

The supportive environment provided by these groups is crucial in creating space for reflective practice. Psychiatry, more than many medical specialties, relies on the clinician's ability to reflect on the emotional and psychological dynamics of the doctor-patient relationship. In this context, reflective practice involves not just

clinical observation but also an examination of one's emotional responses to patients. Balint groups encourage trainees to critically reflect on their emotional experiences, enabling them to better understand their own feelings and how these influence their clinical interactions.

Enhancing Reflective Thinking

Reflective thinking is a central component of Balint groups and is crucial for psychiatry trainees as they develop a deeper understanding of the doctor-patient relationship. Through reflective thinking, trainees are encouraged to step back from immediate reactions and explore the emotional dynamics that underpin their interactions with patients. This reflective process is not only about managing emotions but also about gaining new insights into patient care. For example, feelings of frustration or disengagement with a patient might initially seem unprofessional, but in the context of a Balint group these emotions are reframed as valuable indicators of the patient's struggles, offering new avenues for understanding and empathy.

This reflective practice aligns with transformative learning theory, which emphasises the importance of critically examining one's assumptions and habitual responses. Balint groups encourage psychiatry trainees to reflect on their emotional reactions and reconsider how these affect their interactions with patients. This process of self-examination can lead to profound personal and professional growth, enabling clinicians to become more empathetic and self-aware practitioners. In transformative learning, such critical reflection is key to developing new perspectives, and Balint groups offer a structured environment where this reflective practice can thrive.

Improving Patient Care

Ultimately, the goal of Balint groups is to improve patient care by deepening the clinician's understanding of the emotional and psychological dimensions of the doctor-patient relationship. Reflective practice, as cultivated in Balint groups, enhances trainees' ability to engage more empathetically with their patients. By discussing their emotional responses, trainees become more attuned to the emotional states of their patients, which can lead to stronger therapeutic alliances and more effective treatment outcomes (Salter et al. 2020).

This integration of emotional awareness with clinical practice is particularly important in psychiatry, where the success of treatment often depends on the quality of the doctor-patient relationship. Reflective thinking allows trainees to recognise and navigate the complexities of these relationships, enabling them to respond with greater empathy and understanding. Research has shown that reflective practices, like those fostered in Balint groups, are associated with improved clinical outcomes, as they help clinicians build stronger, more effective therapeutic alliances (Paget, 2001).

Balancing Biomedical and Narrative Approaches

Psychiatry trainees are often trained in the biomedical model, which emphasises scientific reductionism and clinical abstraction. While essential for diagnosing and treating mental illness, this model can overlook the rich emotional and psychological narratives that are critical in understanding a patient's experience (Johnstone, 2006). Balint groups offer a space where trainees can explore these narratives, allowing them to integrate biomedical knowledge with a more holistic understanding of their patients' emotional and psychological needs.

The narrative approach in Balint groups encourages trainees to view patients not just as a set of symptoms but as individuals with unique stories and experiences. This approach fosters a more empathetic and personalised form of care, helping psychiatry trainees move beyond the limitations of the biomedical model and engage with the broader human dimensions of psychiatric care. The reflective storytelling that takes place in Balint groups enables doctors to explore both their patients' and their own narratives, promoting a deeper understanding of the emotional and psychological dynamics at play in the therapeutic relationship.

Challenges and Implementation

While Balint groups offer significant benefits, their integration into psychiatry training programs is not without challenges. One major obstacle is the high demand placed on trainees, which can make it difficult to find time for reflective practices like Balint groups. Many trainees report feeling overwhelmed by their clinical responsibilities, which can limit their participation in these groups (Lustig, 2016). Training programs must prioritise reflective practices, recognising that emotional reflection is not a luxury but a critical component of professional development in psychiatry.

Additionally, not all trainees may be equally open to the reflective and emotional processes encouraged by Balint groups. Some may find the emotional intensity of the discussions uncomfortable or resist the deep personal reflection required for transformative learning. This variability in participants' readiness for transformation is a known challenge in both Balint groups and transformative learning, and it underscores the importance of skilled facilitation in guiding participants through the process.

