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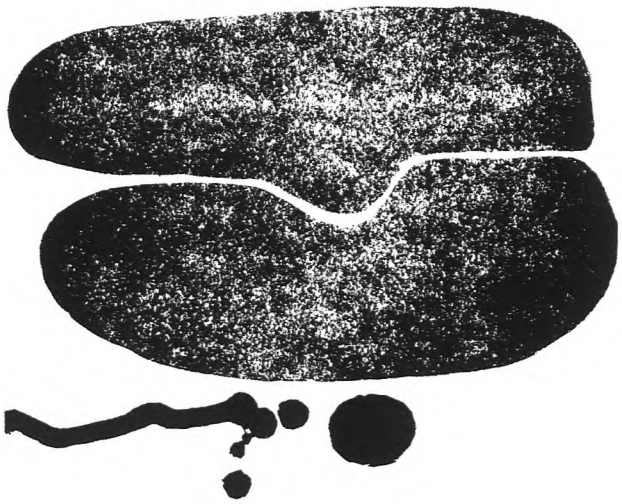

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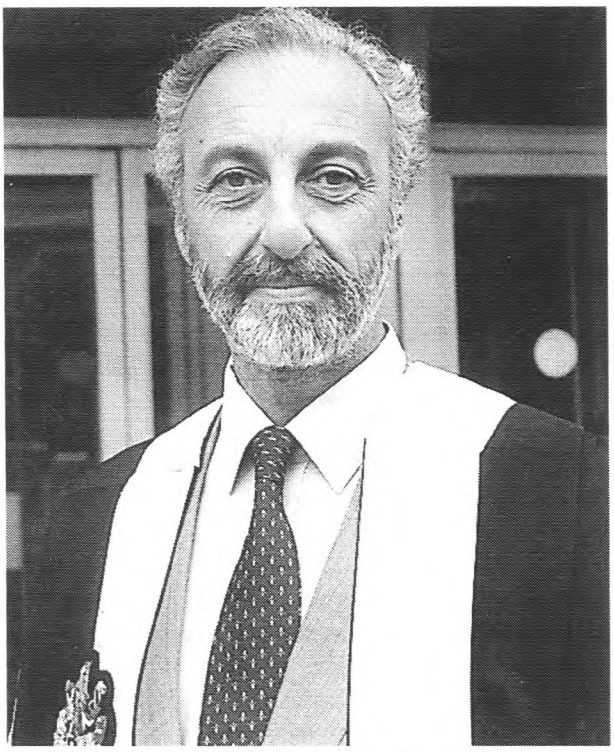

Dr Jack Norrell 1927-2001

The Balint Society:

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

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is an annual residential weekend at Oxford, and there are occasional weekends and study days for elsewehere in the country.

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

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

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

Editorial

The Benefits of Balint

In the Golden Age of Balint (if it ever existed) it was possible, in Britain, for young family doctors to spend two or three years attending a weekly Balint group. These groups, led by psychoanalysts or experienced GPs, well marinated in the Balint process were provided at the Tavistock Clinic or University College Hospital in London and also in a few provincial centres. Some of those who benefited from those groups are now senior members of the Balint Society. Balint has retained a central place in their hearts and in their professional lives. They (or rather we) are never happier than when taking part in a Balint group of one kind or another. We go to Oxford every September and we are available to lead *ad hoc* groups whenever there is a flutter of interest in having a taste of Balint. It might be a group of psychiatrists in Belfast, an education day for hospital doctors in East London, a giant WONCA conference in Westminster or a GP weekend in Chester. It might be a new research group in England or a new training scheme in Eastern Europe. Whatever the occasion, we are delighted to go, to give a talk, to lead a group or simply to take part.

But what has happened to all those others who went through the Balint experience in their late 20s or early 30s and never joined a group again? Did they undergo the 'small but significant change in personality' – or did they remain untouched? One hopes that their group experience gave many of them a useful foundation for coping with the emotions in general practice throughout their careers. We like to think that they remained sufficiently interested in their patients to continue as GPs until their 60s and not retire early, with their souls charred by burnout. We have no quantitative data because so far as we know, no-one has yet tried to find all those groups members who never joined our Society and ask them what, if anything, their years sitting in the Balint circle have done for them. We respectfully offer this suggestion to anyone looking for a suitable Balint research project.

Meanwhile, some distinguished senior GPs who were Balint group members in their youth have spoken or written about how their Balint experience continues to influence and support them. John Horder, who was in the very first Balint group, in a recent appraisal wrote 'I believe that the seminars made me better at my job, but cannot prove this. I would certainly claim that they helped me to deal with unusual or difficult people with less anxiety.'[1] Lesley Southgate in her Foreword to *What are you feeling doctor?* says that, in her early attempts to make sense of the general practice consultation, 'the greatest benefit came from hearing the stories of doctor-patient relationships recounted by other group members'[2]

Those groups for young principals have now largely been replaced by VTS groups for GP registrars. Do today's young doctors appreciate the opportunity, where it exists, to learn about the doctor-patient relationship in a Balint group? What do they think it is doing for them? My own group, when I ask them, say that they value the support of their peer group who are all struggling with the same interpersonal problems. They say they are beginning to realise, as a result of the group, that it helps to see that patients are people like themselves and that they are asking for help rather than deliberately trying to make life difficult for young doctors learning to tolerate uncertainty. These may seem modest benefits but they could be a good foundation for maintaining an interest in the patient as a person throughout one's professional lifetime.

The pity is that so few of our current Vocational Training Schemes incorporate a Balint group as part of their education. It only happens where the course organisers, have had Balint training themselves and are keen to pass on the benefits to the next generation. There is some interest among other course organisers and the Association of Course Organisers (ACO) has for several years asked the Balint Society to lead a Balint group for delegates to their annual conference. We should now respond to their interest more positively and offer them training as group leaders. Most will not have been in a weekly Balint group themselves but this obstacle can be overcome. The American Balint Society has for 10 years run a series of Intensive Workshops and a programme of supervisions for doctors (and psychologists) wishing to lead Balint groups in family medicine training schemes. The results have been very encouraging and Balint is spreading steadily across the map of American medical education.[3] We should follow their example.

References

1 Horder, J. The first Balint group. Br J Gen Pract 2001: **51:**1038-39.

2 Southgate, L. Foreword to *What are you feeling, doctor: identifying and avoiding defensive patterns in the consultation* 2001 (Salinsky, J. and Sackin, P.) Oxford: Radcliffe Medical Press Ltd.

3 Johnson A, Brock CD, Hamadeh G and Stock R. The current state of Balint groups in American family practice residencies: a ten year follow-up study 1990-2000. J. Balint Soc 2001 **29:**11-17

The Balint Society Website

After a prolonged comatose period the website has now awoken and has been refreshed. Please have another look.

The address is **www.balint.co.uk**

Unlike some addresses, this one is very easy to remember and to find.

When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress.
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on **www.balint.co.uk** you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to **www.balint.co.uk.**

Balint group discussion as a prophylaxis for burn-out in physical medicine

Psycho-analytical reflections on difficult patients by Lars Härdelin

Lars Härdelin is a specialist in internal medicine and general psychiatry. He is in private practice as a psychoanalyst and, from 1996-99, was responsible for Balint activities in the Swedish Medical Society's section for medical psychology as well as directing several committees in the fields of general medicine and somatic specialities. Email lars.hardelin@ptj.se

Doctors who are passionately committed to their task risk facing burn-out in their endless meetings with patients who repeatedly consult them about distressing problems to which there is no ready solution.
Participation in a supportive Balint group can act as an antidote to burn-out by promoting greater awareness, self-respect and interest in the psychological processes.

Some 15-20 years ago, before I became a psychiatrist and psychoanalyst, I worked as a general practitioner. I struggled to resolve the contradictory feelings that distressed me with regard to several of my patients. Characteristic of them was that they came repeatedly to the surgery with painful conditions and a very negative, accusatory attitude or, worst of all, with an unstated suffering that expressed such a mood without actually naming it in words. These patients often dominated my mind long after the consultation. And the moment they put their foot over the threshold again the same mood was immediately present. In conversation with my colleagues I referred to them as "threshold diagnoses".

Invaded and made to feel guilty

My own experience of these patients was that, like the genie in the lamp, they streamed forth and invaded me, made demands and caused me to feel guilty; they came almost to pursue an existence as unwelcome strangers within me. Frequently I did not know how I could help them. Generally there was nothing more that I could do for them. Worse still, even if there was something that I could do, I had neither the energy nor the desire to do it.

I developed half-hearted strategies for minimizing my negative feelings in meeting these patients. Communication became very formal. Either meeting them as my last or the first patient in order to feel free for the rest of the day was one strategy. Referrals to specialist colleagues was another way out. Cancellations were welcomed. Developing defensive strategies sufficed to make me feel overworked. The situation was very wearing. Perhaps I was not at a point which we today term as burned-out; rather I was in the early stages, a little singed.

A patient to leave one speechless

It was at this time that I first joined a Balint group. On one occasion when there was a lack of cases to discuss Astrid came to mind. Astrid was in no sense a remarkable patient. There were many other patients who played much greater havoc in my mind. But in some way Astrid's unremarkability forced itself upon me, almost as though it was my fault. I started telling the group about Astrid only to realize that I did not really have much to say. The others were largely silent though someone asked me how I felt about her. I was filled with an alarming sense of embarrassment on account of my lack of contact with Astrid. My reaction came as a surprise to me. I had thought that Astrid would be dealt with very rapidly, a fill-up for a lack of interesting patients. But this was not the case. My silence filled the room and no one said anything. I felt misplaced and excluded from the group.

Astrid was unmarried, had no children and worked part-time. She was aged about sixty and had consulted me regularly for several years to have her blood pressure checked and for back pains. But mostly she came for ... for what? Astrid consulted me more frequently than was strictly necessary. At first the consultations were quite brief and she had little to say. Her blood pressure was usually well under control and her back was the same as usual. From time to time I prescribed painkillers and sometimes referred her for physiotherapy. There was nothing more to be done. Yet she seemed to linger in the consulting room as though expecting something to be said. Sometimes she seemed to be trying to say something but interrupted herself and I could think of nothing to add although I thought that I ought to say something. This caused me to feel that the consultation could not end there and this led to my giving her something such as a prescription or a referral; and for this reason I booked her for a further consultation more often than was necessary.

In the end the leader of the Balint group said that I seemed to be estranged from the group when I had nothing to say. There was something solitary about me when I was talking about Astrid; I remember his using the term lonely. There was something embarrassing about the whole situation when I had nothing to offer and the group could neither receive nor give. The therapist did not recognize me in the situation.

Could my emptiness and need for contact tell us something about Astrid? The question awoke in me an interest in Astrid, and in myself. An exchange of views with the group followed and at the same time it seemed as though the troublesome feeling was resolved.

Some liberating words

Astrid continued to visit my surgery. Astrid was the same yet something was different. Her silent attendance no longer seemed demanding and expectant. And I myself felt freer. I remember saying to her that she seemed dissatisfied, as though she wanted to say something, or that she wanted me to say something or do something more for her. My remark was almost banal but at the time I felt that this was what had to be said.

She replied that this was the case but that she did not precisely know what she expected. Just that if I said something she would feel better. She said that she felt such a poor thing, just sitting there; as though there was some "defect" in her. I replied that we both seemed to lack anything to say, that we were both suffering from the same defect. Not so many words were exchanged but it seemed as though just naming the situation was enough to resolve it.

During the 20 minutes that the consultation lasted, as I checked her blood pressure and inspected her back, we both shed some more light on the "defect". At times we seemed to be talking of her old back as the defect, a shameful injury, a fault that I could do nothing to alleviate. At times we seemed rather to be referring to Astrid's silent waiting and her inability to clothe her thoughts in words. The meanings seemed to shift yet it was as though the condition and the speechlessness were one and the same. In her recollection it had always been thus, that she had always seen herself as a poor thing, as though her entire self was defective. She remembered this from the time when she had spent almost a whole year in a home for disabled children and her mother had not had time to visit her. Her mother had to think of the younger children in the family.

A small but significant change

Astrid began to take form; her world began to be populated. The consultations gradually changed character. Astrid complained less about her backache and she no longer lingered in the same way. Her whole attitude to life altered somewhat. Now and then she casually mentioned something that had happened to her: she had made friends with another woman. She had started to go into town and to buy new clothes. Once she attended a concert.

Her visits to the surgery became less frequent and in the end she came only a few times a year, mainly for a check-up and to get her prescription. A small but important change seemed to have taken place in Astrid's life. It seemed as though my change of approach, thanks to my participation in the Balint group, might have made a definitive contribution to this change of scene.

A unique but ordinary relationship

Every patient-doctor relationship is unique. Yet experience points towards the fact that Astrid and I, in our relationship, formed part of the great mass of patient-doctor relationships in which mental ill-health is formulated as a somatic problem and where patients do not seek psychiatric help but turn to their local general practitioner. Patients primarily suffering from emotional problems, who repeatedly seek medical assistance for feared physical complaints, may account for some 30-40% of primary-care consultations. It would seem that this strange phenomenon may represent one of major unsolved problems of current health care.

And the cost of such patients is estimated at nine times that of "normal" patients. These patients often give rise to very trying patient-doctor relationships that contribute to the tiredness and burn-out that medical staff struggle with today.

Burnout

Burn-out is the term used by Christina Maslach in 1982 to describe the debilitating mental process that occurs in healthcare staff and that has spread like a plague in Sweden as in the rest of the Western world. People with a high level of commitment and a heavy work load and with little time for recuperation have been seriously at risk. The health authority's demands for greater efficiency and lower costs, together with a decrease in autonomy and a lessening of support, have all contributed to burnout. Burn-out, a condition characterized by extreme tiredness and job-dissatisfaction together with feelings of hopelessness, irritability, lessened empathy, suspicion and a reduction in one's level of performance. Burn-out is probably also one of the more important reasons for repeated – and justified – demands from doctors for improvements in their physical working conditions.

But my relationship with Astrid would seem to indicate that there are other factors that contribute to the raging fire. In our meetings with patients with a great need for help and support and where there is no immediate remedy available, a failure in communication easily arises, a "non-meeting" that creates an emotional climate on the part of the doctor that is difficult to deal with and that threatens to exhaust him. And my work in the Balint group would seem to be an example of how doctors can be revitalized when a meeting with "the patient within the doctor" takes place. The doctor's improved state also makes the patient's improvement possible by means of a "meeting with herself".

Why only the body?

Some psychoanalytical reflections may increase our understanding of this phenomenon.

Numerous so-called psychosomatic patients present to their doctor rather vague symptoms and are worried about an underlying illness. They expect a diagnosis. This suits our health service very well since it is organized in accordance with an attitude to health that fits with the phenomena depicted by these patients. But there are problems with this health classification. For if this attitude to health is an unconscious excuse for avoiding a psychological problem, doctor and patient jointly risk defining unsolved existential problems as ill-health. These patients are not helped by the doctor not being able to find any bodily fault. On the contrary, they feel misunderstood and let down and they return with new symptoms. Whereupon the doctor often commences a new series of investigations at a more advanced and more costly level.

Sometimes the doctor and the patient can stop at an organic condition, a secondary fault to which the entire problem is now attributed. A degenerative disc condition or hypertension are surely common conditions in cases besides that of Astrid. This somatic labelling means that the phenomenon is organized under a heading which includes a given method of treatment. But in spite of what might appear to be a positive situation, many patients seem to respond in a negative fashion to the treatment. The medication affords no results, side effects are evident and the treatment is questioned. It is as though bodily illness is preferable to learning the truth about oneself.

The doctor becomes what the patient does not want to be

Understanding this can have other implications. The patient is living under a threat. A warning flag has been raised for sickness, decline and death. Anxiety has placed the patient in a regressive state in which his or her capacity for absorbing fear and dealing with inner conflicts has diminished. Ordinary defence mechanisms do not suffice and the patient's need of the doctor has increased, not only for curing the threatening illness.

From a psychoanalytical point of view, the patient has entered a more unconscious, primitive emotional state, bringing with it uncomfortable feelings that permeate her thinking. The rational causal connections that we, as patients, are expected to understand, will be impregnated with an irrational but persistent feeling that the hardships that threaten our existence are intentional and, in fact, have been purposely put into effect. We often feel ourselves to be subject to malicious and punitive forces, forces that reject or ignore our needs or that actively want to harm us.

It is difficult to accept that this destructive force emanates from our own personality. As patients we therefore have an unconscious need to liberate ourselves from these inner states and to place them beyond ourselves. One needs to lay one's own problems into somebody else. The doctor, who is a central figure to the patient, thus becomes a ready target of the patient's subconscious needs. Through the emotional mood that is born of helplessness and dependency, complaining and blaming for example, as patients we unconsciously make use of a method that places the doctor in an uncomfortable position. For example the complaining and blaming tells him that he is obliged to live with the feeling of not being able to cure the patient of the illness that she does not have. In a sense the doctor has, therefore, to struggle with a sense of unjustifiably having to take responsibility for and feel guilty about having "caused" the patient's irremediable suffering, a feeling that can readily lead to mental repudiation and defensive aggressivity in the doctor.

The patient who wants to achieve liberation by letting the doctor take over his or her problems and by letting the doctor become the bearer of these painful interior states, has in a way succeded. Through a process of identification the doctor has partly become and must remain that part of ourselves that we do not want to recognize. The patient's mental picture of an ill-disposed doctor thus risks becoming a self-fulfilling prophecy and the boundary between phantasy and reality is erased.There is, in these processes, an increasing risk that trust and confidence are reduced and that suspicion and lack of confidence increase.

Patient and doctor caught in the safety-net

And as long as the patient's unconscious need of the doctor as a source of assistance or a depository for the patient's own, painful emotional states is stronger than the patient's conscious need to be cured, the doctor's treatment of the "illness" will be relatively unsuccessful. And since the need is a process that has constantly to be reinforced, the patient will readily attach herself to the doctor who has agreed to become her depot.

In this unchanging and insoluble situation the doctor's experience of the patient will change. Now it is no longer the symptoms that the patient complains of that are the problem but the patient herself. It is as though there is no longer an illness that needs to be treated but the doctor seems to struggle with a forbidden and guilt-ridden feeling of wanting to get his or her own back, cutting loose the patient's attachment to the doctor. But the unexpressed need for each other experienced by the two parties binds them together causing a dark drama to be played out at the clinic. Doctor and patient have caught themselves up in the protective net of the health service and become each other's catch. I lost my freedom in my relationship with Astrid to whom I accorded ever more regular consultations.

Burning for and burning out

Doctors with plenty of fuel in their tanks and a burning interest in their task are threatened by

exhaustion from these unhappy processes with their insoluble and wearing problems. Emotional exhaustion and impoverishment develops with a lessening of one's ability to empathize in one's relation to the patient. The doctor's defence measures increase; common are an increasingly formal approach and a distancing from the problems of health care. Within the doctor there develops a nagging sense of guilt and a devaluation of his or her own abilities. A depressive state threatens with a loss of enthusiasm for the job. Good forces are thus drained off from health care.

Michael Balint and Balint groups.

The doctor now faces the difficult task of finding a solution to this threat. An alternative possibility today is to support doctors in their work in the mental field. This dawning insight causes some of our colleagues in physical medicine to invite a psychoanalytically knowledgeable group leader to collaborate in a Balint group.

The groups take their name from Michael Balint who was a leading figure in the post-Freudian psychoanalytical tradition. In 1951 he started the so-called research and training seminars at the Tavistock Clinic for British general practitioners. The criteria for a Balint group have remained basically the same ever since. A number of doctors from the somatic care sector, usually from six to ten, normally meet for one or two hours every other week.

The group has been seen as a meeting of two cultures of equal competence, the psychological and the somatic. This is a meeting of different experiences. The doctor is used to orientating among the data presented by the patient; what is, so to speak, spelt out, and from this factual information trying to find a causal context. The psychoanalyst, on the other hand, comes from meeting with patients who want to understand more of their own inner lives, their subconscious, underlying motivations and strivings. Unlike the somatic doctor, the psychoanalyst has received a mandate to try to force his way into the underlying causes and has established a habit of listening and of sensing what has not been said; what is between the lines. In treatment he or she seeks to bring this to consciousness and to create a meaningful context.