Conclusion

Balint groups play a crucial role in enhancing reflective practice for psychiatry trainees. By providing emotional support, fostering reflective thinking, and improving the doctor-patient relationship, these groups help trainees navigate the emotional complexities of their work. Balint groups enable psychiatry trainees to engage more deeply with their patients, integrating biomedical knowledge with a more holistic understanding of the patient's emotional and psychological experience. As psychiatry continues to evolve, the integration of Balint groups into training programs will be essential for developing emotionally resilient, reflective, and empathetic clinicians capable of providing high-quality patient care.

References

Balint, M. (1957). *The doctor, his patient and the illness*. London: Pitman.

Johnstone, L. (2006). The Limits of Biomedical Models of Distress. In: Double, D.B. (eds) Critical Psychiatry. Palgrave Macmillan, London. https://doi.org/10.1057/9780230599192_5

Katzman, J.; Geppert, C.; Kilpatrick, J., et al. (2016). The Loneliness Curriculum of Psychiatric Training. Acad Psychiatry 40, 111–116 https://doi.org/10.1007/s40596-015-0461-3

Lustig M. (2016). Balint groups: an Australasian perspective for psychiatrists. *Australasian Psychiatry*, 24(1): 30-33. doi:10.1177/1039856215615013

Otten, H. (2017). *The theory and practice of Balint group work: Analyzing professional relationships*. London: Springer.

Paget, T. (2001). Reflective practice and clinical outcomes: practitioners' views on how reflective practice has influenced their clinical practice. *Journal of Clinical Nursing*, 10: 204-214. https://doi.org/10.1111/j.1365-2702.2001.00482.x

Salter, E.; Hayes, A.; Hart, R.; Orrell, R. A.; Jameson, J.; Knight, C., et al. (2020). Balint groups with junior doctors: a systematic review. *Psychoanalytic Psychotherapy*, 34(3): 184–204. https://doi.org/10.1080/02668734.202

Thompson, A., & Luthra, V. (2025). IIs there still room for the drug doctor in the NHS?. *Journal of the Balint Society, 50: 117-124.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Is There Still Room for the Drug Doctor in the NHS?

Amelia Thompson[1] & Vikram Luthra[2]

[1] Psychiatry Core Trainee (CT3) at Leeds and York Partnership NHS Foundation Trust: amelia.thompson2@nhs.net

[2] Consultant Psychiatrist in Medical Psychotherapy at the Leeds and York Partnership NHS Foundation Trust, and Psychoanalyst, Joint-President of the Balint Society. UK.: vluthra@nhs.net

Introduction

In 1957, in his book *The Doctor, His Patient and the Illness*, Michael Balint used various case reports by general practitioners (GPs) to demonstrate the value of the doctor-patient relationship. Interspersed within the clinical material, he introduced and defined various concepts such as the 'drug doctor', 'collusion of anonymity', and 'apostolic function' to understand the value of the doctor, the effects of moving responsibility for patients between specialities, and the doctor's beliefs as to how a patient should behave (Balint, 1957). For this paper, we will focus on the drug doctor, its application in modern day medicine, and its impact within a post-Covid and financially strained NHS.

Balint's work in this area was carried out around the nascency period of the NHS, at a time when doctors were perceived as 'the only person always available' for people to talk to, something Balint felt significantly contributed to the psychological dynamic between the doctor, his patient and the illness.

Over the past 30-40 years, the role of the doctor has shifted, and current NHS pressures mean higher than ever caseloads. In the last decade, there has been a net loss of 1,083 full-time GPs alongside a net increase of 6.8 million patients.[1] In response to these demands, there has been a drive to support the medical workforce with the introduction of allied healthcare professionals undertaking some of the work once only expected of doctors.[2] The diminished availability of doctors has also been recognised by the public: a recent survey demonstrated that over 40% of patients lacked confidence in timely access to their GP or mental

[1] See Royal College of General Practitioners. Key general practice statistics and insights. RCGP. Accessed 12 June 2025. URL: https://www.rcgp.org.uk/representing-you/key-statistics-insights.
[2] British Medical Association. Report: Physician associates (PAs) and anaesthesia associates (AAs). BMA. URL: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/physician-associates-and-anaesthesia-associates.

health services.[3] Given these statistics, it is not unreasonable to suggest a knock-on effect on the doctor-patient relationship and subsequently on the drug doctor, too.