Balint in practice

The aim of the Balint group is to increase the doctor's capacity to "survive" the patient's need of him as a depository for his relocated feelings, successively to listen in on the patient's difficulties and to reflect on what the patient has set in motion without losing his somatic acuity.

In the practical work of the group a doctor presents a case which is then discussed within the group. The group is free to associate and to express insights, ideas and feelings. Often the cases deal with difficult and "incomprehensible" patients. The focus in discussion is on the patient-doctor relationship, above all the patient's need to direct her own inner drama in relation to the doctor. A basic idea is that one may reach the essence of the relationship problem if one takes one's point of departure in what the doctor is constantly feeling but, in spite of its constant attendance, never actually gets to grips with, the so-called transference and counter-transference, to use psychoanalytical terminology. In the Balint group one searches for foreign emotions that have been aroused in the doctor in the form of anger, disappointment, revenge, rejection, infatuation, or as with me and Astrid, guilty silence and a need for reassurance.

The mood has a tendency to parallel itself in the group. The group's sense of security and ability to concentrate is dependent on the extent to which these turbulent forces can be accepted, identified and verbalized. From the exchange of views the leader helps the group to formulate hypothetical problems in the patient-doctor relationship. Concrete advice and solutions are avoided, something which is often experienced as frustrating. But formulating problems is, in itself, a path to solving them and the doctor is now free to advance in accordance with his own personality and his wishes.

Giving words to the foreign sensations

What happens is that the doctor, via the discussion, has an opportunity to sort out the primitive moods and feelings that have taken root in him and to give words to the foreign sensations. The Balint group then acts as a repository for and a means of transforming the detrimental mental material that is transferred from the patient via the doctor and into the group. In this way a hypothetical narrative of the patient is created in the group which increasingly performs as a person in the context of meanings. The charged atmosphere created by the emotions, that has previously obscured the view, declines and clarity develops as this experimental understanding of the interaction of doctor and patient is revealed. One can now see the wood instead of all the trees.

When the doctor meets the patient again he discovers that his new understanding of the patient changes the relationship. Astrid's silent waiting did not seem as demanding as formerly. The doctor now sits with questions and queries about the person, not just the symptoms, that previously mostly gave rise to a feeling of repugnance.

I do not believe that it is overly fanciful to claim that this shift of position on the part of the doctor contributes to the patient feeling better. If the doctor is also able, from a more secure inner position, to give a name to something in the relationship that affects and is emotionally recognizable to them both, a "flash", this may make it possible for the patient to see some of her own difficulties. Astrid seemed to be longing for some words that might fill up an emptiness inside her. I remember that my own sense of being dull lessened when it could be spoken about. My

simple utterance, then, was that Astrid did not seem satisfied, as though she wanted me to say something more. And at the same instant that Astrid described herself as "dull", her dullness was transformed. Perhaps one might argue that Astrid's defect, before it was named and symbolized as "dullness" was a dullness, a defect. But that the words transformed her dullness into a conception of dullness which is not the same thing. By means of this symbolization, the patient's healing seems, in a specific manner, to be made possible by a similar healing process on the part of the doctor.

Even if these meetings lead to an emotional transformation at the time, there may be no noticeable or remarkable exterior changes in the patient. But very small changes of direction can, in due course, lead to a more evident deviation from a destructive and deadlocked path. The result may only be a somewhat less dissatisfied patient and a somewhat less dissatisfied doctor. But this can involve a decisive shift in the patient's mood which enables her, in future, to "choose" not to define herself as a patient. Astrid's need of me and of health care was reduced and her visits became less and less frequent. This silent work is often a rather laborious process of tiny, unremarkable steps; something that arouses little notice or recognition among those who allocate financial resources or who evaluate healthcare.

The reflective work of the Balint group can also help to lessen the risk of the doctor acting unsuitably. The somatizing attitude, the need for calming the patient with, for example, sedatives and soothing tests and the need to get rid of patients by referring them to other institutions all seem to decrease. And a doctor whose defects lessen runs less risk of getting singed.

Creating - not solving mental problems

In the above mentioned perspective the doctor's demanding psychological task is, in the first instance, to undertake a reformulation, to problematize and, in a manner of speaking, create psychological problems where these have been dressed in a bodily language. Astrid's pain partially transformed into a dullness that, simultaneously, lightened when it had been recognized and given a name. If the doctor succeeds he has carried out a fundamental psychotherapeutic task. But the aim is not that the doctor should develop into a therapist. Therapy requires greater knowledge and technical expertise. And such a task can conflict with the doctor's medical activities. Because a major difficulty for the doctor is that actual and "imagined" illnesses can be misleadingly similar. A missed mood can hide a malignancy. The doctor thus needs to be able to change between an empathetically present bearing and an objectively distanced attitude. Being too concerned with the subconscious and unexpressed message can reduce the doctor's essential attention to what the patient is actually saying.

The doctor's technical approach necessarily includes close bodily or "bodily invasive" contact. This is often not compatible with emotionally charged conversations pertaining to the relationship between the doctor and his patient such as take place in therapy. After such a conversation it is very difficult to ask the patient to undress and to listen to her heart. To undertake a gynaecological investigation or to palpate per rectum is close to an assault on the patient. So that even if the patient needs a therapist, it is more important for the patient to be able to retain her doctor and for the psychological problems to be dealt with in the flow of life, perhaps with a psychotherapist.

For the benefit of health care

It is the general experience of doctors taking part in Balint groups that their participation leads to them feeling better and functioning more successfully in their professional duties. A thorough study of the available literature produced by the Swedish National Board of Health and Welfare's (Socialstyrelsen) Council on Technology Assessment in Health Care (SBU 1999) showed that numerous reports suggest a similar assessment of the activities although the available material was considered too disparate to allow a definitive conclusion.

However, in a recently published report in The Journal of Swedish Medical Association, Dorte Kjeldmand, a general practitioner, presented preliminary results from a relatively exhaustive study that shows that the doctor's sense of wellbeing and mastery of the working situation increases when she or he takes part in a Balint group. The Balint doctor does not feel that her or his health is threatened to the same degree; there is increased awareness of one's own emotional state, professional work is to a better standard with an improved approach to psychosomatic patients. And the effects increase with the length of time that the doctor has participated in the Balint group. The doctors themselves speak in the report of a small but significant change in their professional personality. Of particular interest is the fact that "remittals or needless tests" are less frequently prescribed in order to conclude a consulation. Thus the evidence suggests that Balint activities also help to reduce costs.

In conclusion

In writing this article my intention has been to try to apply a psychoanalytical perspective to the somaticizing and relational process that characterizes the "difficult" patient. Using my own experience, illustrated by a specific case study, and with the help of psychoanalytical theory I have sought to describe how the troublesome patient's subconscious needs actually transfer her problems in concrete fashion to the doctor who then has to live with this strange and disagreeable sensation. For the patient this is a comprehensible defence strategy. But because it

leads to the patient being constantly present to the doctor, it results, together with many other professional conditions, with the doctor risking the exhaustion or burnout that has spread through the profession like an epidemic in recent years.

I have also sought to emphasize how the interlinking problems of doctor and patient can be dealt with in a Balint group. The doctor on the battlefield has difficulty in seeing clearly and has a primary need to act in order to liberate him or herself from the situation. But action often seems non-productive. By the presentation of the case that takes place in a Balint group, the problem can be moved along in a parallel process and can be recognized and given a name. The reflections of the group provide a lodging place for the troublesome matter and help to replace the actions that merely serve to maintain the doctor's and patient's mutual problem. Giving the problem a name, symbolizing it, becomes the healing process that will function as a patient's mental dyalisis machine in which the poison must be removed from her projectional needs.

By refering to the available, though limited, research in the field I have found support for the claim that doctors feel and function better professionally when they take part in a Balint group. The value of the method is, though, proven when there is a small change in the doctor himself, something that leads to scarcely noticeable but important shifts of direction in several patients. Available research would also seem to indicate that this is true over time. Participating in a Balint group thus acts as an antidote to burnout and thereby helps to preserve the patient's best instrument of treatment, the physician. For healthcare that is politically directed and financed it should be of interest that this investment in the doctor leads not only to good staff welfare but better patient care; and almost certainly at a lower cost.

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Thoughts on different intervals between Balint Group Meetings

by Michael Courtenay

The early Balint Seminars adopted a pattern of the groups meeting on a weekly basis. The decision seems to have flowed from the fact that most general practitioners took a free half-day during the week, so enabling them "to attend without serious interference with their practice," (introduction to *The Doctor, His Patient and the Illness*). Michael and Enid became involved with the work of the Family Planning Association, following many requests for help with psychosexual problems from doctors working in the birth-control clinics of the F.P.A. They suggested the formation of seminars to help them respond adequately to their patients' needs. At the same time Michael Balint relaxed his insistence that only psychoanalysts should lead groups, turning to doctors who had been members of the two groups who had recently been researching psychosexual problems under his direction. For reasons which were driven partly by financial considerations (the leaders were paid by the F.P.A. to travel as far as Exeter, which required staying the night before returning to London), they met once a fortnight. When group meetings are only a week apart, there is, perhaps, only just enough time to reflect on the work of one group session before the next one arrives, so that any matters arising can then be discussed by the group. Extending this to a fortnight did not seem to make much difference in my experience, though there was a rather nebulous feeling as a seminar leader that the urgency of the work was somehow diminished. This may have been partly due to the fact that these were psychosexual seminars, so that the area of concern in the work was less wide than observed in general practice.

Later, when Max Clyne was invited to Germany to foster Balint groups he found that it suited both the German doctors and himself to meet for a weekend at intervals of about six weeks. The precedent for a weekend meeting, during which the group met three or four times, was a memorable meeting of the group which led to the writing of *Six Minutes for the Patient*, arranged to take place in Aberdeen by Michael Balint at the invitation of Professor Colin McCance. Max's revolutionary initiative was taken up enthusiastically by the GPs in Germany and led to the formation of the German Balint Society.

Later, when Max Clyne was invited to Germany to foster Balint groups he found that it suited both the German doctors and himself to meet for a weekend at intervals of about six weeks. The precedent for a weekend meeting, during which the group met three or four times, was a memorable meeting of the group which led to the writing of *Six Minutes for the Patient*, arranged to take place in Aberdeen by Michael Balint at the invitation of Professor Colin McCance. Max's revolutionary initiative was taken up enthusiastically by the GPs in Germany and led to the formation of the German Balint Society.

When at a meeting in London of the Balint Society several members took the Society to task for not encouraging further research, it was decided to arrange the meeting of a putative research group at the Oxford meeting of that year (1992). Erica Jones and I were invited to lead the group of experienced Balint doctors, but as I was not able to attend the Oxford meeting, Erica led the first meeting on her own. In coming to making practical arrangements (two of us lived at a distance from London), it was decided to adopt the six meetings a year format, at roughly six week intervals. This group's work led to the book: *What are you feeling, Doctor?*

In the first 18 months of the life of the group the gap was partially filled by receiving the verbatim transcript of the previous meeting, though in the nature of the logistical problems involved in producing transcripts, this tended to arrive shortly before the next meeting. When the topic of research shifted from 'accidents' to 'doctors' defences' I have to confess that the issues raised by each group meeting were so engaging that they aroused thoughts and feelings which were impossible for me to contain for a period of six weeks! Breaking the traditional silence between meetings I began to write 'round-robins' – little working papers to do with ideas about what was happening in the doctor\patient interactions reported in the group setting – sent to every member of the group. The group were very tolerant of my departure from traditional procedure, and were shortly returning reactions on paper to the matters which I had raised. Better still, the ideas expressed were usually an advance on my initial thinking. I remember using the metaphor of trench-warfare to express the elements of defensiveness and adjustment of the distance in the doctor-patient relationship. The early replies included the notion that the interaction of an amoeba with its environment was a better concept. Soon the questions to be answered in the research passed to and fro between the group members, were crystallized at subsequent face-to-face meetings, and eventually became established in formal protocols. Traditional procedure is a dangerous touchstone. While it may act as a sheet anchor for our professional work on a day-to-day basis, it can also be a stumbling block to professional development. Tom Main has described Freud's development of the 50-minute hour as a purely practical device which allowed him to give much more time for a patient than was customary (he

had few patients at first, so that allowed him to expand his consultation time), and also to have ten minutes to write up his case notes before the next patient.

Recalling the experience of weekend seminar meetings, in which the group would meet four or five times (as in the prototype Aberdeen meeting mentioned already, and in the now firmly established annual meetings at Oxford), the momentum of the work seems to build up rapidly over the course of less than two days. Indeed, from time to time great leaps forward in understanding seem to occur. It is noteworthy that shortly before the Aberdeen meeting, Jack Norell (sadly, no longer amongst us) had produced the first case which gave rise to the concept of the 'flash'. This was then developed over the course of the weekend meeting. That group then returned to a pattern of weekly meetings, but in a group meeting only every six weeks or so, there is a danger that the ground gained may be lost. It is in this context that written communication within the group may fulfil a need.

I therefore consciously defend my initiative in starting the round-robin method of communication of ideas emanating from the group work. By this means the work of the research seminar, meeting at six-week intervals, was never allowed to falter. Of course being retired the leaders had much more time than our fellow group members, but being young and vigorous they seemed able to find the time to respond in fine style (if you want something done always ask a busy person).

So productive did our research method seem, that I think the Balint Society should encourage the formation of further research groups which meet at longer intervals but would also be able continue mutual discussion in the interval, perhaps at the present time by E-mail. After all, there is currently a substantial cadre of Balint doctors who have had experience of both research and leadership.

GP Registrar Balint groups: research in progress.

A personal view by Paul Sackin

Two years ago, the Balint Society Council invited a group of seasoned Balintians to explore whether it might be possible to evaluate the outcome of Balint work. We all 'know' it works, of course, but what does 'works' mean and how can you tell anyway? As we sat at our first meeting in Andrew Elder's house I felt overwhelmed by the task, uncertain how we might start to approach it, bewildered about how we could even start to create an answerable research question. Slowly, over three or four meetings, practical ideas began to form. We agreed to look at GP registrar groups, if only because these are about the only Balint groups around in the UK at the moment. We started looking at the literature and developing ideas for a research protocol that might form the basis of a pilot project. For this early work we were guided, helped and stimulated by Zoë Walker, a young researcher from Hertfordshire. Our project has had many highs and lows and no doubt will continue to do so but by far the saddest moment was on September 10th 2001 when Zoë died after a very short illness.

With Zoë's realistic and practical draft protocol drawn up we decided we were going places. At a meeting on February 1st 2001 we already smelled success. We obviously needed some funding to mount the project and no doubt that would be relatively easy to obtain as we should be just in time to help somebody out with their end of financial year underspend. 'Paul Sackin will co-ordinate the project, attempting to get the money in before the end of March, and lead the celebratory fandango', pronounced the minutes of that meeting.

Can you get more naïve than that? We obtained forms from the Scientific Foundation Board of the Royal College of General Practitioners and from the North Central (NOCTEN) and West London (WELREN) Research Networks. The detail required was breathtaking. Without Zoë's calm e-mails drafting many of the replies for me, I would have sunk. The College deadline was first but they were going to take more than three months to come to a decision. NOCTEN gave us the personal touch with some good advice from their research co-ordinator. I discovered an old acquaintance in her opposite number at WELREN only to find that she and all her administrative colleagues were resigning the next day. Our application to that body, submitted in March 2001, remains unacknowledged.

Thus research applications began to take over my life. NOCTEN's internal adviser reviewed our application and in his detailed critique he gave us many ideas for improving the project and strengthening our chances of success with funding. This meant virtually rewriting the whole application and e-mailing numerous drafts between us once more. It was quite a low point when the revised application was rejected for reasons that we could not wholly understand or agree with. Shortly afterwards, the College also rejected our application.

One of the most encouraging moments came after this. Although they had rejected our application, the response from the College was very supportive of the principles of our research. They invited us to meet members of the Scientific Foundation Board to help us redraft the project. As a result Oliver Samuel and I met with Paul Freeling and Bonnie Sibbald. Paul's knowledge and long experience of Balint work resulted him having a clearer vision of what we were aiming for than we did. Bonnie's sound and very specific advice, as well as her offers of further help with a revised application, allowed us to complete our next application knowing that it was likely to succeed. Of course, not everything was straightforward. Bonnie had been clear that we needed an experienced qualitative researcher to oversee the project as well as a research assistant to do the fieldwork. Finding such a person proved a challenge, especially as it was in summer holiday time. Hilarie Bateman, research adviser in Cambridge, proved to be the ideal contact. As well as coming up with the suggestion of Anne McKee for our adviser, she gave us a huge amount of help with our funding application.

Let's fast forward now to early 2002. We have been granted the award and been lucky enough, through the good offices of Heather Suckling, to be offered some further funding from the London Deanery. Anne McKee is in place giving us a wealth of advice and challenging all our assumptions (not easy, this, but stimulating). We have been fortunate to find a leading qualitative researcher in Ruth Pinder to help develop the project and do most of the fieldwork. What exactly are we going to do and why?

Our somewhat arrogant hypothesis as originally stated was that Balint groups in vocational training are more effective in increasing the doctor's understanding of the doctor-patient relationship and in developing interpersonal skills than non-Balint groups. Paul Freeling helped us to see that this might be better phrased as an enquiry as to *whether there were essential skills and insights gained in Balint groups that could not be acquired elsewhere*. If the answer were yes, then that would give vital evidence in support of continuing and developing the Balint approach in vocational training. If the answer were no, we could be encouraged that Balint's ideas had sufficiently permeated other groups (as many people claim) and not be too worried at the possible demise of 'true' Balint groups in vocational training.

The current project can only be by way of

a pilot, to try and develop the methodology to assess the work done by small groups in vocational training and the learning outcomes. The first stage was to send a questionnaire to all London course organisers (having decided to restrict the work at this stage to London as it is likely that most VTS Balint groups are there) inviting them to describe the type of small group (if any) that they ran on their VTS. Oliver Samuel devised this questionnaire with flurries of e-mail advice from the rest of us. It was interesting that when we sent the response rate sending the questionnaire by e-mail, the response rate was a miserable 30% but when we sent it by post the response rate for the 27 schemes eventually reached 100%. The replies enabled us to classify the groups into a) 'Balint' or b) 'managed', where there were clear aims and it seemed sensible to use them as comparator groups, or c) the rest.

During the summer term Heather Suckling, Oliver Samuel, John Salinsky and I have been visiting some groups to observe their case discussion sessions. Between us we are trying to visit four of the Balint groups and four 'managed' ones. We are firstly trying to assess their 'Balintness' by means of a checklist. Oliver Samuel devised this list from the characteristics of Balint groups discussed in this Journal in 1994[1]. Secondly, we have been trying to make some observations that help to characterise these groups, using some headings suggested by Anne McKee. The main purpose of these visits is to see what the reliability of the questionnaire responses is and whether, in the main study that we hope to do later, it will be sufficient to rely on the course organisers' assessments of the characteristics of their groups. In addition we hope to learn more about how these groups work and what aspects seem most useful for the registrars.

Ruth Pinder is carrying out the main part of the project. She is currently observing in depth the Balint groups led by Lenka Speight and Andrew Dicker at the Whittington Hospital. She is observing the group in action, interviewing the registrars about their experiences in it and discussing the working of the group with the leaders. She will work in a similar way with a non-Balint group. It has not been possible to arrange this in the summer term but she is hoping to observe the group at St George's Hospital in the autumn. It is proving a fascinating, though not always comfortable, experience to work with Ruth. She has a fundamentally different approach to looking at things than I, and I suspect most GPs. However open minded and 'qualitative' I think I am being, Ruth is there considering issues that I never thought of or took for granted and challenging my most basic assumptions. At the same time she is always looking to learn – from us and from anyone else we might suggest. Highly productive doctors-researcher (sic) relationships seem assured.

And what of the findings? If you have read thus far your curiosity must be burning. And so is ours. Keep taking the tablets and I hope that one day all will be revealed.

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Michael and Enid Balint: my experience of their contribution

A talk given to the Balint Society on 20 November 2001 by Dr. John Horder, past president of the Royal Society of General Practitioners

First I want to thank you for giving me another chance to think and read about Michael and Enid Balint and their work.

I joined a Balint group in 1951, almost exactly 50 years ago. It was the first of the many groups which Michael and Enid ran for GPs. The members were Drs Dorothy Arning, George Barasi, Norman Chisholm, Max Clyne, Arthur Hawes, Berthold Hermann, Philip Hopkins, Leon Hornung, Aaron Lask, Philip Saville, George Szabo, Jindrich Tintner and Annaliese Zweig.

I want, of course, to talk about that experience and this will form the first half of what I have to say. Then I would like to have an interval for discussion. In the second half I shall need your help in thinking about the present – particularly about the place of Balint ideas, training and research in a context which is no longer the same.

THE FIRST GROUP

To talk about the first group, I need to start by saying something about my own background up to that point and also a very little about Michael's background.

I had become a medical student under the influence of the Second World War. Before that I had read classics at university as I had done at school.

So I was in a category of people described by John Carey as: "one of a new species of educated, but benighted beings, with most of modern knowledge blotted out." I had planned the change to medicine before serving in the wartime army, with the ultimate intention of becoming a psychiatrist if I survived. Returning to Oxford as a medical student and already married, I undertook a Jungian analysis as part of my training. When it came to house appointments at the London Hospital, I chose them with psychiatry in mind, starting with neurology and ending as a medical registrar, while partly working in the psychiatric outpatient clinic for chronic patients. While waiting for another registrar job, I acted as a locum in the practice in which my wife was already an assistant. This was a revelation to me. It was the first time that I was completely sure that I had not made a big mistake in changing to medicine – a medicine which largely neglected mental and emotional suffering. I realised suddenly that this was the job I really wanted to do. I had become unsure about a psychiatric career after discouraging experience in the psychiatric clinic. Here in general practice there was plenty of psychiatry to be carried out in people's home settings. Anyway I felt reluctant to give up general medicine entirely, as I was struggling with the membership examination of the Royal College of Physicians. I also felt convinced that the role of general practitioner was an essential one in our society. My unusual initial preparation for it through the humanities seemed to be an advantage rather than the opposite. It had concentrated on people as individuals, on their differences rather the similarities, on their life-stories, relationships and ways of expressing themselves, on their relationships in smaller or larger groups.

This sudden second conversion had the force to motivate me through the rest of my career, but I have to say that it might not have been so, had not the College of General Practitioners started just at that time. I joined it immediately and have owed it a very large debt ever since. It has played for all of us a central role in providing something previously missing – an understanding of the role of the generalist within an increasingly specialised medical world – an understanding of the sort that could attract idealists and enthusiasts, link them together, inspire them to think for themselves and to take responsibility for their own discipline.

To a lesser but still important extent my experience in a Balint group also motivated me throughout the rest of my career. The two experiences were very different, but complementary to each other.

So I became a trainee in general practice, passed the membership examination of one College, joined another new one and joined a Balint group – all within my first year as a GP. I was then 32.

I need to have gone over this background because it is relevant to my reactions to Michael and to what he offered.

MICHAEL'S BACKGROUND

You must know as much about this as I do – perhaps more. I only want to raise one question – why was he, a psychoanalyst from Hungary, then aged 56, interested in general practitioners in this country.

His father was a general practitioner in Budapest, but a man with a violent temper with whom Michael had a stormy relationship. He never attributed his interest to this beginning. It is clear this his collaboration with Enid from 1947 in the Family Discussion Bureau for training social workers was directly relevant. In this initiative of Enid's he was actually working as her assistant and psychiatric advisor. But in describing this work, he refers also to work that he had done much earlier in Hungary in the supervision of psychoanalysts and to an article he wrote in 1926 about psychological training for general practitioners. Particularly interesting is a

quotation from his teacher, Sandor Ferenczi, in a book about psychoanalysis written with Otto Rank in 1924. This may have influenced him:

"We have to wait until psychoanalytic knowledge, that is to say knowledge about human beings, becomes the nodal point at the center of all medical knowledge and unifies this discipline fragmented by specialisation. The old family doctor, friend and counsellor of the family, would regain his important role, but in a much more profound way. He would be the comprehensive observer and have intimate knowledge of whole personalities. He could influence in an appropriate way the development of the child and the man – from birth, through education and the difficulties of development at puberty, to choice of profession, marriage, to emotional conflicts slight or serious, to physical and mental illnesses. So his role as counsellor would not be limited only to the physical, but could take in psychological aspects, which are almost more important, together with the mutual interaction between body and mind.

In addition to the family, this doctor of the whole person would naturally influence the condition and habits of society in a way hitherto unimagined and so could have an indirect influence on the improvement of education and in this way contribute to the prevention of the neuroses. The bringing together in the person of the doctor of knowledge which at present seems so heterogeneous would perhaps also contribute to the unification of the sciences more generally. Hitherto they have been separated too strictly into the sciences of nature and the sciences of the mind."

Sandor Ferenczi, O.Rank. *Perspectives de la psychanalyse.* Paris, Paylot 1924.

This seems to me a very exciting dream, but hopelessly ambitious in the burden of responsibility which it would load on one man or woman. I have to say though that there was a time when I nursed ideas which were not very far removed from these.

MY EXPERIENCE IN THE GROUP

My aim in applying to join the group was to learn more psychiatry for use in my new situation. I found myself in a group of 12 general practitioners, plus Michael and Enid and a typist. The weekly session would start by Michael asking: "Who has a case?" This seemed to imply: "a case that is bothering you." So one of us would jump in and describe a current patient and the nature of the difficulty, which might vary widely across the whole clinical range, but increasingly tended to include an element of difficulty in dealing with another person. Michael strictly forbade any reference to case notes, so we had to rely on memory. This allowed more free associations within what we said.

It became clear to me fairly quickly that another course in psychiatry was not being offered. For example, all forms of psychosis were excluded from discussion, as being alien, mysterious, to be mentioned only in hushed tones. Physical approaches to treatment, especially electro-convulsive therapy, were actively condemned. Sedatives were reluctantly accepted. There were, of course, no antidepressant drugs in 1951. More importantly, the central focus, as I gradually realised, was on the relationship between patient and doctor, especially on the doctor. This was new for me – indeed no such direct, sustained and critical concern with the doctor's own behaviour, reactions, habits, beliefs, values – and weaknesses – had featured in my medical education. Case discussion in a small group, combined with what would now be called problem-based learning, was also new to me and sometimes rather frightening, as both would probably have been to most of my contemporaries, accustomed as we were to passive learning in lectures or ward rounds, with their temptation for authoritarian teaching.

Given this unexpected exposure, I needed support, but this seldom came from Michael. He seemed at that stage to behave like an analyst, keeping silent on principle. Meanwhile I felt ill at ease with some of my colleagues in the group. The others had been together for several months already and they had all had years of experience in general practice. Any support came only from Enid, who attended all the meetings of this group alongside Michael.

Another problem for me had to do with orthodoxy and respectability. Within the army and the two medical schools I had attended, there was minimal respect for psychiatrists, and even less for psychotherapists or psychoanalysts. There was also little respect for GPs, particularly at the London Hospital, in the East End, with one or two local exceptions. When I was a student there, I did once see one GP who was visiting one of his patients in a ward. That was all. So, despite my unusual start and new choice of career, I was still infected with teaching hospital snobbery and the prejudices common in MRCP candidates at that time. Michael undoubtedly liked to throw squibs at that culture. My loyalties were divided.

All these influences made me a marginal member of the group, despite regular attendance for two years.

I did not help myself by the choice of patients I presented for discussion. Here is one example. The patient was an educated woman of about 30 whose symptoms had started several years before. It did not take many interviews before she revealed, with difficulty, that her brother had been killed in the RAF, the day after returning from leave. She had been deeply attached to him and, on the previous day, she had had intercourse with him. This was, of course, a problem beyond my competence, as must have become apparent in the group discussions. It involved me in a number of long consultations and there were signs that she was falling in love with me. The situation was complicated by the fact that she was the matron of a small home for disturbed children, supported by a highly

respectable military charity. But I was the medical officer. Before long and after several discussions in the group, I did manage to untie the knot by referring her for therapy privately. An excellent medical psychotherapist took her on and she flourished, making herself a career as a writer of stories for children, but never marrying. It was a narrow escape for me.

So far I have presented a negative view of my experience in the group. But this is not the whole story.

I was immediately grateful to Michael and Enid for the fact that they valued the role of the generalist at a time when few other medical people seemed to do so. Indeed there were influential people in this country in the fifties who said that they could see no future for general practice because of the impact of specialisation. That view was reinforced by what was actually happening to general practice in comparable countries like Sweden, Finland and the United States. I was already myself an evangelist for general practice and I welcomed these allies.

I came to see the point of examining the doctor's behaviour, however painful the experience might be. I gradually learned to stand back from emotional involvement with patients, so that I could recognise some recurring patterns. I learnt to recognise patients who were flattering me or making me feel angry, so that I could deal with my own reactions as the urgent initial problem, even before whatever problem the patient presented. Perhaps this was the nearest I came to Michael's intention of securing a "limited change of personality" in those who undertook this training – a claim which always made me feel uneasy.

Burning my fingers with patients who were too difficult, too intrusive or took up too much time, I did become slightly more cautious, although not enough to avoid all subsequent problems of that sort.

I came to realise that Michael withheld support because he expected us to take more responsibility ourselves. He was not prepared to be a daddy or to take on our burdens. I later valued this, along with two of his many memorable phrases: "the dilution of responsibility" and "the collusion of anonymity." These two phrases usually implied passing the buck to a consultant or to one consultant after another, only to have the patient returned in a more complicated state, with their problems unresolved. But perhaps those two phrases themselves colluded too much with my own mission for empowering general practice, by encouraging me to take on responsibilities which would have been better passed or shared. I think I had a more ambitious idea of the GP's "apostolic function" than many of my colleagues had.

Of all the short, pithy phrases for which Michael had such a gift, I still think that the most fundamental and the most valuable was and is "if you ask questions, you will always get answers, but hardly anything else." Other people had said something like this before him, but as a student I was only taught to ask questions. Since then even more people have underlined the importance of listening and all medical schools now give time to learning about communication with patients. But it is easier and seems quicker to ask questions. It is very sad that hurry remains a feature of general practice consultations, as it has been since the Health Service started. It makes it very difficult to listen enough.

All this was in the 1950s and I have been talking mainly about my own reactions to the influence of the Balints. What was the general reaction among GPs? I think that most would have regarded this activity as eccentric, if they had heard of it at all. Michael was not once to seek favour. He preferred to challenge. Senior members of the Royal College of GPs were cautious or critical in their attitude, although Michael was asked to speak at one of the earliest annual symposia. The college still needed to worry about the status and respectability of general practice in the eyes of the rest of the profession. It was particularly concerned with continuing education, morbidity outside hospital and with the classification of diseases seen by general practitioners. In the field of general practice psychiatry there were other contributors, for instance Dr Arthur Watts, a GP in a small town in Leicestershire, whose important work on the early recognition of depressive illnesses was done just before the earliest antidepressive drugs became available. The Maudsley Institute of Psychiatry, particularly Michael Shepherd who consistently advocated the role of GPs in the psychiatric services, was critical. But by 1968 the Royal Commission on Medical Education had given unequivocal support to the need to provide a proper postgraduate preparation for future general practitioners and the College Council invited six younger members to propose the overall content of this training. Three of them had been members of a Balint group. The resulting book: *The Future General Practitioner: Learning and Teaching* aimed to shift the balance between the physical and the psychosocial aspects of general practice in favour of the latter. It was first disowned by the College Council, only to become a standard textbook for the MRCGP examination during the following year and afterwards.

After that it was not long before the College presented Michael with its Foundation Council Award and it later fell to me, when I was president to offer the College's Honorary Fellowship to Enid. This was, of course, after Michael's death. I had not had much contact with him in his last years, but I am very glad that I saw much of Enid in the twenty years before she died.

THE PRESENT

I want now to jump to the present, and to ask what need for Balint ideas now, what need for the sort of observational, descriptive research that was undertaken in the groups and what need for more training groups?

I'm going to start to answer these questions by reminding you of what Michael said about his aims in his first book and recalling that Enid said in her last book that they had changed little.

About research:

"The chief research aim is to describe certain processes in the doctor/patient relationship which cause both the patient and his doctor unnecessary suffering, irritation and fruitless effort ... and to help the doctor to recognise them in good time ... The aim is also to indicate when therapy might be applied, but only to a limited extent."

About training:

"At first the aim was a very modest one, amounting only to the awakening of awareness of psychological factors."

"The aim should be to help the practitioner to acquire a new skill ... of becoming aware of what the patient wants to convey to him, not so much by his words as by the whole of his behaviour ... And how his own behaviour and actual responses influence what the patient can actually tell him."

"Events which influence profoundly one's attitude to life in general and still more so to falling or being ill ... are governed by almost automatic patterns, originating mainly in childhood, but influenced by emotional experience in later life. Our first task is to awaken in doctors an awareness of these automatic patterns and then to enable them to study how these influence the patient's attitude towards his own illness, how they colour or even determine his relations to any human being, and especially to his doctor ... and then to help the doctor, whose responses are also partly governed by automatic patterns, to become aware of them and gradually to acquire at least a modicum of freedom from them and to have a wider range of responses.

"To use group methods to achieve to a certain extent the necessary changes in personal attitudes ... The skill is tantamount to discovering some hard and not very pleasant facts about one's own limitations."

I scarcely need to say that the context has changed since 1951, in a number of ways. Some of the relevant ones are:

- raised public expectations and criticism of medicine.
- greater acceptance of psychological influences by both public and professions.
- great increase in technical knowledge and capability of GPs.
- specific training of GPs, including some Balint ideas.
- larger group practices and multiprofessional teams.
- man/woman-power shortages in health professions and increased hurry and stress.
- increased demand for evidence of effective results.

Against this sort of background, it seems to me that the sort of observational, descriptive research done by Balint groups is still needed, not only because it is inseparable from the training, but also because it illuminates what has variously been called the other half of medicine, the interpersonal half, bio-psychosocial medicine or patient-centred medicine. This aspect has had to struggle throughout the last 50 years against the pressure of technical developments based on the physical sciences and mediated through specialisation.

But earlier I said that I could not judge whether I was better at my job because of having been in a Balint group. Were the Balints' declared aims achieved in my case? Were they achieved for any of us? How can we judge that? These are evaluative questions about the effectiveness of the training, and they seem ultimately to be questions about whether our patients benefited. Clearly we entered our groups with this hope in mind. But has there been or could there be the sort of research which might demonstrate that this was not just hope but a real outcome.

I am aware of two important efforts to evaluate the effect of Balint training on the practice of group members and on their patients – the work described by Enid, originally in 1966 in the Journal of the College and later in her book: *Before I was I*. The second effort is in the book: Six Minutes for the Patient, which looked at a series of consecutive GP consultations. In this book the question of the effectiveness was examined by an external evaluator, who applied strict criteria which could satisfy critical readers. He was not able to say that the work described in the book fulfilled such criteria.

This does not surprise me. I have met the same difficulty about evidence of effectiveness in a different context – one which has occupied most of my time in the past 17 years – shared or interprofessional learning for health professionals of different sorts. This is based on the belief of hypothesis that those who learn together are more likely to work better together. In this context too it has proved difficult even to provide evidence that this belief is either correct or incorrect, even though there have been hundreds of studies. Moreover no one has ever been successful in making the double link between shared learning, better collaboration and resulting gains for patients. But if one looks more widely, it is apparent that it is always difficult, although not always impossible, to prove that any particular educational intervention with doctors benefits the health of their patients.

So this is a very demanding, complex field for research. But some of Michael's stated aims were modest, as he said himself. I can imagine that it would not be too difficult to study whether some of these aims are achieved by using before-and – after questionnaires and interviews – for instance for the first aim: "the awakening in GPs of the awareness of psychological factors."

In regard to the question which still seems to be the most important one – does Balint

training of GPs benefit patients? – I wonder whether John Howie's work of the last 20 years could help to a limited extent as a pattern. To put his findings very crudely, he used as a criterion of a doctor's or a practice's quality the principle of enablement, represented by these six questions:

"As a result of your visit to the doctor today, do you feel you are:

able to cope with life?
able to understand your illness?
able to cope with your illness?
able to keep yourself healthy?
confident about your health?
able to help yourself? (Much better/ better/same or less?)

As a result of a number of large and careful surveys, he was able to show that the two most important characteristics of a doctor or practice for enabling patients were, first, the average length of the consultation, and second, the degree of personal continuity maintained between one doctor and one patient.

I think that most of us would agree that what he meant by "enablement of patients" is important and valuable, even if it does not go as far as showing that their health improves as a result. However our own context is about a form of training. Consultation length and personal continuity are as much matters of organisation as of training.

I cannot take this any further. It does seem worth mentioning this important work, in case anyone has the courage, the persistence and the resources to study the effect of Balint training on the patients of group members.

I am not going to pursue the other question in any detail – what need is there for Balint training today? I have virtually answered it by saying that it illuminates the other half of medicine and that this interpersonal half is continually under threat from the technical half. I am seriously worried about the extent to which group practice, particularly in large groups, has diluted personal continuity. Only one-third of group practices in this country make a major effort to ensure that patients see their usual doctor. We now know from Howie's work that continuity is better in smaller practices and that it is related to quality in other ways. Continuity has always been regarded as a major feature of personal care and as a necessary feature of generalist medicine.

I am equally worried about the mean length of consultations. This has always been a problem since the Health Service started. We compare badly with other countries. The average length has gone up, but so has the number of technical tasks which need to occupy the time. It is no easier to give time to listening now than it was 50 years ago.

Of course it is usual for old men to complain about change. Nevertheless I am convinced that what we are talking about this evening has an important relationship to the fact that both the public and the professions are complaining more at a time when so much more can be done to promote health and to limit illness than 50 years ago.

Snakes and ladders, another look at the body mind problem

A Talk given by the Balint Society on 18th November 2001
by Dr Jeffrey Roberts, Member of the Institute of Group-Analysis

Quote: Overheard in a prison: "They are all snakes."
"The inmates you mean?"
"No, the officers!"

There is an ancient Chinese curse "May you live in interesting times". We are currently (18/11/01) experiencing extraordinarily interesting times. However, besides the implied meaning of the curse we can now for the first time in the history of mankind make scientifically valid statements on the anatomical and physiological bases of consciousness.

Investigations allowing imaging of cerebral activity are showing pictures of neural connexity in action. Science is closer now to understanding the relationship of mind and brain than would have ever have been thought possible only a few years ago.

This paper presents practical clinical material, some old and new knowledge and attempts to follow in the footsteps of Freud (1950/1895) in correlating neurophysiology and events in the psyche. It is likely that conscousness depends on iterative events in pathways which include the frontal lobes. These iterative events are likely to lead to activatation of "large neuronal assemblies" (Greenfield, 2000) which when thresholds are exceeded, achieve something closer and closer to consciousness. It is also probable that there is a long ladder to be climbed by those who aspire to consciousness and that the ladder is rooted in a snake pit. **Table 1** demonstrates the range of possible psychosomatic ineractions. This is not comprehensive but rather surprising in its quantity. Today I will focus on **alexithymia.**

My inspiration for this paper was a visit to the Henderson Hospital (Belmont, Surrey) where psychosomatic disorder was discussed in a multi-disciplinary seminar. The practice of the Henderson Hospital (Rapoport, 1960) is based on developing a sense of community in people who are almost always demonstrably alienated from "community". Membership of the "Henderson Community" is entirely conditional on abiding by the core rules of the organisation. These proscribe interpersonal violence, self harm and damaging the building or its content. There is also an obligation and right to fully participate in all aspects of therapy and life in the community. In short, impulsive antisocial behaviour is forbidden. Compliance with the rules often leads to complaints of a range of somatic symptoms and disorders. This is a fascinating reciprocal of a phenomenon I observed when conducting groups for psychosomatically ill patients (Roberts, 1977). Intermittent unexpected impulsive behaviour, with no obvious personally owned emotional psychological content, occurred in these otherwise very well behaved people.