The Drug Doctor

In his notion of the 'drug doctor', Balint (1957) explored in detail how the doctor themself may act as a kind of symbolic treatment method for the patient. The doctor therefore is not merely a treatment vector, but acts as an independent (unconscious) therapeutic agent, mediated through the doctor-patient relationship.

As with all drugs, the drug doctor is best when delivered in the optimum dose, frequency and duration which are influenced by the doctor-patient relationship and the individual doctor's behaviour, attentiveness and way of relating (Balint, 1957). Balint (1957) acknowledges the possibility of side effects that could result from an unsatisfactory doctor-patient relationship. While most doctors may not refer to themselves as drugs, the principle that the doctor may have a treatment effect cannot be dismissed. A variation of this can be seen over the past 30 years at the level of medical education, where widespread emphasis on communication skills (including active listening), along with teaching the biopsychosocial medical model are in most curricula (Kopelman, 2014). The drug doctor and its associated effects became particularly apparent during the Covid-19 pandemic.

[3] Healthwatch England. One in three people in England lack confidence they can access critical NHS services. Healthwatch. 12 September 2023. Accessed 3 June 2025. URL: https://www.healthwatch.co.uk/news/2023-09-12/third-people-england-lack-confidence-they-can-access-critical-nhs-services.

The Effect of the COVID-19 Pandemic on the Drug Doctor

The pandemic led to several seismic shifts for the NHS, one being the widespread implementation of telemedicine which completely reimagined clinical encounters, especially at a time where contact with patients would not have been otherwise possible (Mahdavi et al, 2025). Although remote working has allowed the doctor to be more 'available', it has led to a fundamental change in the individual doctor's setting. The notion that patients must physically come to the doctor is no longer a given, thereby potentially reducing the private and personal nature of face-to-face consultations. Conversely, remote consultations have permitted some patients (especially if anxious) to feel more autonomous and empowered to speak freely given they are in their own setting.

One limitation of telemedicine is the loss of physical examination and observation of the non-verbal cues and behaviours essential to communication (Mahdavi et al, 2025). For most consultations, this loss must be instantly accepted without any space for mourning. Thus telemedicine (a factor in the treatment like the drug doctor), although a powerful communication tool and treatment driver, could also be said to have impacted the doctor-patient relationship and diluted the efficacy of the drug doctor via the screen barrier and impersonal encounter (Mahdavi et al, 2025).

Another way in which the pandemic impacted the doctor-patient relationship was the shift in perception of the doctor. While doctors have long held a particular role in society, they were rapidly placed on a pedestal during the initial waves of the pandemic. Patients accepted directives to stay away from their doctors and even took time to 'clap for carers'. Perhaps similar to how branding can boost the potency of a drug's placebo effect, the same may have taken place for the drug doctor via the government or media (Faasse et al, 2015). However,

this temporary 'positive' (or perhaps not) side effect soon wore off as the pandemic resolved and as industrial action commenced.

The Effect of Industrial Action on the Drug Doctor

Although the unprecedented toll of the pandemic gradually subsided, the increased workloads and scarcity of resources continued to rise. Post-pandemic, the number of doctors identified at 'high risk of burnout' doubled (10% versus 21%) and chronic pay erosion spiralled with consultant real pay down 35% from 2008.[4] Many doctors felt undervalued and there was attrition from both the NHS and the profession, in contrast to the elevated position during the pandemic. Ultimately, this coalesced in 2023 with industrial action by doctors.

The drug doctor is closely tied to the sentiments driving strikes. For example, current doctors find revisiting Balint's 'long interview' logistically unfeasible. Doctors taking industrial action seek working environments in which a higher dose of the doctor is allowed through better staffing ratios, and greater efficacy of the doctor is provided via less burnt-out doctors who have greater emotional capacity and ability to listen. An expired drug could be thought of as the bio-equivalent of a burnt-out doctor.