Alexithymia

In both Henderson clients (the majority of whom have some variation of psychopathic disorder) and patients with psychosomatic disorder it may be hypothesised that when powerful affect is present it is generally expressed in dysfunctional and usually destructive ways. The psychopathic client emits destructive behaviour in lieu of "feeling bad". The psychosomatic patient "feels bad" and may develop physical symptoms or illness in lieu of "behaving badly". In both patient/client groups it is clinically observable that there is a significant deficit, global or in specific sensitive areas, when an individual is challenged to put his or her feelings into words. Such a disability has been termed "alexithymia".

The concept of "alexithymia" was first articulated by Nemiah and Sifneos (1970) and means: *"inability to put feelings into words."* The French equivalent is "pensée opératoire", (operational or machine like thinking). In this form the concept was fashioned by French physicians, namely Marty and de M'Uzan (1963). It has been observed but never conclusively proved, despite the original discoveries being made as long ago as the late 1950s, that alexithymia tends to be associated with physical illness (with "cellular pathology"), in which there is evidence for psychological factors contributing to onset, duration and severity of condition. Such discorders include the so called "classical" psychosomatic disorders namely: essential hypertension, ulcerative colitis, peptic ulcer, thyrotoxicosis, rheumatoid arthritis, asthma and eczema.

To confine alexithymia to this narrow concept of psychosomatic interaction restricts its usefulnes and probably has blocked a proper understanding of the process of becoming chronically ill as a result of this kind of psychosomatic interaction. Moreover further studies of this kind of disability may open up the current troublingly incomplete understanding of psychopathy. It seems that beyond describing the psychopath and suggesting his frontal lobes are in some way defective there is no coherent theory of the underlying disorder. Unsurprisingly this has led to therapeutic nihilism in this group of people who are not infrequent visitors to courts of law and residents of Her Majesty's Prisons. New

erosions of human rights (Government White Paper, 2000) are currently being proposed as a solution to the problem of the dangerous and unpredictable behaviour of some of the most severly disordered psychopathic personalities.

Clinical Examples

In the following series of anecdotes and several short case studies I will discuss the mechanisms at work in these cases and how they articulate with current knowledge of the psyche and its somatic matrix.

My interest in liaison psychiatry and psychosomatics beings in the North of England during a first job as house physician. A 35 year old man was admitted and sadly died during a first episode of fulminating ulcerative colitis, following total colectomy. The colitis began within weeks of his marriage. No attention was paid to the state of his psyche or the state of his relationship!

On a happier note, when later working as a psychiatrist at Kings College Hospital, I was aksed to see a man awaiting surgery for a longstanding and severe peptic ulcer. He talked about his entrapment in an enraging situation with his landlord. Within two days the ulcer disappeared. He left hospital and embarked on training to become a butcher!

During psychiatric training at King's College Hospital I attended seminars on psychosomatic medicine with Dr Murray Jackson. He is a fine teacher, and a master of the intensive case study. He also had the ability to conduct a searching exploration of his patient's psyche in front of a small audience.

He told a young patient who throughout his teenage and young adult years had a scarcely controllable inclination toward violent outburts. Around his mid 20s this behaviour stopped. Almost immediately he developed ulcerative colitis.

The following are the true stories of heavily disguised interesting characters, each of whom has at least a partial alexithymia.

1. **Angus:** the urbane Glaswegian industrialist.
2. **Gerry:** an oil tanker captin from New York.
3. **Margaret:** an attractive and articulate part-time consultant and sportswoman.

In addition there are some short notes on a fictitious exemplary Psychopath.

Case Histories

1. **ANGUS** is an urbane and charming Glaswegian business man. He had been a charming little boy who lived in a home with mother and grandmother. They competed for his love and he shuttled between the two and was never (or at least rarely) out of favour with both. He came, not from a rich family, but is the only person I know of who by the age of 11 personally owned a large O Gauge steam railway in his garden.

He hoped to train in medicine but failed to reach the academic requirements. He studied at university and from small beginning has become an engineer and managing director of a large company. He has a failed marriage and a history of severe ulcerative colitis, which had been treated by a total colectomy before I met him.

By this time he had settled into a life of two-timing relationships. This had resulted in his living with a social worker whom he did not care for, having lost a relationship with a woman he claimed to treasure. On finally realising he had lost the treasured relationship, he viciously attacked his wrist with a razor. It was in fact soon after the hospitalisation which followed this that I met him. He has now been in a therapy group of mine for some years wherein significant progress has been made. He is now happily remarried and no longer has compulsive second relationships. Along the way there was an occasion when he felt mad with jealousy. On this occasion he impulsively removed half his moustache with a razor.

Finally it is illuminating to consider the place of confrontation and explosive feelings in this man's life:

a. His condition produced explosive diarrhoea.
b. He could never face situations in which anger might erupt.
c. In his profession he manufactured explosive items for military use.

2. **MARGARET** is a tall, attractive and apparently articulate woman, who seems confident and competent.

She however, subject to a multiplicity of stresses in a demanding job succumbed to a severe depression at the end of a relationship. Only after extended psychotherapy has she adequately been able to articulate her feelings about the slow dying of her ambivalently loved Olympic athlete father from a series of small strokes. She is also aware of scaring boyfriends with an underlying and initially inapparent dependency. She had limited success with men and believes that polycystic ovaries may compromise her fertility.

She came from a sporting family in which richness of emotionally informed verbal communication was not particularly valued. An interesting feature of her depression was the fact that her quite serious suicidal ideation was expressed through obsessional thoughts. These manifested as a fear of knives and windows. She continues to harbour unconsummated rage for the almost totally alexithymic accountant who ended a relationship with her in a cowardly way because he was unable to tolerate her behaviour and her overtly expressed feelings of vulnerability. She has a talent for caring for her fast deteriorating father in a way which relates to his former self rather than the pathetic invalid he has now become.

She probably has serial wishes that he would die however for he has terrorised his carers at home! Indeed not very long ago she told of a

vivid dream in which she took the role of a famous serial killer. She also, a few weeks later, announced, unsolicited, that she is learning new ways of self expression in the group.

3. **GERRY** is from New York. He is a maritime legal consultant who had been a successful trainee of a large oil company with a masters certificate earned in their fleet of oil tankers. When aged ten he suffered torsion of the bowel. He was also found in his youth to have one of the disorders of blood clotting. This made his tonsillectomy life threatening. As a sailor he contracted a chronic ameobic dysentery, only diagnosed and treated 3-4 years ago. Lifelong he has had bowel problems. These are diagnosed as "irritable bowel syndrome". He is convinced he has an allergy, probably to dairy products. No confirmed allergy has emerged and tests for coeliac disease were negative.

He continued in irregular individual psychotherapy when his somewhat nomadic lifestyle permitted. Latterly he had been less troubled by his bowel disorder until suddenly he experienced a very bad week of pain and diarrhoea. He was sure that this had been caused by eating a pie made by his sister (chicken in some kind of sauce). In a very clever way a veil was drawn over what he actually did eat, making it almost impossible to even think about allergenic candidates. However, he also has considerable financial problems and is, as he said, not at all envious of his brother in law's considerable wealth.

As a child he was regularly humiliated and told he would never amount to anything by an autocratic lawyer father. His worst times are when he faces defeat at the hands of a male authority figure. His ability to understand his emotional life, except in a simplistic search for wealth and an ideal woman, is surprisingly limited. He has also made little use of such insights he may have gained in group-analysis and individual therapy.

4. **INDEX PSYCHOPATH (Indy)** At the top end of Hare's psychopathy checklist (Hare, 1991 & 1998) there is a daunting character ruled entirely by impulse. He is the kind of man whom it was said in the army, he's fine, provided you point him at the enemy.

Indy has no problem at all in responding rapidly without thought or delay to every opportunity, challenge or hurdle which falls in his path. Indy has no time for plans or strategy. Glib and persausive he may be, but on a careful examination he will show alexithymia and there may be some doubt as to whether he would pass a "Turing Test" (Turing, 1950). It is very likely that a significant amount of impulsive psychopathic behaviour lies outside of conscious control. In many cases of murder, rape and paedophilic crime automatism may be common. A "Not Guilty" plea may be authentic, and what is presumed to be the denial of the memory of a conscious act is a true statement about a genuine absence of "mens rea".[1]

The hypothesis of "alexithymia" being linked to impulsive behaviour is often rebutted by invoking the articulate charming and attractive psychopath who can talk his way into and out of almost anything. However closer examination reveals in my opinion a pseudoarticulacy with little if any link between verbal output and affect and behaviour. The plausible and attractive self presentation is pure window dressing for a "snake pit".

The Neurological Basis of Alexithymia

The human brain should probably be regarded more as a complex of wires and junctions than a bath of chemicals. The human brain is among other things an extremely complex decision making machine. It has also been called the "Matrix of the Mind" (Wood Jones & Porteus, 1929). The neuroanatomist Maclean (1990) calls the human brain "a triune brain!" and regards it as having three types of animal brain effectively nesting one inside the other. These are respectively repilian, apelike and human.

In the study of human development and behaviour the frontal lobes have had a chequered history and until recently have been the subjects of despairing statements like "silent area" or the "organ of delay". More recent investigation leads to an increasing attribution of some of the very highest mental functions to these areas of grey matter. In an article published in Archives of General Psychiatry Raine et al (2000) using structural magnetic resonance imaging demonstrated reduced prefrontal grey matter volume in subjects with antisocial personality disorder. There are also a number of papers which identify deficits of frontal lobe functioning in individuals with antisocial personality disorder (Lapierre, Braun & Hodgins, 1995, Deckel, Hesselbrock & Bauer, 1996, Kuruoglu et al., 1996). There are confirmatory pieces of research which identify the frontal lobes as having important discriminatory and decision making functions (Coolidge & Griego, 1995k, Godefroy et al. 1999, Masterman & Cummings, 1997) as well as being implicated in awareness levels of sensorimotor processing (Stephen et al. 1999, Nishitani, Avikainen & Hari, 1999).

The delay which happens prior to an impulsive act is clearly very important and is incorporated in folk psychology in an instruction to "count up to ten" before doing something rash. It is simplistic but probably correct to suggest that the frontal lobes are the part of the brain through which an impulse to behave is directed in the interest of processing and developing an alternative strategy. Highly developed frontal lobes are absent in apes and they may be the seat of the civilising process.

Hughlings Jakcson (1884/1958) taught that the development of the brain brought a kind of anatomical and functional ladder with each rung modifying and refining the one below. As

with Margaret's father, if you lose the higher rungs your behaviour beomces increasingly unrefined. It is a reasonable hypothesis that my three actual patients and one fictional are on different rugs of a maturational and neurophysiological ladder which represents a climb towards **articulate conscioiusness**. The following are plausible if considerably oversimplified suggestions as to the mechanisims involved in managing an impulse to "behave" in these subjects.

1. **Index Psychopath:** The primary source of aggressive, dangerous and unrefined behaviour in the face of complex stimulous is likely to be the basal ganglia.

2. **Angus:** In Angus it seems that the majority of the "impulse to behave" is diverted to "somatic expression' rather than taking a longer journey to and through the frontal lobes. However, it is also possible to identify episodes of an "escape phenomenon" under certain conditions in which he struggles and fails to think about life events, ultimately producing destructive impulsive behaviour. This, as therapy progresses, becomes more symbolic (removing half his moustache) than actually self destructive.

3. **Gerry:** Gerry inclines towards symbolisation through complex and less impulsive behaviour. He has also manifested severe depressive reactions to losses without awareness of the significance to him of the precipitating life events.

4. **Margaret:** She is successful in using the frontal lobes as an organ of delay. She does not achieve transcendence however. Margaret is very obsessional. Her thoughts burn tracks in her mind like perpetually circulating electric hares and greyhounds on a race track. Thus as with fully developed Obsessional Compulsive Disorder the "impulse to behave" is perpetually delayed in the frontal lobes and never reaches consciousness in a form of thought which is capable of progressing to resolution.

Hughlings Jackson's ladder has a top and bottom with many rungs in between. At the bottom lies impulsive behaviour and primitive unconsidered response. At the top of the ladder is articulate consciousness which enables refined understanding of environmental challenge. The result of this is a "thought through" response which includes a well worked out series of self consistent hypotheses as to why one has been challenged by the challenging situation. This, given a fair wind, is followed by the selection from a range of motor or verbal responses, the action or intervention which is genuinely proportionate and likely to generate a creative outcome. The individual and collective responses that have been observed arising out of the "Twin Towers" atrocity (11/9/2001) gives an excellent example of the "variations and vicissitudes' of this process. This has been visible in a multiplicity of newspaper reports and articles plus television and radio broadcasts. On the one hand there has been an inclination to panic with the unleashing of destructive behaviour at all levels and in many places. At the same time there has been a counter movement of promoting considered and proportionate response guided and enforced by international law. Unfortunately the result of impulse is delivered more rapidly than the outcome of thought.

Cognition and behaviour are areas in which psychologists have researched in some depth. Cognitive Behaviour Therapy (CBT), bridging the ladder with a neat phrase and acronym, has been developed from this research. Clinical psychology holds both the top and bottom of the ladder. This does not mean however that the intervening territory is won.

Psychiatry has taken responsibility for the management of some of the consequences of maladaptive response to complex sensory input and its implications. Indeed when the body appears to suffer, physicians and surgeons are also frequently summoned.

Most important of all, this substantial intervening territory, which includes a vast complex of unconscious mentation, is surely the natural territory of psychoanalysis. Indeed it is becoming increasingly clear that "the psychotherapies" in one form or another enable and facilitate a struggle for articulacy in those whose genotype, family environment and impoverished education left them with alexithymia and equipment sufficient only to bring regular dysfunctional response to environmental challenge.

Cognitive Behaviour (an uncomforable and intellectually unjustified marriage) Therapy, whilst being an important form of psychotherapy, misses all of the rungs of the ladder lying between training for desirable behaviour and cognitive problem solving. In the author's opinion, cognitive therapy is a scientifically validated often successful but rather bald basis for therapy. This of course acknowledged in the more recent development of Cognitive Analytic Therapy.

It is clear that much therapy lies in the region between cognition and behaviour. The distance between the top and bottom of the ladder is bridged in childhood with firm and educative parenting. It continues as a civilising process in good schools and is the constant work of groups and communities. It is also the territory of psychoanalysis and the expressive therapies. I am a Group-Analyst and would wish to draw attention to a Foulkesian "motif" concerning the overall group-analytic process, i.e. "ever more articulate". However the cognitive behavioural abyss can also be bridged with surprising rapidity through a good conversation in which there is trust and a recognition by the listener of what the alexithymic person does not understand about his/her currently threatening or dangerous life situation. Michael Balint had in this author's opinion a peculiar talent for making and teaching this kind of intervention.

TABLE 1

A. Psychosomatic interactions. (psychological process affects soma)

1. Cellular pathology = classical psychosomatic.
2. Somatic manifestations of anxiety.

B. Somatopsychic Interaction (Somatic state or events happening to body affect psyche)

1. Psychological responses to acute and chronic illness.
2. Psychological responses to traumatic events.
3. Psychological consequences of substance use and abuse.
4. Psychological responses to sleep deprivation.
5. Deliria and dementias.

C. Psychogenic Disorders

In the complete absence of cellular pathology and in the presence of normal blood chemistry there are a wide range of somatic symptoms which are generated it would seem entirely by psychological processes.

1. Psychogenic pain.
2. Various complaints of paralysis, disorders of sensation, clarity of consciousness and balance.
3. Debility and tiredness. i.e. ME
4. In their early stages: eating disorders.
5. A range of memory abnormalities and complaints.

TABLE 2

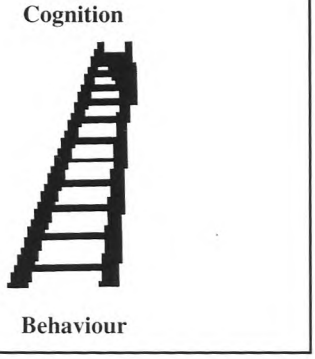
1. 10 thousand million neurones.
2. 1 million billion synapses
3. Number of possible patterns of connection

   =10 + 1 million 0s
4. Number of particles in known Universe

   (give or take a few) 10 + 79 0s

These figures from Gerald Edelman (1999) Professor of Neurobiology, Scripps Insititute California.

Figure 1



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[1] In order to convict for the majority of crimes both "actus reus" (guilty act) and "mens rea" (guilty mind) are required.

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Doctors on the Edge

edited extracts from a talk to the Balint Society on 19th March, 2002.

By Dr Linden West, Canterbury Christ Church University College

Thanks for the invitation to talk to the Society, which is a great honour. I am aware, as a psychotherapist, of the importance of Michael Balint's life and work. I greatly enjoyed reading Philip Hopkins' account of Balint's life (Hopkins, 1998), especially how he faced and learned from many difficult, often traumatic experiences. He was injured in the First World War; suffered under the anti-semitism of post-war Hungary, and lived through times of frightening degrees of change and instability. He left Hungary in 1938 and his first wife, Alice, collapsed and died shortly after their arrival in Manchester. His parents committed suicide, taking lethal injections of morphine, to avoid being arrested by the Hungarian Nazis early in 1945. In the last few years of his life, Balint suffered from diabetes and glaucoma, which greatly impaired his vision. There are more than enough 'challenges' here for many lives, which touches on the central theme of my talk. As Philip Hopkins suggests, this experience, or rather what he made of it, gave him important insights into emotional suffering, his own and that of others. Here was a lifelong learner, in the profoundest sense: the theme of subjective, especially emotional learning, and its place in General Practice, is at the heart of my talk.

I wonder what Michael Balint would have made of the current state of General Practice and medicine more widely? The editor of the BMJ recently commented that Dr Harold Shipman seems to have replaced Dr Kildare in popular mythology about doctors, and stories of doctors' mistakes far outweigh the triumphs (Smith, 2001). David Aaranovitch (2002), commenting on the idea of patients paying for GP services concluded that 'there were always secondary arguments for charging', including that it might diminish the 'dreadful paternalism – of noblesse oblige – that so often characterises doctor-patient relationships...doctors might be nicer if patients paid'. Clearly, according to these voices, the attitudes and performance of doctors leave much to be desired.

Doctors too seem unhappy and the editor of the BMJ suggested the causes of unhappiness were varied and deep. There could be a mismatch, he wrote, between what doctors were trained for and what they are required to do. He quotes Christian Koeck, a doctor and professor of health policy, in arguing that the intellectual model of medicine may be wrong and instead of being trained to apply the natural sciences to peoples' health problems, doctors should be trained as change managers: 'that way doctors can help people adjust to the sickness, pain and death that are central to being human'. This begs questions, of course, about what is meant by change management, but it is an interesting thought in a post-modern, globalising culture of profound, sometimes frightening change and uncertainty.

I am interested in people managing change and life transitions, and its emotional aspects. My research has encompassed adult learners living in communities undergoing major economic and social dislocations, and struggling to recompose their identities through participation in educational programmes (West, 1996). I also work as a psychotherapist: responses to change and transition, and the extent to which people can be open to new experience, rather than being paralysed by it, lies at the heart of some of this work. I believe that contemporary psychotherapeutic insights have a great deal to offer GPs struggling to manage their own, as well as their patients' experiences, in a changing world. Disturbance, as Michael Balint taught, disturbs, and doctors need to understand the impact of this, and their own disturbance, on interactions with their patients. The time is ripe for a new dialogue between an increasingly relationally focused psychotherapeutic world and GPs.

On the edge, as metaphor

I used the metaphor of 'on the edge' in my recent study of doctors and their learning (West, 2001). The metaphor works in a number of different but related ways: partly to illuminate the fragmented and neglected condition of the inner-city. There is a mounting crisis of social exclusion, escalating problems of mental health, growing alienation as well as increasing inequalities in health and health care. One major report noted that there are higher levels of mental illness, unplanned pregnancies and substance abuse, as well as higher mortality rates, relative to national averages, in these areas. Two thirds of asylum seekers and refugees in England and Wales arrive and settle in London. There are large numbers of people sleeping rough, squatters, hostel dwellers, and inner-London is the focus of a national HIV epidemic. The capital has the highest levels of mental illness than any other city in the UK. (Bardsley et al, 1998). Some doctors talk of there being an 'epidemic' of mental health problems.

'On the edge' can also be applied to the state of some health services. The Tomlinson Report, in the early 90s, expressed deep concern over standards of care and the poor shape and inadequate resourcing of many inner-city practices, and a number of other studies have echoed this theme (West, 2001). Doctors, too, can feel on an edge when working in such contexts: the morale of many doctors is poor and incidence of stress, alcoholism and mental health problems, even suicide, appear on the increase. Moreover, as Burton and Launer have remarked (Burton and Launer, forthcoming), GPs often have to deal

with difficult and demanding workloads, without guidance. They can, they suggest, easily become brutalised and adopt mechanical working practices. 'Unreflectiveness', they argue, 'has become institutionalised...and the contrast between the neediness of doctors and they myth they are so highly trained, is great'. The contrast may be especially marked in the inner-city.

The metaphor of the edge works epistemologically too: subjective, especially emotional knowledge is still marginal in a profession, which tends to deify hard facts and what can be directly observed. Despite the mushrooming of communication modules in medical training, as one recent anthropological study revealed (Sinclair, 1997), psychosocial perspectives, including subjective learning, remain marginal in the medical habitus. Ian McWhinney (1996) observed that medical culture tends to privilege 'scientific' knowledge – of the world out there – while the softer skills of human communication and psychosocial medicine are sometimes disparaged as 'other'. The work of GPs, as Ian McWhinney also noted, fits uncomfortably in the highly scientistic milieu of the medical school. Moreover, General Practice is under constant pressure to become more 'scientific' as well as more theoretical and quantitative. Evidence-based medicine may be exacerbating this, with its stress on the objective assessment of medical interventions, via randomised control trials. Subjective ways of knowing can easily be lost and disparaged in this hard, evidence-based world.

In certain regards, the situation may in fact be getting worse. Writing about the effects of greater accountability and weeding out the unacceptable in medical practice, Salinsky and Sackin (2000) conclude that the study of interpersonal issues, especially the doctor-patient relationship, is in danger of going to the bottom of the pile, while 'the archaic system of junior doctor training in medical schools means that many students become less person-centred and lose their humanitarian ideals'. For GP registrars, 'the bottom line of training is passing the very basic test of summative assessment' while anything not directly connected with that can be considered irrelevant. The increasing pressure of the GP registrar year can make it more difficult, they conclude, to develop the humanitarian side of their work. These accusations, if true, are deeply worrying.

Self directed learning groups

The starting point for my research was Self Directed Learning (SDL) groups. These were a response to the perceived crisis in health care in inner London. I was asked to evaluate the impact of SDL on a number of GPs who worked there. The groups were designed to give space for GPs to consider 'critical incidents' with selected patients, which might be causing particular anxiety. These might include the unexpected death of a patient, or a doctor feeling muddled, inadequate and disturbed by a patient with emotional problems. The aim was to address the doctor's fears and anxieties in the role as well as to consider different management options and what they might need to learn to progress. Each group consisted of about eight doctors, was confidential, and led by a skilled facilitator. The idea was to create, like a Balint group, more of a learning than a blame culture, in which the GPs could be open about their experience, without fear of criticism. The evaluation provided the basis of a more extended study of how GPs manage their work and learn, in the context of a changing health care system, and the growing social 'disease' of the inner-city. It lasted four years, and involved 6 interviews, with most doctors, lasting upwards of 2 hours each. Transcripts and tapes were used to establish themes and consider their meaning and significance, collaboratively and dynamically, over time. The study progressed into a deep, 'auto/biographical' process.

Auto/biographical methods

There is a big turn to biographical, life history and/or narrative research methods across the social sciences, including in medicine and primary care (Chamberlayne et al, 2000; Greenhalgh and Hurwitz, 1998)). The turn represents a reaffirmation of the importance of people as active agents, consciously and unconsciously, in the construction of their social worlds. And of the idea that understanding such worlds requires their active collaboration. If that is, in the work of doctors, we are to illuminate more of the complex interplay of professional sub-cultures and individual practice, public and private lives, formal and informal learning, dominant myths of what it is to be a doctor and personal experience.

The term 'auto/biographical' requires some explanation. This challenges the idea of the detached, objective biographer of others' lives, and the notion that a researcher's history, identity, (including gendered, raced, classed and sexual dimensions), and power, in the research encounter, play little or no part in shaping the other's story; or ought not to, in the name of rigorous and objective science. Liz Stanley writes, instead, of an 'intertextuality' at the core of biography, which has been suppressed in supposedly 'objective' accounts of others' lives. This is, of course, part of preserving a kind of *de facto* claim for biography and life history research as science: a process producing 'the truth,' and nothing but the truth about its subject (Stanley 1994).

Michelle Fine (1992) insists that researchers have persistently refused to interrogate how they create their stories. There has, at times, been a presumption, as in the natural sciences, that theories and methods neutralise personal and political influences: 'That we are human inventors of some questions and repressors of others, shapers of the very contexts

we study, co-participants in our interviews, interpreters of others' stories and narrators of our own, becomes, in some strange way, irrelevant to the texts we publish as 'research'. Fine argues, instead, for the reflexive and self-reflexive potential of experience, in which the knower is part of the matrix of what is known, and where the researcher needs to ask her/himself in what way has s/he grown in, and shaped the processes and outcomes of research.

In asking questions of doctors about experiential learning and managing change, I realised how much I was asking questions of myself. In hearing their stories of what facilitates or inhibits professional development, I was seeking to understand more of my own learning history, including working as a psychotherapist. Around, for instance, the role of a male therapist in a profession discursively infused, over many decades, with the symbolically 'feminine' notions of breast, feeding, good enough mothering and empathy (Sayers, 1995). I was asking questions too about being a man socialised into a competitive individualism in a profession that places empathic attunement at the core of its work. I came to share more of my own experience, in the research, as relationships with particular doctors developed and as they bared their souls to me. The dialogue, in these cases, focused, in increasing depth, on the relationship between learning, identity and the emotional aspects of being a GP. The outcome was a series of insights into profounder forms of learning.

Themes

A number of key themes emerged from the study: on the personal motives for becoming a doctor and how this was often to be understood as part of the doctor's own life history, such as illness in parents, the loss of a sibling, and or instabilities in family relationships. Gender too was a central theme: including highly gendered work places characterised by a continuing inequality of emotional labour. 'Who spent time with the receptionists and other staff, keeping the show on the road? Often the women GPs', as one doctor put it. Many of the women GPs felt torn between emotional responsibilities at home, such as looking after children, even when they were the major breadwinner, and the demands of the workplace. Some strived to be superwoman, and failed in the task. Many doctors found it hard, even frightening to talk, about their emotional difficulties: dispensing drugs, they admitted, too soon and ubiquitously, partly to protect themselves. Even in Balint groups, it was hard to talk about more personal issues, for fear, often exaggerated, that the group might lose focus on patients.

Racism, as well as misogyny also stalked some stories; 'minority' doctors felt they went to the parts that white colleagues avoided, but then were pilloried for their efforts. A number of these doctors were driven to prove themselves 'whiter than white': producing, for instance, the best ever Practice Plan and levels of performance, sometimes to the detriment of their own health, as well as some of their staff. And yet, working in the inner-city could also be a cutting edge: there were many doctors who had transcended their own disturbance and doubts, and the inadequacies of initial training. They told stories of integrating physical and emotional medicine, the objective and subjective aspects of their work, in life enhancing ways. I want to share two stories, at this point, to illustrate just what may be involved.

Two case studies: insiders and outsiders

Dr Aidene Croft is an outsider and lesbian, who works in a difficult and impoverished part of London's East End. She is white but talks with a 'different' accent. She told me she had experienced a major 'mental breakdown' in her career and, in the course of a year, phoned the BMA Stressline and Samaritans, and sought psychological help. She had often felt over the edge as a doctor, unable to cope with patients and their disturbance. Some of the pain of her troubled life history was no doubt stirred up by interactions with particular patients: her own story included a mother who died when she was four, difficult relationships with a succession of step-mothers, and a distant, emotionally withdrawn father. Becoming a doctor, she surmised, was part of an attempt to heal a fragile inner world

She mentioned her sexual identity, from the outset, and that this fitted uneasily into the 'male' and predominantly heterosexual culture of medics. She was working as a single-hander when we first met, having left a group practice and suffered an emotional crisis. She had needed, most of all, she said, to find her own authenticity as a doctor. She felt torn between her feelings and living in the head as a doctor. Her life and work did not feel 'real': 'I was very much trying to connect the two...I couldn't actually tolerate that level of incompatibility'. Aidene was sceptical of conventional 'male' medicine. She worked in a women's hospital where doctors had dismissed the notion of pre-menstrual tension. But 'there wasn't an ovary in the room', she said. She was also critical of her profession's neglect of mental health problems.

She talked, early on in the research, about the relationship between aspects of her identity and interactions with particular patients:

> You know I think because if your sexuality is outside the normal experience of people's expectations of their doctor, it leads to identification with everybody from Greeks to Turks, black people, Irish people, you know what it's like to be an outsider, you know, to fudge around issues, to not quite explain, for people to instantly lose their curiosity or suddenly go quiet or whatever. All my experience is about being out of orb...you just know that there is that hesitation that people then rethink... And I think it makes me more accepting of people. A lot of doctors find it

terribly difficult to just accept people as they are without trying to change them into the wrong perception...

Aidene knew what it was like to feel lost in an alien culture, and to struggle to explain this to others. She was sensitive to the mental distress of many minority patients, and wanted to research mental health issues among different ethnic populations. She talked of how black and Irish people were over-represented in mental health services and quoted research indicating that rates of depression in various minority communities exceed those of the 'English'. Levels of schizophrenia were high too, as were a range of anxiety states and personality disorders (Tilki, 1996; Cochrane and Singh, 1989).

A significant other

Aidene almost left medicine completely. She hated hospital medicine and its mores, including the very male, 'clubbish' culture that often predominated. She disliked many aspects of her formal training; becoming a more effective doctor, on more of her own terms, as she perceived it, was rooted in experiences outside medical schools and hospitals. She found, for instance, more humanity in general practice as she forged a strong relationship with a GP trainer. This enabled her to learn, experientially, in profounder ways:

> I had a wonderful trainer, very...astute, insightful, a really very very nice man. And thought yes this is it. This is where it is at...Feed me, feed me, this is a fascinating subject...You could be very honest about your deficiencies in learning. I had done paediatrics and gynaey and house jobs. I knew sod all about dermatology...this was a really clever bloke. I mean clever, clever in a very wide sense. Within two or three weeks I was in there saying – Jesus I haven't a clue about dermatology, give me some pictures, skins, I had no experience of this kind of skin...I had left home when I was 16 and was one of 11 children and suddenly here I was being given this – I had gone to boarding school...And suddenly it was all – now what would you like? Where can we go?...it just seemed incredibly generous and useful...he was somebody who respected people. I could learn from him that much more...

For the first time, she felt seen, valued and 'fed' in the medical world, as she did in her personal life with a new partner. It enabled her, alongside therapy, to understand more fully her own needs as well as those of her patients, and that she could be a doctor on more of her own terms. She also learned to be realistic over what she could offer: she could not solve a housing crises or the abusiveness of officialdom, but she could nonetheless listen, as she put it, 'to, for and with' the patient's story. Empathic relationship and narrative-based practice were at the heart of effective health care, and of her own most significant experiential learning.

The impact of new relationships – with colleagues and others – were at the core of Aidene's professional growth, as they were in the narratives of many of the medics. Sean Courtney, in reviewing processes of adult learning and change management, noted how frequently a significant other was essential to what he termed 'life spacing': taking risks, experimenting, and managing personal transitions and crises (Courtney, 1992). There were similar findings in my earlier research into men and women managing change, and using education, in communities undergoing major economic and social dislocations (West, 1996). What often seems critical to successful transitions is being able to share – with a colleague, a teacher, a friend or therapist – uncertainties and doubts, and feelings of failure, in a non-judgemental, empathic but also challenging relationship. There was space and encouragement to think, and be open, without fear of blame. Aidene's trainer offered time, support and space to learn, during a period when she felt badly about herself as a doctor. The SDL group, as well as personal therapy, also offered a transitional space in which to experiment and 'life-space'.

Psychoanalytic, especially feminist object relations theory, can help explain some of these psychological processes. Individual development, in this view, is always to be understood in an intersubjective context, and 'inner' experience is shaped by a person's interaction with others (Diamond, 1998). Psychological development is conceived as perpetually contingent and profoundly social as subjective life is forged in the relationships in which we are embedded and the wider scripts that inform these (Frosh, 1991; Schwartz, 1999). Object relations theorists, for example, in considering how inter-subjective experience translates into intra-subjective life, often use the metaphor of psyche as a cast of characters, of people and dynamics in the social world, which become internalised. Some people injure or constrain us; others may inspire and accept us, and provide us with a sense of basic legitimacy and hope. People 'out there' become part of an internal drama, which forms the basis of personality.

But the drama can change, as new, more empathic others enter the social stage, and we are given more space for play and experiment. Such 'good objects' may be people we know directly, whom we respect and can identify with. They may be friends, teachers, other learners and colleagues who mirror, in their actions and responses, new biographical possibilities (West, 1996; Sayers, 1995). From this inter-subjective perspective, human beings exist in a shared space of affective intercourse in which there is fundamental overlapping between one and another. This involves a different philosophical assumption about personhood to the Cartesian separation of each person's inner-space from the other, as if we were mere physical bodies positioned according to distance arrangements.

Such an intersubjective perspective on the development of personality is now taking hold in developmental psychology, phenomenology as well as psychoanalysis (Diamond, 1998).

Our need for others may be strongest at times of change, or of disturbance, when primitive feelings of anxiety may be evoked. For a doctor, the disturbance of a patient may dig deep into his or her own pathology as one life connects with another; or, at another level, a doctor can feel bereft at the loss of idealism, in the face of harsh reality. Such experience can induce a paranoid defensiveness and acting out in omnipotent ways. One psychiatrist has described how the latter can induce states of denial, turning to drink, having an affair and or playing pointless power politics in the medical profession (Bennet, 1997). Or alternatively, disturbance, to return to Balint, can be the means to profounder forms of learning, about self and being a doctor.

Despising the mainstream

Take the case of Dr Daniel Cohen. Like Aidene, Daniel felt himself to be an outsider in medicine:

> ....I don't believe in what I think the mainstream believes in...I am actually often appalled by the discourse, just appalled by...the whole set of assumptions about the nature of reality, about the assumption of the doctor's power and the assumption of sexist and racist...ideas and...the collusion around that.... I feel profoundly alienated by it, which is why I have so little to do with it... Like mining a seam of gold called the medical fact...from a pile of shit, which is the patient's sort of life...a way of talking about...patients as if the patient isn't there...

Daniel's crisis came 8 years ago, over the amount of work and its endlessness. There were very few professions, he said, having such a workload in terms of volume or intensity. And there was no career development path for the GP; at the age of 37/38 you might 'look forward' to 20 years struggling with the same sorts of issues, with few other options.

Being a doctor had forced him to ask questions of himself, at many levels. There was no neat distinction between questions patients asked: "who am I?" or "where do I come from?" or "why do I have the kind of problems that I think I have?" and those of the doctor. There was a seamless web connecting their story to his. Daniel used psychotherapy and experiential groups to reconsider aspects of his own family history and identity, in what he termed a process of narrative recovery and reappraisal. He was the child of refugees from Nazism, which led many like him into the caring professions. The desire to heal, he thought, was primarily directed at self. He was brought up, he said, with the experience of Nazism and fleeing persecution, the emotional dimensions of which were hardly talked about at all. There was, for him, a powerful imperative to succeed and never to rebel. He described himself as having been outwardly successful but inwardly distressed.

We shared and compared experiences of needing to perform for parents, and of being raised as males to succeed in highly competitive ways. We talked about the place of the feminine and masculine in the work of a doctor as well as in therapy, and the need, perhaps, for a kind of Jungian balance:

> I suppose a great deal of my job is masculine...as we tried to start this interview it was interrupted by a phone call from hospital with information as to whether a patient did or did not carry a particular germ...I have to deal with that...the feminine side is that I am constantly striving to contain and manage those sorts of moments in order to create space for feminine types of experience [rather than] omnipotent theatre...The feminine? Yes. Acceptance, tolerance, understandings of process rather than events and outcomes...things that are fluid rather than chopped up and categorised. A sense of connection being more important than anything...

There was, he said, continuing suspicion of subjectivity and emotional learning within medical culture. Yet such learning, and cultural literacy, was often at the core of becoming a better doctor. A Somali woman refugee came to mind as he talked:

> ...A mother and five children, father not in this country...may have been killed in the war there...Children with a huge range of problems from asthma to epilepsy...Often just turning up out of the blue without an appointment...And the anxiety and the sort of tension that arrives with that sort of situation are absolutely massive for a GP...And I struggle to create situations where I can meet more of their needs really by putting an hour aside for them at a special time with an interpreter... the mother of that family brought me a present for Christmas. Somebody had come over from Somalia with this and she brought it to me as a gift and I was immensely moved because it was a really strong symbol that we were providing...a secure base...and that she identified me as one white British person in authority who she can trust... And we ended up having the most extraordinary conversation with the mother about Darwinian evolution in relation to why were her children getting asthma and eczema here when children didn't get it in Somalia and we talked about the way the immune system might be adapted for one environment but actually then is mal-adapted to another environment because the sort of ancestral immune system as it evolved is not to meet what it meets here.

He found himself having a grown up conversation with this mother and she was transformed 'from being an exotic stereotype into an intelligent equal'. This was part of a process of her becoming a person again, through being

understood, by a significant other. 'That she could actually have what I would guess is her first conversation with somebody British which wasn't just about immediate needs, about housing or benefits, or prescriptions and that sort of stuff but actually recreate her as an equal adult'. And in telling this story, he realised, for the first time, that he was making a direct connection between his own history and that of the Somali patient. A GP, in his own family's narrative, provided a supportive space for his parents and other relatives dislocated by war and persecution. '...I think it is in a way always coming back to the business of a personal search, actually trying to find out what life is about and what you should be making of it', and having others there who listen and encourage.

Daniel, like Aidene, placed changing relationships at the heart of learning to be a doctor: with two colleagues, with a therapist, a new partner and their young children. And the availability of transitional spaces was important – in SDL, therapy and other groups – to take risks and experiment with the story of being a doctor. He understood himself, and his cultural roots, more deeply, which helped him develop professionally. GPs, he concluded, like him, were situated between the truth discourse of the mainstream and the uncertainties and messiness of whole people and whole problems. A subversive synthesis was required, taking what was essential from the medical model but locating this within a person and narrative-focused practice in which doctors had to learn from within. The personal and professional were, for effective practice, all of a piece.