Industrial action has the associated adverse effect of the patient being cut off 'cold turkey' from the drug doctor and runs the risk of withdrawal. Alongside the loss of their doctor, patients have also had to face an uncomfortable reminder

[4] See General Medical Council. (2023). The state of medical education and practice in the UK: Barometer survey 2023. GMC. Accessed 10 June 2025. URL: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/the-state-of-medical-education-and-practice-in-the-uk-barometer-survey-2023. See also British Medical Association. (2025). Fixing pay for consultants in England. British Medical Association. Accessed 12 June 2025. URL: https://www.bma.org.uk/our-campaigns/consultant-campaigns/pay-in-england/fixing-pay-for-consultants-in-england.

that their doctor's motive to care for them is, in part, financial. This seems contrary to the fantasy of the idealised, altruistic pandemic doctor, leading perhaps to the diminished shine of the recent "wonder" drug doctor. This shine has also worn down public support for strikes, which has declined as action has progressed and pay offers are rejected.[5]

The Importance of Balint Groups in the Current Climate

In today's NHS, doctors face escalating risks of emotional burnout and professional identity erosion, struggling to find space to inhabit the role of 'drug doctor' within an increasingly pressurised system. In Balint's (1957) words, 'to care for the doctor is to care for the patient'.

Balint groups offer a rare, protected space in the doctor's schedule, free from service demands and targets. These sessions allow doctors to reflect on their practice, relational dynamics, and assumptions, and to maintain empathetic engagement. They may also foster insight into how doctors prescribe themselves, their optimum dosages, indications and limitations. Since the pandemic, many groups adapted and moved online. Although not without compromise, virtual groups remain a valuable alternative, mirroring the telemedicine landscape in which the doctor–patient relationship resides.

In an overloaded NHS, access to Balint groups feels more relevant than ever, enabling doctors to hear their patients and themselves. For many, medicine began as a calling and a desire to fulfil the role of the drug doctor. Balint groups help sustain that vocation, even amid shifting pressures and uncertainty

[5] See YouGov. (2025). Public opinion on junior doctors' strike action – May 2025. Accessed 14 June 2025. URL: https://yougov.co.uk/topics/politics/survey-results/daily/2025/05/27/afee1/2.

References

Balint, M. (1957). *The Doctor, His Patient and the Illness.* London: Churchill Livingstone.

Royal College of General Practitioners. Key general practice statistics and insights. RCGP. Accessed 12 June 2025. URL: https://www.rcgp representing.org.uk/ representing-you/key-statistics-insights

British Medical Association. Report: Physician associates (PAs) and anaesthesia associates (AAs). BMA. URL: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/physician-associates-and-anaesthesia-associates

Healthwatch England. One in three people in England lack confidence they can access critical NHS services. Healthwatch. 12 September 2023. Accessed 3 June 2025. URL: https://www.healthwatch.co.uk/news/2023-09-12/third-people-england-lack-confidence-they-can-access-critical-nhs-services

Kopelman, PA. (2014). The future of UK medical education curriculum – what type of medical graduates do we need? *Future Hosp J,* 1(1):41–46. doi:10.7861/futurehosp.14.011

Mahdavi, S., Fekri M., Mohammadi-Sarab, S., Mehmandoost, M., Zarei, E. (2025). The use of telemedicine in family medicine: a scoping review. *BMC Health Serv Res*., 13;25(1):376. doi:10.1186/s12913-025-12449-7

Faasse, K., Cundy, T., Petrie KJ. (2015). Impact of brand or generic labelling on medication effectiveness and side effects. *Health Psychol,* 35(2):187–90. doi:10.1037/hea0000282

General Medical Council. (2023). The state of medical education and practice in the UK: Barometer survey 2023. GMC. Accessed 10 June 2025. URL: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-

research/research-and-insight-archive/the-state-of-medical-education-and-practice-in-the-uk-barometer-survey-2023

British Medical Association. (2025). Fixing pay for consultants in England. British Medical Association. Accessed 12 June 2025. URL: https://www.bma.org.uk/our-campaigns/consultant-campaigns/pay-in-england/fixing-pay-for-consultants-in-england