Conclusion: challenging ways of knowing

So, to return to Richard Smith and his ruminations on the deeper causes of the present malaise among doctors; and how processes of change management may be central to what doctors do, and need to learn. The two stories at the heart of this talk suggest that being able to work with diverse patients requires a capacity to learn auto/biographically, about the interplay of the cultural and psychological, the patient and self. And rather than this being marginal to effective practice, it is in fact at the core. And yet, the evidence persists that such ways of knowing continue to be on the edge in the dominant stories medicine tells itself. Despite claims that medicine is, at long last, encompassing multiple ways of knowing the world, the objective and arguably 'male' way – taking us into the real world and out of ourselves – remains powerful (Hodgkin, 1996). A Cartesian split of mind and emotion, intellect from feeling, self and other, remains rooted in medical culture, and in the academy more widely, and continues to take its toll.

I think there is a need for accessible languages, which can illuminate more of these auto/biographical processes for hard-pressed GPs. Some doctors (Campkin, 2001) rightly disparage particular psychoanalytic jargon, as like a mysterious foreign language or religion. Maybe, even, a language whose time has gone (Salinsky, 2001). I think it would be a mistake for the Balint Society and general practice to give up on this or to forget that psychotherapy itself is a living and changing field. The contemporary language of object relational psychotherapy, if made accessible, offers important insights into the dialectic of the doctor and her patient, one story and another. Such perspectives, it should be noted, have shifted from an emphasis on innate drives to a focus on qualities in relationship, including in the here and now. They can illuminate how and why, for instance, significant others, transitional spaces and reworking the stories we tell to self and others may be important in learning to be a doctor on more of one's own terms.

Moreover, psychotherapeutic ideas can, with some effort, be communicated intelligibly. Susie Orbach (2001) writes, for instance, in an intelligible language about emotional learning. She was referring to therapists, but her points could be applied equally to GPs. They are, in a profound sense, their own instruments. Their own subjectivity, what and how they feel in their bodies, the passions or ennuis that are stimulated in their work are as important as the blood pressure cuff, the thermometer, the swab, the urine analysis, the x-ray and the ECG. For many doctors 'on the edge' this can be a matter of personal as well as professional survival.

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Six Sessions for the Patient

The Balint Society Prize Essay 2002 by Don Bryant

"Fashions change in nonsense no less than in ladies' hats." So wrote one of the best-selling popularisers of the early 1950s for the use of rationality in human affairs[1]. Half a century on, with the decline of the very notion of 'ladies', let alone their hats, that part of the once-catchy quotation itself seems quaintly out of date. Yet the ever-changing stream of fashions in nonsense is still very much with us, no less in ideas about the general practice of medicine than in those about many other of the important practical affairs of mankind.

Michael Balint was a great one for nonsense. He relished both confronting and challenging the more dangerous kinds of nonsense, like the therapeutic usefulness of physical contact[2,3] and, paradoxically, the absolute taboo against touching.[4,5] He enjoyed paradoxes and liked playing with the harmless and useful kinds of nonsense. He was a master of aphorisms and metaphors: the doctor's *'apostolic function'*; the doctor as the *'drug doctor'*; the *'Detective Inspector'* approach; the *'flash'*. But it was on questions of time – how much time for the patient? – that he was at his most outspoken, challenging many of the conventional assumptions.

It is now almost thirty years since Enid Balint and Jack Norell[6] published "Six Minutes for the Patient" in which they reviewed if not the nonsense, at least some of the myths about the effectiveness of new technology and methods of working that had grown up in general practice since the early 1950s. This work, based on research by a team of GPs and psychoanalysts under the leadership of Michael and Enid Balint, looked at the ways in which Balint groups could help GPs to become more responsive to a wide range of their needful patients (and not just those they got on well with, but also the difficult ones).

The book included a chapter by Michael, in which he wrote: "In spite of our efforts so far to create a technique suited particularly to the setting of medical practice, the *long interview* [my italics] has remained a sort of foreign body in the GP's normal routine." During the early years, GPs in Balint groups had tended to become semi-psychotherapists[7] or even to imitate their psychoanalyst leaders in behaviour described as "a gross parody".[8]

Enid herself was to note later[9] that the research team had felt it was a bad idea that their earlier work had picked particular cases out of the ordinary routine, and the GPs had given these selected patients a special long conclusion, and so went on to examine: "what could be done in the ordinary, what we call the 'six minutes' of a morning 'surgery' (which is the time given to an ordinary patient during an ordinary surgery)".

Other important challenges to existing myths emerged from this work: some of the authority that the doctors previously had was to be given up so that patients were able to show them what *they* wanted rather than the doctors taking the lead without listening to the patient; the need to tune in to the patient and to the practitioner-patient relationship, and to the changes in the feelings and the stories being told; the need to identify and then to withdraw from the identification.

The notion of the 'flash' – a moment of mutual understanding between the practitioner and his patient which was communicated by the doctor to his patient – which originally emerged from these ideas, has itself been subsequently challenged: "the authors were full of enthusiasm for this sudden change, or golden moment, that could make a valuable change in the patient's feelings, and we have been trying to live down this enthusiasm ever since".[10]

Other groups have since studied the same kind of event, but now the doctor does not necessarily communicate to the patient what he thinks. There is some confusion whether the 'flash' is a sudden new perception by the doctor, or shared by both patient and doctor together – and whether it should consist not only of sensing and understanding but responding appropriately (i.e. if it led to a change in the doctor's behaviour towards the patient).

On the general question of time that GPs have to listen to their patients much has been said. Thus the GP's timescale is one of his setting's great strengths, building his knowledge of his patients and their families through repeated short contacts over several years. He has a flexible appointment system; he can vary the duration and frequency of consultations. If listening is just letting people talk, however, he does not have enough time, but it isn't. Accuracy of attention and an ear that 'hears' what is said (and not said), in the echoes and resonances behind the words, are what counts. No long preamble or fact finding is needed as much important data will already be on record.

Many criticisms and disappointments with the 'six-minute' concept have however been voiced,[11,12] for example, seeing this setting as "rather a rosy picture of the feelings of ordinary GPs in a setting where time is short and uncertainty long!"

In 1993, however, John Salinsky, who had then been in General Practice for some 17 years, published an account[13] of how he had been able to help people with serious emotional problems by offering them a form of long-term psychotherapy. Although most of his consultations were indeed of the brief 'six minutes for the patient' form, actually ranging from five to ten minutes, he also saw some single patients, one or two days a week, for long sessions of 35-45 minutes, at the end of evening surgery – 'The Last Appointment'. This was the title he chose for

his book, in which he presented several detailed case histories, simply and at times movingly, and an honest appraisal of the results. While he makes the case for other GPs to extend their psychotherapeutic skills before referring these special patients on to the formal psychiatric services, he hints that his particular own blend of interest, skill and commitment to longish-term psychotherapy may not be appropriate nor available to many other GPs.

The main bugbear, nearly always, is time. Despite all that has been said about doctors having enough time, family doctors are haunted by the spectre of time.[14] There are external time pressures within the NHS, probably built in unwittingly from its inception, and many recent changes in general practice, although intended to improve health care, have made the situation worse. Partnerships are larger, but the chances of patients seeing their 'own' doctor get less and less. The tradition of personal doctoring – knowing the life stories of all the families on the list personally – is at risk of becoming all but lost. Various strategies for managing time have been proposed: revised appointment systems; double appointments for selected or more vulnerable patients; specially planned long consultations out of surgery hours; and, for those patients with painful past histories, referral to external counsellors or to community mental health teams.

By the 1990s with the advent of NHS trusts, and the money that went with them, it became more feasible to set up counselling services within GPs' surgeries. Ideas from brief therapy and time-limited counselling[15] led to the development of a *'Six Session'* model for the patient. Principles and protocols have been laid down[16] – some bureaucratic, some less so – but many tensions and difficulties in practice have been described in the counselling literature.[18 19 20]

There now follows a case study example of one particular interaction between counsellor and patient in a GP's surgery to illustrate the philosophy and workings of the model. The focus is the practitioner-patient relationship, but where the practitioner is now the counsellor, not the GP. This focus does have, moreover, ramifications not only for the GP but also for the Practice Head, Practice Manager, Receptionists, and others in the surgery system and for administrators and others within the primary care group, and, indeed, for the counselling service organisation itself.

Case study: Six sessions for Sidney

(All names and some other details have been altered to preserve confidentiality and protect anonymity)

Contractual Background:

The 6-session counselling scheme is offered by a local counselling service in partnership with the North Loamshire NHS Primary Care Group (PCG). The PCG insist that the sessions are carried out at the Doctors' surgeries, so the Counselling can be included in the variety of services – such as Practice Nurse, Maternity Clinic – currently on offer at the surgeries. Detailed protocols exist for counsellors' job descriptions, procedures for supervision, referrals and record-keeping, and for PCG contractual requirements. There is a lot of paperwork. In essence, the patient's own doctor makes the referral to the PCG Contract Administrator, requesting six weekly sessions of counselling, The Administrator appoints the Counsellor and writes to the patient with details of dates, times and place of the sessions and encloses information about the counselling service. Sessions are free, normally the same day and time each week and always with the same counsellor. The first session is an assessment and takes 90 minutes. The following five sessions take 50 minutes each. Whatever the patient discusses with the counsellor is held as strictly confidential to the Counselling Service. Nothing is relayed to the referring Doctor. [Patients are told that there are certain exceptions – such as disclosures of child abuse, or a *firm* intention to commit suicide – and only then after prior discussion with the patient.]

At the end of the six sessions, a brief comment about progress is sent to the referring doctor, provided the patient agrees.

Referral notes:

Dr Adams referred Mr Sidney Smith for six weekly sessions of counselling and commented as follows:

"Anxiety and depression. Has been sacked last year through long periods of absence. Started new job Monday 21 Jan and can't cope. Has started Citalopram 20 mg.; has been on Fluanxol (?) for months."

Appointments made 28 Jan (one week later) for first session on Friday 8 Feb for 90 minutes and thereafter the following five sessions on Fridays for 50 minutes each.

First session (assessment)

Client name:	Sidney Smith
Date of Birth:	1.4.47 (Age 55)
Assessor/Counsellor:	C.D.
Date of Assessment:	8.2.2002

First impressions: Sidney arrives at the surgery ¼ hour early with wife ("to give him confidence"). He is reluctant to let go of her and seems scared and bewildered. Wearing dark, nondescript clothes, he looks overweight. His tone is heavy, flat and depressed. It's hard work getting him to open up.

Current life situation: Sidney has been married to Joan for 32 years. They have 2 grown-up sons and a 3-year old granddaughter, of whom Sidney is very fond. All his working life has been in the motor trade until September 2001 when he went sick for two months and felt forced to accept early retirement. At present unemployed and drawing sick benefit. He drives Joan to and from her work at the local hospital and does odd jobs around the house.

Presenting problem: "Anxiety and

depression" according to referring GP. Client says, "Can't cope at work"... left job of 25 + years standing due to pressure and no support from management or colleagues. He started a new job (filling shelves at a supermarket) but left after 2 days – "feeling useless and felt like killing myself. Now I have a phobia about writing things."

Client history: Sidney has two older sisters (by 10 and 1½ years) and two younger brothers (by 2 and 7 years). His mother is 80 (and whom he still sees). His father, who was very strict and saw little of him, died suddenly (at 80) 3 years ago. Sidney never cried at the funeral and says that's when things started to go wrong. He bottled feelings up then and again when his wife had a touch of cancer after a hysterectomy. Sidney's work situation changed dramatically after his closest workmate died suddenly of a heart attack and another left. Their replacements (in their late teens) didn't know the job and didn't respect him. His new boss, also young and inexperienced, pressurised him to do more work in less time.

Assessor's view of client's problem: On the surface, the problem appears to be a classic example of stress at work – changes in the pace of working; automated technology; new, younger and less committed workmates and boss; loss of his natural status as a "wise old retainer" – coupled with the lack of any personnel management and/or trade union support seem to have come together all at once to give his present sense of despair, futility and uselessness.

Assessor's view of client's psychological state: In addition to the above situational factors, there is probably a long-dormant predisposition to anxiety and depression. Suicide **was** contemplated but he has at last managed to talk about it with his wife and he says he doesn't think he could do it now.

Psychological or medical involvement: No psychological involvement in the past or at present. Client is receiving medication from GP: Venlafaxine 37.5mg (since 1 Feb 02). Client says previous medication was "too strong and nearly knocked me out".

Client's expectations: To regain self-worth and to be able to face up to his problems.

Counsellor Session Notes:

Session (2) 15th Feb 2002. Sidney came (to Westwood – offsite from the surgery) on his own. He feels more relaxed coming here (than to the surgery). Using the material from the assessment, we looked together at the events and feelings leading up to his first breakdown at work and his enforced early retirement due to ill-health. He's beginning to look at his anger about how he was treated.

Session (3) 22 Feb 2002. He was able to express more feeling about his sense of loss of his old workmates (one died suddenly, another retired) and began to express murderous rage towards their younger replacements who tormented him. He also talked about his 'writing phobia'. He saw Dr Williams (his regular doctor) this morning, who gave him more pills and asked him about his counselling.

Session (4): 1 March 2002. Noticeably more alert, he reported progress on 'beating stress' (e.g. playing with his granddaughter; brisk walking) and getting a big lift from supermarket offer to re-employ him. We began to look at his feeling he's let his wife down, challenging his negative self-image, encouraging him to review his strengths.

Session (5): 8 March 2002. Looking lighter in appearance and brighter in manner, he is enjoying job satisfaction from his home decorating projects. Says he still worries about coping if and when he goes back to the supermarket job. We explored in more depth his anger and how and why he bottles it up, also his diffidence about speaking up when he doesn't understand things.

Session (6): 15 March 2002. We reviewed themes and progress made and, reflecting on the ending, he said he was feeling good about getting back to work, but needed to be checked out as fit by doctor. He said counselling had really helped (but was nervous about it at first, expecting 'psychiatry') and would go back to his own doctor, seeking referral for more counselling if he has any worry in future.

Confidential Client Closure Form:

1. Future plans, if any.

Sidney plans to visit his doctor to check whether, after a further 2-3 weeks doing odd jobs at home, he might be fit enough to take up supermarket job offer (see section 4 below). He would seek his doctor's referral for further counselling should any difficulty arise in future.

2. How did the work develop?

Following the assessment session, we looked together at the events and feelings leading up to Sidney's enforced early retirement due to ill-health. By session 3 he was able to address his hitherto unacknowledged anger about the unfair way he had been treated at work. The later sessions were focussed on challenging some of his negative assumptions about himself and encouraging him to work at his strengths and to reclaim his sense of self-worth.

3. Would you assess patient as feeling (tick as appropriate):

(a) worse than at intake,
(b) about the same,
(c) slightly improved,
(d) considerably improved

4. Any other relevant factors.

In session 4 Sidney reported a call from the supermarket personnel manager who said "there's a job here for you when you feel ready to come back." Sidney said, "This is the biggest lift

I've ever had – nobody has ever said anything like that to me before – they actually want me!" This was undoubtedly a key factor contributing to the considerable improvement in energy – and sense of joy.

(Sidney agreed to this information being disclosed to his referring GP Dr Adams.)

Summary and Reflections on the Case Study

In this case study we have been able to review only the bare bones of Sidney's story as revealed by the rather terse protocols of assessment, session notes and closure format as specified by the PCG. The counsellor's own clinical notes and post hoc reflections are other sources which could be used to flesh out a more coherent history. But the brief notes are perhaps enough to give a flavour of how the 'six-session' philosophy can work in practice, and to make a case for exploring a range of other types of time-limited initiatives in the practitioner-patient relationship, falling between the two extremes of the once-obligatory "six minutes for the patient" and the classic perception of psychoanalysis interminable.

The presentation was very much focussed on the patient and said relatively little about the interaction with the practitioners – the counsellor, the referring doctor, and, less still, with his "usual" doctor. There were of course many other actors who played their part in Sidney's story and who contributed to the reported – in this case favourable – outcome. The action of the supermarket personnel manager in phoning to re-affirm a job offer was undoubtedly one key influence. Another was the support given by his wife. In PCG work there are many lessons to be learned from the potential contribution to the patient's well-being to be made by other health professionals.

The situation has changed dramatically from the heroic days of the single-handed practitioner for whom his weekly Balint group or the annual "Oxford" conference offered the only chance to discuss patients with other like-minded colleagues. Nowadays many more doctors have their practice partners as well as a range of 'health care centre' personnel – practice nurses, health visitors, counsellors – to whom they can, and maybe should, relate professionally.

There are, however, some major threats to progress: the increasing emphasis on doctor-centred health promotion acting with absolute performance targets, and the pursuit of initiatives which concentrate on what can be easily measured rather than what is important.[21]

Within the surgery and in its interactions with the "outsider" – bodies such as the counselling service and the PCG administrative staff – there can be tensions and scope for misunderstanding between individual people, all of whom may feel rightfully concerned with their conscious perceptions of the primary task, yet may be unaware of the organisational difficulties arising from the need to contain unconscious anxieties about illness and mortality. To lose sight of the "anxiety-containing" function of the organisation can mean an increase in the potential for turmoil.[22] Implications for *all* members of the surgery organisation, whether senior partner, doctor, practice manager, or receptionist, include the need for clarity about this primary task, the authority structure, and opportunities to participate and contribute.

Balint groups in their traditional form are often mourned for being in decline. But the difficulties experienced in PCG work as well as the potential benefits of initiatives such as working with "six sessions for the patient" point the way to experimenting with new forms of "in-house" groups, led by experienced 'Balint' leaders, working with not only fellow "professionals" – doctors, practice nurses, counsellors – but also the many other actors – practice managers, receptionists, PCG administrators – whose potential involvement, dedication and special gifts of human warmth and understanding can be so critical for the health of the organization as well as its patients.

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Relationships in Contemporary Medical Practice

by Ena Grbic, GP in Croatia

Our undergraduate study educates us perfectly about somatic diseases. After I finished my undergraduate study I thought I would cure all of my patients. I'd learned all about diagnostics and somatic diseases and it seemed there was no reason to be unsuccessful. But, during my practice I saw that some patients came very often to their GP. They were very unsatisfied, and so were the doctors who treated them. The doctor has been trained only to see a disorder. He doesn't see a person neither does he listen to the patient. Although modern diagnostic procedures have become highly developed, in many cases they can't help my patients. At the beginning of my practice I produced unsatisfied patients and I was unsatisfied too.

I was very happy when I started my postgraduate study, thinking that I would renew my knowledge and be able to help my problematic patients. During my specialization I attended Balint groups at the Clinic for Psychological medicine. My memories of this are rather unpleasant because the colleagues who were reporting the cases always seemed to be analysed more than their relationship with the patient. Balint was not for me, I decided, and I had no intention of joining such a group.

Ten years later, I discovered a totally different Balint group. In that group I could tell people all about my fears and frustrations. When I had come to a dead end with the patient, Balint helped me to deal with that problem. Balint taught me how important it is to listen and talk to my patients. I became aware how important it is to know their psychological problems, their manner of life, their position in their families, their job, their disappointments and their hopes; because their stress and their fears may cause many illnesses which I can diagnose with the methods I have learned.

I have now been in Balint for seven years. I wanted to know how many hospital doctors spent time talking with patients. I looked at what was happening in my own practice. Within four months I did 110 hospital orders (referrals). 20% of my patients were sent for one day elaboration, 5% for chemotherapy, and 75% were hospitalised. 35% of hospitalised patients were treated at internal medicine, 25% at neurological medicine, 25% at surgical medicine, 10% at orthopaedic medicine, and 5% at ophthalmological and urological medicine.

The evaluation was terrible. I was very surprised how little time our hospital doctors spent talking with the patients. Some patients were leaving the hospital without knowing their surgical results. Sometimes more information was given to the patient's family if they asked the doctor's opinion. In those cases the patient was usually a child or a seriously ill patient. The results show that the hospital doctors very rarely began the conversation with the patient, except when they took the history. The patient had to 'hunt out' the doctor for a talk and the doctor was always busy.

When the doctors do their rounds they talk between themselves, and with the nurses or students in a language the patient cannot understand. The patients told me that they were afraid and excited but couldn't understand what the doctor was saying to them and they couldn't remember the details of the conversations. During the rounds, the patient's humbleness doesn't allow him to ask about his illness. That is the reason why the patient often asks the nurse about his illness, and the nurse tells him that she is not able to give him the information, and that he must ask the doctor. When the patient leaves the hospital the doctor tells him: 'Report to your doctor (GP). He will tell you everything that you want to know'. The patient comes to me and asks me: 'Please, will you be so kind and tell me all about my health. What is going on? Which procedure must I go through?' I often ask the patient why they didn't ask the hospital doctor. The answer is usually: 'He is very busy and he doesn't have a time to talk with me.'

Before I discovered Balint work I also thought that talking with the patient about his life style was losing time. But I changed my mind. It is very important for the doctor to notice how the patient keeps a vigilant eye on the doctor's nonverbal communications such as frowning eyebrows, mumbling, or shaking the head. If the doctor says nothing the patient can read from the doctor's face and he knows everything. Conversation with the patient and with his family is more important in our practice than giving medication. Nowadays many patients are complaining not about doctors' lack of knowledge, but about their behaviour. Also in a therapeutic way I think that if the doctors talk with their patients many problems will disappear.

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The Key to the Door

by Katrín Fjeldsted

Keynote paper given at the Oxford Balint Weekend in Exeter College on Friday 14 September 2001

It is a great pleasure and privilege to have been asked to address you at the opening of the 2001 Oxford Balint Weekend. Oxford is such a perfect setting. There is an academic smell in the air - hopefully not so much so in the dormitories - but the students are still mostly away. Here you may be certain that there is a perfect atmosphere for weirdo meetings. On at least one occasion I remember our weekend coincide with a convention of Tolkien admirers all dressed up in hobbit clothing. It is said that all kinds of eccentrics like to gather in this historic city, even witches. So be on your alert when you go out during breaks, manwatching, it will probably be worth your while.

I come from faraway Iceland and have been a GP there for twenty years after having completed my postgraduate training in London where I lived for almost 7 years. I did my house jobs in this country and initially intended to do anaesthetics. During my year as a house officer, however, I soon realized that I preferred patients in their conscious state. I tended to take much too long clerking in new patients and listening to their fears, joys and sorrows and discovered thereby that I had a GP gene on one of my chromosomes.

Later, when working as an SHO at Edgware General Hospital I found out that a GP called Gerald Michael ran a Balint group for trainee GPs (or registrars as they are now called) at the hospital. I applied to join and was accepted even if I was at that time still not formally a trainee in general practice. I had done my medical training back home and only held a temporary registration. Such a registration was sufficient to complete any specialist training except general practice and, even if that was a source of frustration to me, it was a wonderful relief to get to know some of the Balint doctors. They helped me to understand that training for general practice demands a much greater sense of enthusiasm, empathy, humility, dedication, accuracy and understanding than most other specialities, e.g. medicine or brain surgery. I later joined another Balint group for GP registrars at Northwich Park Hospital in Harrow under the leadership of Oliver Samuel and reached a point of no return.

And now, you may ask, what is a Balint doctor then? Well, to my mind the Balint doctor has a special attitude to the patient. It all started with the title of Michael Balint's book, *The Doctor, his Patient and the Illness*, almost half a century ago. All of a sudden these three were on equal footing. The patient had acquired a voice and had a say. It was not any longer just the brave and dedicated doctor fighting the illness like Don Quixote chasing after windmills. The patient became the key to the door behind which the hidden solution to his problems might be found.

The influence parents have on their children lasts forever even if we as doctors may worry about future parenting with the decrease in fertility as the sperm count in men has been reduced by half in the last 40 years. Dave Peltzer's book, *A Child called 'It'*, is a description of parenting gone wrong and the author is the at present best known survivor of a mother's cruelty. At the airport on my way here I picked up Lorna Sage's recent book, *Bad Blood*, a well written account of childhood misery. Motherhood has been glorified through the ages and mostly for a good reason.

The earliest known surviving example of a lullaby in the English language is from about the year 1300, thought to be by Friar Michael of Kildare.

Child. if it betideth that thou shalt thrive
and thee,
Thench thou were yfostered up thy moder
knee,
ever hab mund in thy hert of those thinges
three,
Whan thou comest, what thou art, and
what shall come of thee-
Lollay, lollay, little child, child, lollay,
lollay,
With sorrow thou com into this world
with sorrow shalt wend away.

The patient became the key to the door. After Balint, the words and phrases chosen by the patient during the course of the consultation had to be listened to and interpreted. They are by no means incidental. The effect the patient has on the doctor, even the doctor's feelings, making us angry, frustrated, full of joy or sorrow is undeniable. During hospital training we were taught to be objective and it was thought to be non-medical behaviour to have feelings or show them. After Balint it became possible to look those feelings in the eye and realize that they are legitimate, necessary and can even be understood. Thus also the feelings of the patient are brought into focus and understood. On many occasions this may lead to a turning point in the doctor-patient relationship.

Non verbal communication is also important. It has been said that when we communicate with each other only 7% is words, 38% lies in the tone of voice and 55% in body language. I believe this to be true and it does explain why people, husbands and wives often manage to argue about who said what and what was meant! Therefore, looking at the patient is necessary and the presence of a computer on your desk can make this more difficult. Please try not

to write your notes and talk to the patient at the same time. You will probably miss the whole message! And besides, let us not forget common sense and general knowledge, although common sense is rather uncommon, and general knowledge hardly ever general.

I remember a story about a middle-aged woman who had a heart attack. While on the operating table she almost died. She saw God and asked, "Is this it? Am I dead?" and God said: "No, you have another 30 to 40 years to live". She recovered and decided to stay in hospital for a while to have a facelift, liposuction, breast augmentation, tummy tuck, hair dyed (I didn't realize you could go to hospital for that) and so on. She figured, since she had been allotted another 30 to 40 years, she might as well make the most of it. After the last operation she walked out of the hospital and immediately got hit by an ambulance. She arrived in front of God and asked: " I thought you said I had another 30 to 40 years?" To which God replied, "Sorry, I didn´t recognize you....."

Well, she had changed her body language, hadn't she?

Invariably the Balint group has a leader and often a co-leader. The group consists of a small number of people, around 8-12, who are in active practice. This is to make sure there are always fresh cases to present. Nowadays Balint groups may include other health professionals as there are others involved in treating patients in an intimate and confidential setting and many nurses, counsellors and psychologists have found this model useful. The group sits on chairs that are arranged in a circle with the leader and co-leader facing each other. I remember the eye contact between Oliver and Nadine, his co-leader at Northwick Park, when something of importance cropped up during our meeting. A raised eyebrow for a fraction of a second maybe, supposedly invisible but not so to the trained eye....

Now the group has sat down, everybody is comfortable, and the leader says the magic words: " Who's got a case?" and there follows a silence. Usually there are urgent cases, sometimes from the same day and even in an experienced group there is only time for a limited number of cases. It is important to allow people to talk about what is worrying them and not to push them into presenting a case. On the other hand it is useful for the whole group if the participants are active both in presenting and in the discussion following the presentation. The role of the leaders is crucial. I have been a member of a leaderless group which gradually got deeper and deeper into a leadership struggle and subsequently, after a few months, had to be dissolved. The leaders try to look at the process and keep the discussion focused on the doctor-patient relationship and also may come to the rescue in awkward situations such as to protect an individual doctor if under a verbal attack!

An average Balint group takes one and a half to two hours usually with a short tea break in the middle. It meets on a regular basis, maybe once a week, once every two weeks, once a month....I have heard of a group in rural Norway meeting a few times a year and another such group was operative in northern Iceland for a while....or even once a year for some of us who have been able to use the Oxford Balint weekend for that purpose. In this age of evidence based medicine and quality assurance the International Balint movement has strived to analyze its work to try and find measurable aspects to be able to follow the tide. This is understandable in theory:

a definition of theory:
you know everything but nothing works as expected;
a definition of organization:
nothing works as expected, everybody knows why.
a definition of general practice:
everything works, nobody knows why).

I harbour certain doubts in my heart that everything is measurable and I have grave doubts about some of the measurements of quality, as quality can easily be turned into quantity. Or as T.S. Eliot said: 'Where is the life we have lost in living? Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?'

Through Balint work I have learnt to love my patients and enjoy working with them even if I have for the time being entered another world trying to influence the health of a nation as a member of the Icelandic Parliament. Taking part in Balint work has taught me that to know how to relive the past with pleasure is to live twice. I am certain that love and joy cannot be measured. That doesn't make them any less important.

Enjoy your Balint weekend and hold on to the key to the door.

Dr Katrín Fjeldsted

Can Hospitals embrace Balint? A study of a Paediatric Intensive Care Unit's response

Polly Blacker

(This paper was presented at the Oxford Balint Weekend in Exeter College, 15 September 2001)

Introduction

This paper draws from my experience with a project proposing the introduction of multidisciplinary Balint groups as a pilot-scheme within the Paediatric Intensive Care Unit of a Children's Hospital, which proved difficult to carry out. As a preliminary stage I had interviewed 62 (of a potential 68) of the clinical staff about their feelings and concerns at work using a semi-structured format informed by Samuel's "Eye Group Interview Schedule"[1]. The staff included were nurses, consultant anaesthetists, and professionals allied to medicine - physiotherapists, pharmacists, dieticians and the unit's technician. I then produced a report for them that discussed linked themes that emerged and also offered some comments and suggestions as to how their ideas might be taken forward.

Throughout the project I had kept a diary documenting my thoughts and counter-transference feelings. From my experience came an incentive to explore psychoanalytic theory about thinking and its facilitation, as well as some of the existing literature referring to studies of unconscious processes involved in clinical hospital work and possibilities for intervention. This formed the basis for the dissertation I submitted for a Master's degree in Psychoanalytic Observational Studies in June. In this short paper I will focus on just one aspect of that study. I will first consider the relationship between the Balint group process and understandings about thinking, and then focus on the relationship of the hospital staff to the concept of multidisciplinary group reflective space. In conclusion I will consider how Balint groups might be introduced more widely into the clinical arena and, specifically, be accepted by the multidisciplinary teams of the Clinical Governance framework within hospitals.

Thinking and the Balint group process

When working well, the Balint group process aligns very closely with the understanding of thinking and its facilitation developed from psychoanalytic theory. Thinking, in this sense, concerns the effort to gain emotional knowledge in relationship with others. Group members tolerate increased tension[2] between group sessions and use the group time to relieve this, "playing" with ideas both subjectively and objectively in a Winnicottian-like transitional space[3]. A therapeutic alliance is formed to consider the clinical relationship experience and seek understanding, with the aim of moving from unconscious defensive behaviour to using, in Main's phrase[4]:

> "elastic, bespoke defences tailored for each case and each [clinician]."

The sharing of this activity increases group cohesion and mutual understanding as well as understanding of ourselves and our responses in relationships. Hinshelwood describes this as a "reflective space"[5], similar to Bion's concept of "maternal reverie"[6] providing[5]:

> "a container in which the members' experiences can be formed, reflected upon, and more or less protected from attack."

The work of the leader is fundamental to the successful development of thinking in a Balint group. Balint originally described the function of his groups as for "Research-cum-Training", similar to action research, but stressed the importance of the training being derived from the experience rather than from didactic teaching. Gosling noted that[7]:

> "as a result of a traditional post-graduate course a doctor was inclined to go back to work considerably impressed by the sagacity of the lecturer but also uncomfortably oppressed by a sense of his own ineptitude".

A leader perceived as omnipotent would tend to constrict thinking, whereas[7]:

> "the growth of one's own awareness and confidence to use it depends upon renouncing to some extent the belief that one can gain it by looking to someone else; the importance of this other person has in some way to be diminished in one's mind. ... Freedom to think for oneself always requires a struggle, but the struggle may be easier if the leader is more interested in the process of struggling than in whether what is arrived at is something that they approve of or not."

An exceptional commitment is required to keep working and Gosling describes[7]:

> "Balint's relentless encouragement of the group members to explore further the predicaments they found themselves in without recourse to premature closure for the sake of their peace of mind, and his refusal to take over when things got difficult or to offer spurious reassurances".

The leader offers containment and tolerance of uncomfortable emotions, while maintaining the work focus on the relationship with the patient, so that the initially raw expressions of feeling can be re-ingested in a semi-digested form gradually approximating more closely to objectivity. Elder has argued for the necessity of a Balint group experience in order for a doctor[8]:

> "to be both experiencing and using his own emotional world at the time of the consultation."

Currently there is great emphasis on practicing 'evidence-based medicine'. I think we must take into account the abundant evidence that clinicians have subjective responses connected with their

work role and study these, so that the knowledge gained can be used.

Discussion: responses of the staff to the concept of multidisciplinary group reflective space

I want to stress that the Paediatric Intensive Care Unit and the hospital functioned effectively to achieve their primary task much of the time. However, it was clear that there were many anxieties, both for the staff on the unit and for the hospital management, which were contained by defensive working structures that themselves caused problems. The concept of how healthy or unhealthy the situation was, is less helpful than consideration of the different pulls and pressures on the staff to protect or to defend against or project anxieties. The hospital's senior management maintained a somewhat distant position from the unit staff, neither intervening nor offering support to any great extent, and in this way contained some of their own anxiety. Under an onslaught of rising expectations from the wider society, a somewhat unsatisfactory and precarious equilibrium was being maintained. But the problems were thrown into focus at times of conflict.

I had suggested the project at the same time as it was felt that action was needed to improve inter-professional communication, both in response to an audit and - separately - to a parent's complaint. However there was a tension for the hospital management between the project concept of action research and a preoccupation both of theirs and the funding bodies with measuring outcomes. The senior managers wished to tie the project down, changing its title to focus on communication awareness, reducing the association with psychoanalytic ideas. Uncertainty, and the conflict between trusting the process and taking control, seemed to be managed by securing my commitment without making any financial commitments[IX]. It also felt as if I needed to supply proof of the outcome before starting, like a fundraiser being employed on condition of raising at least four times her salary. The Balint concept of professional development through thinking together as an exploratory, experimental process with intrinsic validity, seemed beyond understanding or contemplation.

Of the clinical staff, some of the nurses expressed considerable uncertainty about multidisciplinary meetings. The uni-professional group, or mother profession, was part of their identity and anonymity as a nurse among nurses would be reduced when identifiable as a nurse within a multidisciplinary group. They voiced particular concerns about the doctors, and their sense of cohesion seemed to come in part from identification in opposition to them as a common adversary. Few made space to consider the position of doctors, and why they might behave in particular ways that were found difficult; it seemed that the nurses own aggressive feelings had to be projected. In parallel, the consultant anaesthetists as a group seemed to have absorbed this projective identification and were the most aggressive and suspicious about the idea of groups. Several seemed to feel that multidisciplinary meetings would not only be unhelpful but also have negative consequences.

Why did the idea of thinking together feel so difficult? It seemed to challenge both omnipotent and persecutory phantasies, which would require anxiety-provoking readjustment of their internal worlds.

"Meetings may be avoided in order unconsciously to preserve self-idealisation based on projection".

The caring professional self is phantasised as all-giver; any needy aspect is disavowed by projective identification onto others who are seen as demanding. There seemed an idealised stance in both the nurses' and the consultants' considerable resistance against acknowledging the extent of the mutual dependence of the professions. Bion[10] described a dilemma for the individual in relationship to the group when effective co-operation to fulfil tasks must be established. Lack of dialogue frustrates the possibility of change and development but evasion and defence by splitting affords relief from the anxieties aroused in trying to contain conflicts. A culture of managing anxiety rather than reflecting upon it had developed and vitality had been lost.

Another problem raised was the issue of timing. A typical comment was:

> *"There mightn't be anything to discuss. Then when we need to discuss something it won't be the group time and it will be too late once it is."*

Bion[6] discussed the capacity for positive abstraction; that is a belief in a satisfying object that can and does give what is wanted. These staff lacked this capacity, their comments demonstrate that rather than a good object, absent at times, their phantasy is of a frustrating bad object[11], of a Balint group that would take time rather than offer an opportunity. Focusing for a time and then letting go will be unbearable without sufficient experience of having been held in mind during periods of absence. The unconscious desire not to let go inhibits engagement in the first place so that time cannot be used and is, in this way, wasted.

I have tried to weigh up the evidence indicating obstructions to thinking and that suggesting potential for thinking with others and acting upon these thoughts, that is for action research, in the unit.

The interview process went some way towards exploring the sources of shared and different anxieties of professional groups as well as towards helping the staff in their self-observation. They had keenly volunteered to talk to me individually pleased to be given the opportunity to express their opinions and several commenting that they felt unburdened afterwards. Some wished to think about the possibilities for

developing ways to work together more effectively and satisfyingly and some changes in the working of the unit occurred while I was there. The structure of the unit meeting changed, which was experienced positively and one nurse who told me about this thought it had occurred as a result of discussions prompted by the interviews.

The discussion following my presentation of their report demonstrated that the staff who attended had the potential to use a reflective space[5]:

"The capacity to link emotion to emotion, and thereby member to member".

However the enormous anxiety they contained was demonstrated by their inability to end the meeting properly. They acted on need by getting up to leave rather than thinking about ways of attending to their concerns, particularly by acknowledging one another and expressing the mutual appreciation of expertise in the unit they had individually described to me, or of ways to take the process any further. Responsibility for change was dealt with by projective identification which I absorbed, worrying that I had not done enough. I also felt there was some envy of my position - my ability to come and go, to observe and think - which was shown by a lack of acknowledgement of my work on the report. The opportunity to establish ongoing multidisciplinary groups has been relinquished in order to retain the relative cohesion of their social defence system[7].

Conclusion

There are many conclusions in the existing literature on working with staff in the caring professions substantiating the benefits of support systems and of an external facilitator, (e.g.[13]) but the staff's ownership of such structures is essential for these to be of value. This raises a question: about how realistic proactive preventative work can be. At present the hospital's management structure largely responds with interventions to crises. If a crisis is helpfully contained this is likely to engender some increased sense of security that someone can be called on for help; the potential presence of a good object. However, endeavours to attend to psychological motivation often arouse anxiety and are rejected. Each step, therefore, needs to demonstrate attentiveness, responsiveness and reliability to engender trust. Whitaker stressed the importance of paying attention to the feedback from an organisation in response to initiatives[14]:

"If a person responds to successive failures by trying gain, or more often, or harder, he is at some risk of merely reacting to failure with increased investment of effort. Anyone who continues to do this abandons purposeful behaviour. ... If instead some element of the outcome of each unsuccessful venture enters into the decisions made about the next effort, in such sense as to make another effort more likely, then there can be a reactive self-sustaining sequence not controlled by measuring the success which one's efforts are producing,"

From my experience with this project I think any further work of this sort within the hospital should start with senior management first, be requested, and securely funded. Stokes discusses the necessity for stability and ability to contain ambivalent feelings by the management of organisations, otherwise disorder is expressed individually and interpersonally and replaces[15]:

"a more appropriate and creative struggle with the task of the organization. Unless management includes the management of opportunities for staff to understand these pressures, there will inevitably be an increase in stress at the personal level."

In the present state of feeling under siege, the senior managers are incapable of offering adequate support to attempts by their staff to think, but if supported themselves there might then be potential for ongoing groups, which could continue in a cascade through the hierarchies to reach the new multidisciplinary clinical teams. Additionally those managers, who have a non-clinical background, would gain crucial understanding from the experience of working with clinicians in a group. A culture involving support for management and from management would thus be achieved throughout the Hospital. Additionally those managers, who have a non-clinical background, would gain crucial clinical understanding from the experience of working with clinicians in a group.

An alternative, or parallel, possibility is to introduce Balint groups into the education of health care staff. In order to manage co-operation and conflict, social and emotional skills are required which have to be learned. In my opinion this group learning needs to start early and preferably be multidisciplinary before individuality has been subsumed in a tight identification with the professional group to meet dependency needs. The experience of containment in a student Balint group will also increase the capacity for positive abstraction. Repeated experience, e.g. for trainee anaesthetists and for nurses, technicians and physiotherapists on the paediatric intensive care course, would develop the potential to become observing participants when qualified. It would also provide a foundation of openness to internal as well as external motivating factors and a process of continuous review.