YouGov. (2025). Public opinion on junior doctors' strike action – May 2025. Accessed 14 June 2025. URL: https://yougov.co.uk/topics/politics/survey-results/daily/2025/05/27/afee1/2

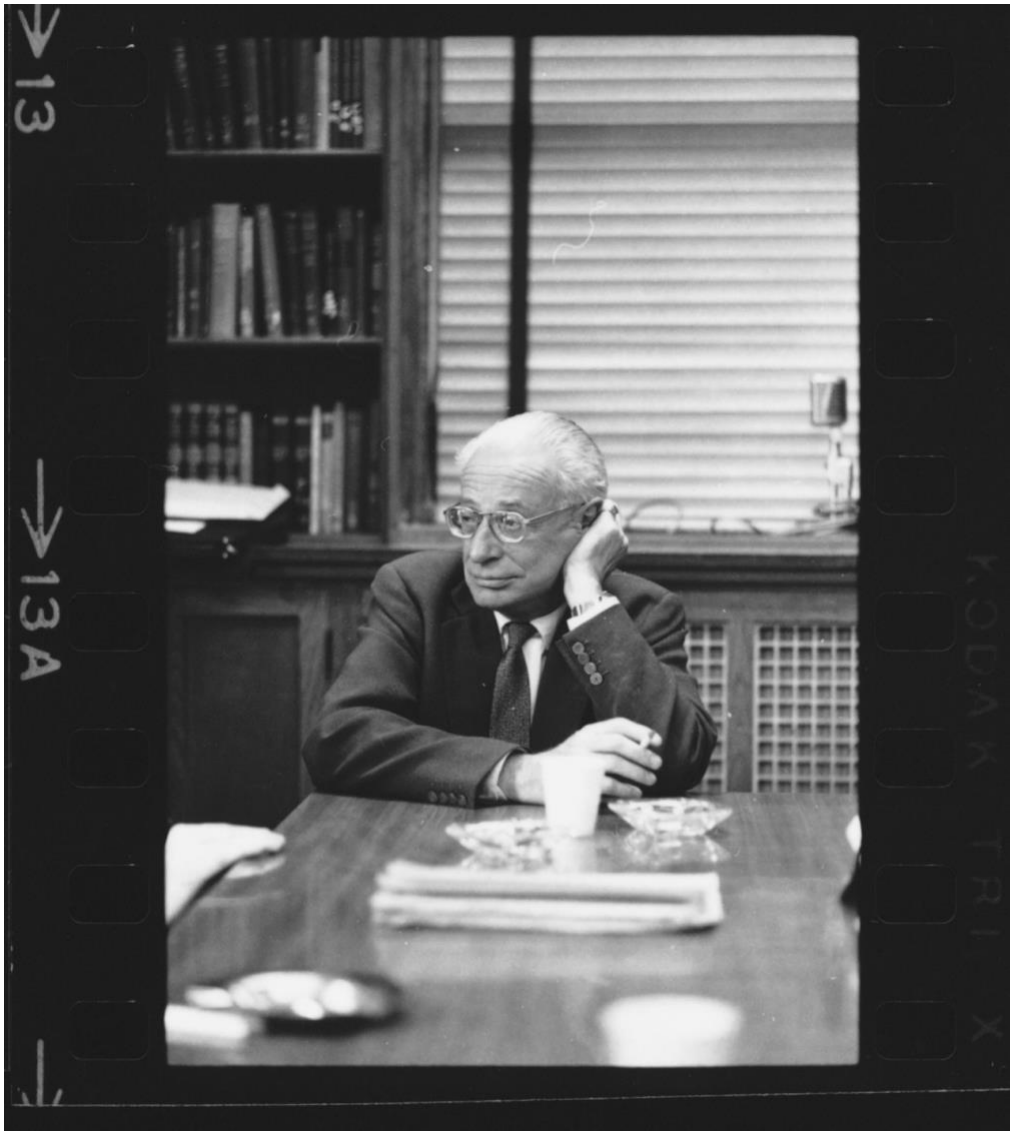

Figure 7.
Michael Balint in April 1967. Photograph by Edward H. Stein, M.D., Department of Psychiatry, University of Chicago Hospitals, Chicago, Illinois.
Picture courtesy: Susan Lawlor.
Enlarged from contact sheets by Raluca Soreanu, Ewan O'Neill and Hugo Coria, with the support of the FREEPSY project.

Salinsky, J. (2025). My Life as a Psychiatrist. *Journal of the Balint Society, 50: 126-130.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

My Life as a Psychiatrist

John Salinsky[1]

[1] Balint Groups Leader, former President of The Balint Society UK: jvsalinsky@aol.com

I should say, to begin with, that I was never actually a psychiatrist. But I did, as a medical student, spend a month attached to the medical staff of the Warneford Hospital in Oxford. My girlfriend was a student at one of the Oxford colleges, so Oxford was the obvious place to go for my four-week 'elective' period. In any case, I was interested in psychological medicine and intended to specialise in psychiatry when I qualified.

The Warneford was a very special hospital, founded in 1826 as The Warneford Lunatic Asylum, whose mission was to provide something like the atmosphere of a gentleman's country house. Its purpose would be 'the accommodation of lunatics from the higher classes of society', (later changed to 'the educated classes'). 'So reassuring', their families must have murmured as they signed the paper that would relieve of them of the burden of the problem relative. Of course, by the time I checked in for my four-week stay in 1965, things had changed considerably. Many of the patients were students of the University who were suffering from depression, for a variety of reasons; or acute anxiety about the prospect of sitting exams for which they had done little preparation. It seemed to the consultants that these young patients (all of them men) would feel a good deal of empathy with a friendly young student and, indeed, they seemed to be very happy for me to take their histories and get to know them.

Of course, they would still have to study and sit their university exams and for this the hospital provided a psychologist called May Davidson to act as their tutor. She was happy to act as tutor to any student, whatever their subject. She must have been not only a polymath but a brilliant teacher because her group's exam results were said to be better than those of most of the Oxford colleges.

As well as clerking the new patients, I was allowed to sit in with one or other of the three consultants while they did their outpatient clinics. My favourite consultant was a very genial man called Dr Seymour Spencer. He told me that he was Jewish by birth and had studied the Hebrew Torah in depth as a young man

but had subsequently become a Roman Catholic. In those days, there were quite a number of young women who needed the endorsement of a psychiatrist in order to have a termination of pregnancy. Their religion would determine to which of the consultants they would be allotted. If the patient was Catholic or Jewish, she went to Dr Spencer, while the Protestants were referred to one or other of the two C of E psychiatrists. If the patient was Jewish, Dr Spencer told her that she could certainly have a termination if she did not feel able to be a mother just yet. If she was a Catholic, on the other hand, she was reminded that abortion was a Sin, which he could not condone. I asked him why he had given up the Jewish faith himself, and with a smile and a shake of his head he said, 'impossible to practice'. I have to say that I enjoyed the sessions with Dr Spencer who, despite his idiosyncratic rules, was very amiable and great fun.

During ward rounds, I was introduced to some of the more colourful long-stay patients. The staff were very fond of one rather dignified man who believed that he was the rightful King of England, Edward the Ninth. They told me that he was usually quiet and well-behaved, but every so often he would escape from the ward and make his way by bus and train to Buckingham Palace where he informed the duty policeman that he was Edward the Ninth and had come to London to claim the Crown. When this didn't achieve anything, he said he was currently living at the Warneford Hospital in Oxford and could he please be taken back? But, how did he get out? On one occasion (it was said), his aggrieved doctor asked the other patients, 'who left that door unlocked?' And the patients chorused, 'you did, Doctor'.

Of course, these stories had become legends and maybe they were not all true: but they certainly enlivened my stay.

I was able to follow up some of the patients and to see some striking improvements. One middle-aged woman was so depressed that she insisted on sleeping on the floor, because, she said, she didn't deserve to sleep in a bed.

Antidepressants were no help, so the next routine step was electroconvulsive therapy. This was given under a very light anaesthetic and seemed quite brutal. But, on the next day, the patient was sitting up in bed and saying, 'I can't believe I wanted to sleep on the floor!' Occasionally, it was decided to treat a depressed patient by 'insulin coma'. To me this seemed drastic, though I didn't question it. Whether it was at all effective I never discovered.

My accommodation in the hospital was quite good; at least I had a bedroom of my own. On one occasion, after an evening with my girlfriend, I returned to the hospital quite late and used my own key to the front door. I was immediately challenged by the fierce Night Sister who said, 'What's your name, which ward are you from, and what are you doing out of bed?' I explained who I was and she decided, reluctantly I thought, not to throw me out.

My meals were provided in the doctors' dining-room where I formed an alliance with James, the registrar. This was necessary because all the consultants were quite right-wing in their political views, whereas James and I were both Democratic Socialists. When our seniors expressed their views, from behind their *Daily Telegraph*, we two would show each other inflammatory articles in our copies of *The Guardian*.

I enjoyed my stay at the Warneford, and I learned a lot; although most of it is now of historical interest. Afterwards, back at my teaching hospital in London, we students were each asked by a committee of three consultants what speciality we wanted to go into when we qualified. When I said: 'psychiatry', they all found this very amusing. Then, they grew serious. The one on the right said, 'all right, but you should do some proper medicine first and get your MRCP.' And the one on the left, who was a surgeon, told me I should then get my FRCS as well. And if I still wanted to be a psychiatrist? He shrugged and gave me up as lost. I suppose they thought they were trying to save me from joining the least distinguished branch of the profession.

Well, I did do some medical jobs, and I did get my MRCP after a struggle and with some help from the wonderful evening classes given by the brilliant renegade, Dr Maurice Pappworth. We all enjoyed his scathing remarks about well-known consultants. But I ended up as a GP and soon joined my first Balint group. Looking back, I am certain I made some very good decisions.

And the girlfriend? Reader, I married her!

Pathak, S. (2025). Balint's Seminars: What I Miss Most Since My Retirement! *Journal of the Balint Society, 50: 131-135*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

Balint's Seminars: What I Miss Most Since My Retirement!

Suresh Pathak[1]

[1] Retired G.P. Worked and lives in Romford, Essex, Research associate, Queen Mary's Medical School, London: SKPathak137@aol.com.

I retired as a GP in May 2001, having joined a general practice in September 1971 straight from hospital medicine. I had not done any GP traineeship but was inducted into two doctors' practices. My senior partner was a very experienced Scottish doctor who became my trainer, mentor, guide, and family friend. I owe my existence in general practice to her.

It was not an easy passage for an Indian-trained doctor to learn English general practice, which is an institution. I had a short stint as a general practitioner in India for about a year and a half. For an Indian patient, a pill is necessary for every ill and so, initially, my prescribing here was high compared to my other partners: most of the patients walked out of my consulting room with a handwritten prescription. But I developed an interest in 'consultation.' Among many books I read, I was clean bowled over by reading *The Doctor, his patient & the illness*, written by Michael Balint. I read it from cover to cover a couple of times before I realised what I was reading, what it meant and how to bring this concept into day-to-day practice. As a doctor sitting in the comfort of my consulting room, I am only looking at the presenting symptom of the patient seated in front of me. Who he is, what he is wearing, who is accompanying him, what is his background – I ignore these vast unspoken features. I remember reading in one of the medical books: 'if you know a thing, you see it; if not, you do not see it'. So, I fit into this category. I did not know my patient. I was only aware of their presenting symptoms. Reading Balint's book, all my faculties were suddenly activated.

I read the book and studied it. The result was that my consultation style changed: I could identify the person sitting on the other side of the table and I assessed him beyond what he was telling. Reading this book also made me aware of the importance of taking serious note of what goes on within the consultation. Doctor-patient relationship was the new concept coined by Balint. This book, *The Doctor, his patient & the illness*, is based on weekly seminars, conducted by Balint at the Tavistock Clinic in North London. Between eight and ten GPs attended these

seminars. He functioned as a group leader and psychoanalyst. Doctors presented the cases, and Balint guided these doctors and analysed these cases. The essence of these groups is to share experiences and enable people to observe and rethink aspects of their relationship with patients and their work as doctors.

I was overly impressed reading this book, which is all about the day-to-day work of general practice. What the histories I read about taught me is how a simple case, when unfolded by doctors during a discussion, became difficult, tangled with complicated relationships within the family. The patients described in the book have found it hard to deal with the problems of their lives and have resorted to becoming ill.

I learnt at medical school, in various medical clinics and outpatients, that medicine was based on a relationship model of object and subject. The doctor is an active agent, and the patient is a passive one. But Balint's theory is that a doctor is as much a medicine as a prescribed drug. When to prescribe, how much to prescribe 'himself' as a drug-doctor was a new phraseology. I was so interested in joining this Seminar after reading this book that I wrote to the Tavistock Clinic educational department. I was invited to attend an interview, and I was offered a place at the weekly run seminars. Back in those days – I am talking of 1986 – there were two seminars weekly, one on Wednesday and another on Thursday. I opted for the Thursday seminar because this was my half-day in practice. I had to travel to Finchley Road from my home in Romford, which took me more than an hour and a half each way.

For a few weeks after joining the seminars, I felt unsettled. But soon, the magic of the cases presented in the seminars by the doctors; the responses from other doctors, with many questions and sometimes a grilling; and finally a summing up by the group leader, a psychoanalyst; was so overwhelming, so educative, I saw it was an exercise par excellence. I presented my first case when I was merely three or four weeks into the seminars. The aura of seminars was so

strong that it always lingered on my lonely train journey back: the case I had presented, or the case another doctor had presented. Gradually I become wiser in understanding what is going on within the four walls of the consultation, between you and your patient and his illness. I am not saying that it offered solutions to all those 'heart-sink patients', or the patients who came with a list of their symptoms, but it made me aware that these patients needed help. This help may be just listening to their complaints.

These seminars were addictive to me. Every Thursday, my half day in practice, I became restless if I was delayed at the practice. My seminar started the moment I boarded the train from my local railway station and lasted till I returned and picked up my car from the car park. Seminars started sharp at 2.00pm and lasted till 3.30pm, not sharp. I attended these seminars for 14 years, with a good attendance record. Three group leaders retired during this period, but my addiction continued. During these seminars, we did some academic and research work as well. We discussed cases of accidents and trauma for more than six months. For a considerable length of time, we discussed our referral patterns to secondary care. Why we refer these cases – and how helpless we feel when we refer – was a revelation. I remember presenting a case when a female patient of mine wanted to be referred to a teaching hospital, which I declined. I was grilled like anything for my refusal, but my reasoning was accepted by the group after an intensive cross-examination.

My retirement from practice and my withdrawal from the Seminar also coincided with the termination of these seminars at the Tavi. I enjoyed them for 14 years, as I mentioned, and I was a loyal supporter of these seminars. I must have been seen at the Tavistock Clinic by 1.50pm whatever the weather or transport conditions. Several times I would reach it early, and I would use the canteen for a sandwich and a coffee or use the library. I recall once the Indian cricket team was playing a test match at Lords, which is on the way to the Tavi. I skipped the match

at the lunch break, dashed down to attend the seminar till 3.30, and came back to see the reaming cricket match (mine is a cricket-mad family).

Besides the difficult or heart-sink patients, we were able to talk it through when the presenting doctor was going through a bad patch, a partnership problem, a complaint, or any issues relating to his or her professional life. I was able to discuss the problem I was facing with my VTS trainee. At the end of the day, I would say that one learnt something from these seminars. I would put it this way: the outcome of these seminars is like a vaccine, where the long-term benefit is immense and ongoing; it is slow but strong professional development.

During my long spell of attending these seminars, I have seen doctors come and go. Some came for a short spell and some for a long spell. We shared experiences and enabled people to observe and rethink aspects of their relationship with patients and their work as doctors. In these seminars, the group's identity develops, and the group leader and members mutually influence each other's views when presented with these cases. In the setting of these group laboratories, new observations are made about the doctors and their patients, and changes occur. Facilitating the observation of work in general practice and evaluating it has been the main aim of Balint's seminars. I miss going to the Tavi once a week: the interaction with other colleagues, and the wisdom of the group leader. It has been more than a decade since I retired, but I sincerely and sorely miss these seminars.