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The Oxford Weekend 2001

By Julie Thompson, Sue-Anne Toh, Jenny Harrington and Dennis Remoundos
(four Cambridge students)

We found out about the weekend through a GP seminar we had at the end of one of our attachments. I'm embarrassed to say that at one point we had no idea what the Balint Society was, nor was it explained to us. Nevertheless, we had an interest in training as GPs and well, let's face it, a weekend in Oxford for £25 is more than reasonable.

On arrival we realised that there weren't just two but four of us from Cambridge who had all been cunningly separated into different groups. After dinner we had our introductory lecture and then headed off for our first group session, still a bit bewildered by the proceedings.

We all came out of our first encounter with a Balint group enlightened. At last we knew why we were here! Everyone recounted a similar order of proceedings. Firstly the words "Who has a case?" were uttered. This was followed by silence, in some cases for ten minutes, which I must say provoked some concern and malaise. Finally, a brave volunteer came forward and so we began. The result was an insight into the dilemmas facing the professional in practice and proof that ten heads really are better than one at tackling complex cases, particularly those where emotions have been invested in the doctor patient relationship.

As the weekend went on, it became clear what a vital role these groups played in forming a support network for the professional. Many of the members spoke of how they had stopped looking at problems, in case the Pandora's box they opened was too difficult to cope with. As medical students we were made to feel very much part of the group and were able to share our thoughts and ideas freely. The experience provided a valuable insight into dealing with the emotional content of the clinical relationship and we have to say that it is reassuring to know that such a resource exists.

Many thanks for the opportunity to join you all in Oxford. We look forward to being involved again in the future.

Oxford Weekend 2001

Book Reviews

A General Practitioner, his Patients and their Feelings by Sotiris Zalidis (2001). Free Association Books, London and New York. Paperback pp 243. £16.95

The work of Sotiris Zalidis will be familiar to members of the Balint Society. He has won the Society's prize essay on several occasions, has talked to the Society and has had many articles published in this Journal. This book includes details of all the projects we have heard about before and much, much more.

The introductory chapters describe Sotiris's career as an intended psychodynamic psychiatrist turning instead to general practice and discuss some theoretical concepts about psychosomatic medicine. The rest of the book is based on the patients Sotiris has seen, grouped in particular project areas such as asthma, herpes zoster and obesity.

I found it quite difficult to get into the book. The pages are dense with fairly small print and some of the early chapters are rather theoretical. Once the cases started, I felt quite differently and, in the second half, found the book difficult to put down.

The book reveals the work of an extraordinary general practitioner, one whose immense knowledge, insight, curiosity and dedication are put entirely at the service of his patients. He epitomises Balint's main thesis that all you have to do is to listen to your patients. *All* you have to do! And just what emotions, what suffering, so many of our patients bear, if we could but bear to hear it ourselves. Reading the book as a doctor in the later years of my career I at times felt uncomfortable, knowing that I cannot bear to hear of my patients' suffering in the way that Sotiris can. As a result I have simply not learnt some of the techniques that Sotiris uses to seemingly amazing effect. I just could not imagine spending the time and effort in playing the squiggle game with Alice, a ten year old with a persistent cough that reflected major family problems, or seeing Simon for numerous sessions about his panic attacks that eventually enabled him to gain enough insight to benefit from formal psychotherapy.

As the title might suggest, this is a book about *a* general practitioner, not the main body of our profession. It is a deeply humbling read. It shows just what the scope of our work *could* be, a very far cry from the vision of our negotiators and the government and for which current vocational training is inadequate and unsuitable.

Paul Sackin

Medicine and Literature by John Salinsky (2001) paperback pp 275. Radcliffe Medical Press Ltd., Oxford.

This book's subtitle is 'The doctor's companion to the classics'. Its chapters offer us, the readers, an invitation to meet or to revisit some famous books which have given the author particular pleasure, and to reflect on their relevance to our professional as well as our personal lives. Most of us will have our own favourite books whose characters and their stories form part of our mental furniture. It is an unusual pleasure and a challenge to compare ours with those of another and to be offered a tempting introduction to some we may not yet have approached and encouragement to reconsider some we had rejected.

But perhaps we have not, to the same degree as has the author, consciously brought these characters and stories with us into the consulting room, to allow them to shed light on some of our encounters there. 'A young woman hopelessly in love with the wrong man will remind me of Anna Karenin; a frightened anorexic little waif makes me think of Fanny Price from *Mansfield Park*; a clever but tormented student could be Joyce's Stephen Dedalus; and the family of three brothers in my practice, of whom the older two are schizophrenic, always make me think of the Karamazov boys'. It seems that recognition of some similarity between a patient or a relative and one of his literary acquaintances can enliven, or render more tolerable, or more understandable, a dull, tiresome or puzzling professional situation.

His enthusiasm is infectious – I am sure the vocational trainees who have been exposed to it in his half-day release course as well as the readers of the quarterly journal *Education for General Practice* (now renamed *Education for Primary Care*) in which these essays first appeared, have gained much from an experience which is now on offer to a wider public.

Most chapters start with a short introduction to the writer to set the scene, followed by a brief canter through the main events of the story, described in delightfully quirky and colourful prose and interspersed with personal comments and reflections on the situation, with occasional quotations from the text.

For example here are two snippets from the chapter on *A Midsummer Night's Dream*

'Oberon, King of the Fairies, and his Queen, Titania, are in the middle of a spot of marital coolness when we meet them. Both of them want possession of 'a little Indian boy' whom Titania has adopted and Oberon fancies as – well, we had better not go into why Oberon fancies him. Let's just say it is a child custody battle without the benefit of social workers.'

'Poor Hermia is on the verge of tears and Lysander observes that 'the course of true love never did run smooth'. One of the pleasures of reading Shakespeare is that you keep stumbling across well-known quotations in their original context and greeting them with little cries of pleasure (well I do anyway).'

And this is from the account of *Bleak House* – describing Mrs Pardiggle 'who likes visiting the poor in order to urge them to wash more often and to read the improving little books she leaves for them. (Since they don't know how to read this is rather pointless.) Esther is taken along to visit a poor brickmaker's family and Dickens seizes his chance to show us what the lives of the poor were really like ... The brick-maker's young wife has a black eye (a blow from her violent husband) and a baby on her lap, As we watch them, the baby dies. This is truly shocking and brings us up with a lurch. In the middle of the gentle satire on ridiculous people, we are given a sudden dose of brutal early-nineteenth-century reality.'

The book also includes a few chapters by guest contributors and 'postscripts' to the author's own chapters, which are in keeping with the main substance of the book. It ends with some suggestions for the use of classic literature in undergraduate and postgraduate teaching. It is encouraging to read that seminars on literature and reading are becoming more common both in medical schools and VTS courses.

Incidentally – the writer of the book happens also to be the editor of the Balint journal. I would like to make it clear that this review was volunteered, not commissioned. Having felt myself to have been both entertained and enriched by the book, I considered that members of the Society who find their work constantly illuminated by patients' stories would be equally appreciative. Possibly this could even make a topic for a future prize essay 'The Doctor, the Patient and the Book'.

Marie Campkin

The International Dictionary of Psychoanalysis (Calman-Levy, Paris, 2002) is edited by Alain de Mijolla with the collaboration of Bernard Golse, Sophie de Mijolla-Mellor and Roger Perron ... and some 460 authors, mainly researchers, from around the world.

Imagine the *synergie* during seven years of gestation! Although inspired by the *Vocabulary of Psychoanalysis* by Laplanche and Pontalis, the *Dictionary* is different in several respects. It describes the history of the movement and its ideas through articles on the institutions, the countries where psychoanalysis is practised, the biographies, the techniques, the events, the schools and associations; and there is also a succinct analysis of the written works. There are 1572 entries presented in alphabetical order and each article reflects and complements others. A bibliography and a glossary for the translations of the ideas into five languages: English, German, Italian, Spanish and Portuguese completes the ensemble. This amounts to a total of 2017 pages, presented in two volumes, enclosed in a beautiful blue and white slip-case, illustrated with a reproduction of a detail of the picture 'Passage au Bleu' by Majera. The book sells at the attractive price of ¤119 (Euros). There is an email address: dicopsy@calmann-levy.fr which you can contact to notify the publishers of any possible errors.

Michael Balint at last gets a deservedly important entry. There is a biographical article by his neice, Judith Dupont, followed by an account of the principal concepts (the basic fault, primary love and regression, benign and malignant) by C Denbigny and, of course, the story of the Balint group (by myself).

Here you will find nearly everything you want to know about psychoanalysis – or at least, a guide to further reading – and it is not closed to doctors.

Michelle Moreau Ricaud

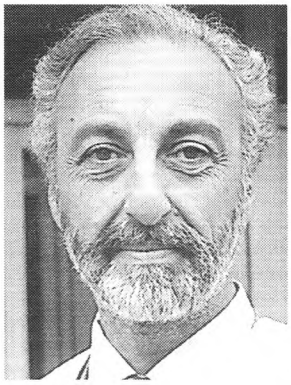
(Michelle Moreau Ricaud is a psychoanalyst in Paris and vice-president of the Quatrième group OPLF. She is a member of the International Association of the History of Psychoanalysis).

Obituaries

Dr Jack Norell 1927-2001

JACK NORELL FRCGP died on the 11th of December 2001 of cancer of the colon.

He was one of the principal architects of the renaissance of British general practice, which began in the 1950s with the founding of the Royal College of General Practitioners. He made significant contributions to raising the standard of care provided by family doctors and to the development of an excellent system of postgraduate education for general practice. He was dedicated to improving understanding of the doctor patient relationship and worked closely with Michael Balint, the psychoanalyst who revolutionised our thinking on this subject.



Jacob Solomon Norell (known as Jack) was born on the 3rd of March 1927. He was educated at South Devon Technical College, served in the RAMC (1945-47) and studied medicine at Guy's Hospital, London, graduating MRCS, LRCP in 1952 and MB BS in 1953. He was married to Brenda Honeywell (1948) and they had three sons. The marriage was dissolved in 1973. He worked as a family doctor in a group practice in North London from 1956 until his retirement in 1990. He became MRCGP in 1972 and was elected FRCGP in 1982.

In the late 1950s he became a member of one of the first of the psychological seminars for GPs run by Michael and Enid Balint and, subsequently known as Balint groups. This was the beginning of Jack's life-long interest in the emotional content of the doctor-patient relationship. After the death of Michael Balint in 1969, he became a founder member of the Balint Society, one of a number of Balint Societies formed across Europe. He was elected president of the Society (1984-87) and subsequently became president of the International Balint Federation (1989-93). In his role as International president and subsequently as 'Ambassador to Eastern Europe' he dedicated himself wholeheartedly to supporting and encouraging Balint work in many countries. He was a frequent visitor to Hungary, Romania, Slovakia, Croatia and Slovenia where he helped many young family doctors and other health workers to understand their patients (and themselves) a little better and to gain more fulfilment from their work.

Here in England, in the 1970s, he helped to set up Vocational Training for general practice and strongly advocated the importance of small group work in the curriculum.

He was appointed Dean of Studies of the Royal College of General Practitioners (1974-81) and was later a council member of the College (1984-91). As Dean, for several years he insisted on taking the College Membership examination himself so that he would know what the candidates were experiencing. He also helped to launch a College initiative called 'What Sort of Doctor' in which a group of colleagues would visit a doctor's practice to carry out a friendly and unthreatening quality evaluation. Visits of this kind have since become the basis of approval of GP training practices and of the College's own 'Fellowship by Assessment'.

Jack was a good writer and speaker. He produced numerous papers on the consultation, postgraduate education, raising the quality of care in general practice and the doctor-patient relationship. He was co-editor with Enid Balint of *Six Minutes for the Patient* (1973). This influential book showed how the experience of being in a Balint group could help family doctors to reach a deep understanding with a patient, in a very brief encounter. In 1984 he gave the Royal College's William Pickles lecture in which he reproached the profession for losing touch with some of its important core values. He was often challenging and controversial in discussion, but was always ready to listen to the opposing point of view. Where matters of principle where concerned, he remained steadfast and his ideas have had a lasting influence on the education of family doctors. He was a striking figure, tall and slim with an aquiline profile and a commanding presence as a speaker. Despite this rather formidable appearance, he had a friendly, engaging smile, he was a good listener and would always put himself out to help a friend or colleague in difficulties. He was a good teacher and always maintained that he learned the most important things from his patients. Sadly, in his later years, he developed a degenerative brain disorder, which cruelly eroded his fine intellect. Despite his difficulties he continued to travel to Balint conferences in continental Europe where he was loved and treasured by his many friends and colleagues. It is good to remember him as was in his prime. He enjoyed long distance motoring, preferably in his yellow open-topped sports car. He thrived on good food, good wine and good company. He loved walking in the country and would often cover immense distances, on his own or with friends. It was always a pleasure and a privilege to walk and talk with Jack.

John Salinsky

Dr Jacques Dufey

President of the International Balint Federation 1984-1989
Born 4 October 1928; died 7 April 2002

Jacques Etienne Dufey was born in Algeria of Swiss parents. He studied medicine at the University of Algiers and from 1948 in Lausanne, Switzerland. He gained experience in medicine, surgery, obstetrics and psychiatry in Swiss hospitals and took his doctorate in medicine in 1963. He was a general practitioner in Villeneuve, Switzerland from 1963 and was elected president of the Swiss Society for Psychosomatic Medicine. He was very active in promoting Balint work within the Society and organised the 6th International Balint Congress in Montreux, Switzerland in 1984.

Remembering Jacques Dufey

By Roger van Laethem, past General Secretary and Treasurer of the International Balint Federation

Jacques was a nice man, loving food, good wine and nice company, always laughing at the jokes of his friends (I think naturally at mine!).

I first met him in 1978 (the year of the 4th International Balint Conference in London) where he represented Switzerland. After long discussion, the Swiss Psychosomatic Society was allowed to join the Federation as a full member; nevertheless, it did not bear the name of "Balint Society".

At that time we called each other "My dear Dufey, my dear van Laethem" but we were very familiar with each other. Why? As the poet J Prevert says: "je dis tu à tous ceux que j'aime, même si je ne les ai vus qu'une seul fois. Je dis tu a tous ceux qui s'aiment, même si ne les connais pas."

Progressively, with the Balint Congresses, the board meetings of the International Balint Federation, the national Balint meetings in France, Switzerland and Belgium, we became good friends, meeting each other with our wives and children in Brussels or in Rennaz.

Then Jacques became President of the Swiss Psychosomatic Society. We organised, with the board of directors, the 6th International Balint Conference at Montreux where Jacques became the third President of the Federation, after Mrs Enid Balint and Dr Pierre Bernachon.

An old document (Berne, October 1985) of Jacques' reminded me of a number of discussions (which did not diminish our friendship) with our English or French friends about *dogmatic* Balintians (close to the psychoanalysts) and *liberal* ones. All those participating in these sometimes passionate discussions will certainly remember them.

During the bi-annual meeting of the Federation in October 1985 in Zurich, he took out a part of this opening speech from the Balint Congress in Montreux.

> *This 6th International Congress marks perhaps the passage to the "after" Balint. Dear Madame Balint, I know you will not misunderstand the meaning of my words and I can assure you we like you enough, to hope to have you among us again for the 7th Congress. But we are adults and must know how to face the future alone. In most of the countries that we represent, the future will not be easy for the medical profession. Certain pessimists, one of which I am not, believe that the fight for survival in the economic sphere will be stronger than our desire to understand and help our patients in a human fashion, respecting their entire personality. This desire, which is one of the reasons that motivates our presence here during these three days, we have been able to realize, more or less well up to now, by imbuing ourselves with this certain something, always so difficult to define: it's not a method, still less a technique, it's not an instruction, but it is learned as much with time and sensibility as with intelligence ...of course—it's BALINT.*

These sentences show the rigour of Jacques but also his sense of nuance, his concerns for the future of Balint and his fear, (sometimes expressed) of a break between general practioners and psychoanalysts.

A passage from another speech that he made in Ascona in March 1986 shows us his realism and the awareness he had of the difficulties still existing in the development of Balint in the world.

> *In Montreux in 1984, when you chose me as President of the International Balint Federation, I tried to learn a lot about the work of Balint, his essential theories and his activities in the world. I brought several people together, who met each other in Paris and Berne. We reached the conclusion that <u>even if we had the will</u>, we could not impose absolute Balint criteria in all the different countries. We had to take into account <u>the cultural differences</u> and especially the different conditions of medical practice. That does not mean to devalue the originality of <u>common</u> research between doctors and analysts. A month ago, I received a letter from Enid Balint saying in a few words some*

essential things: the analysts left something that will never be lost, the possibility to listen and to hear the UNEXPECTED, as well from us as from our patients.

In May 1986 we met each other with Mrs Balint and the Hungarian authorities to unveil a commemorative plaque on the house where Balint created his first Balint Group and where the first Hungarian Society of Psychoanalysts met. What recognition for a Communist country! I remember it was raining cats and dogs!

Also in October 1986 I met Jacques during the meeting of the International Balint Federation in Brussels. We went with him to our great new art museum, the Horta House. After that he told me that he had some apprehensions about our discussion concerning the present and the future of the Balint Group but the atmosphere was so relaxed and friendly that he never spoke publicly about his apprehensions.

Jacques was also concerned about research. He wondered: "May we consider that the expression 'training-cum-research' still makes sense and does it have a future?" (Ascona, March 1988). He constantly raised "the idea of an international meeting at a small level between general practitioners, psychiatrists and psychoanalysts to take stock of our mutual connections in the different countries." Many of the points he made in his speeches as President are still important.

In May 1998 we met at his home in Praz Riond in Switzerland at the end of his career as a general practioner. We spent lovely hours together, particularly in the restaurant of the son of Hans le Montagnard. In 1984 we had already spent a nice time together with Canadian and Filipino friends during the conference in Montreux. In October 2000, during the Conference in Paris "Vieux garde et nouvelle vague" (organised by our dear friend Dr Marie-Anne Puel) I found him not so well but I never imagined it would be the last time I saw him.

Farewell Jacques, my old and dear friend, see you in another life.

ROGER.

Heide Otten (current International President) with Jacques Dufey at Oxford 1998.

Dr Arthur Trenkel, psychiatrist and Swiss colleague also remembered Jacques Dufey in an obituary published in the Swiss Medical Bulletin and the Balint-Journal of the German Balint Society. We reprint the following extracts:

In 1979, Jacques Dufey was the first general practitioner to be elected president of the Swiss Society for Psychosomatic Medicine. Despite the challenges inherent in such a role, he mastered it with growing conviction. Beside his ability to speak a multitude of languages, his natural gift for sharing his daily experiences in a clear and understandable way helped him in this task. He spoke with great awareness of life and the simple intention to reach his listeners. When speaking with specialists he sought primarily an authentic connection, without any attempt to impress. In this way, the Balint group became his forum for exploring the different perspectives and experiences involved in an evolving discipline that placed the patient at its centre.

His voice also found resonance in wider circles. He organised the International Balint

Congress in Montreux in 1984 and was elected president of the International Balint Federation, continuing in office until the next Congress in Stockholm in 1989. He remained part of the International Balint Federation and continued to play a part in several national societies as well as helping to run the French-Swiss seminars in Annecy as he had done since 1984.

In the autumn of last year, I saw my long-time colleague and friend for the last time at a weekend seminar in Genf. He was already suffering from the illness that would lead to his death. He will stay alive in our memories.

Arthur Trenkel, Massagno

Professor Muradif Kulenović

Born 4 August 1937 – died September 2000

Muradif Kulenović was born in Bosnia. His family moved to Zagreb very soon after his birth. He finished his elementary school, high school and medical edication in Zagreb. After specialising in psychiatry and neurology he worked at the Hospital for Psychiatry in Popovaca and the Vrapce University Psychiatric Hospital in Zagreb. In 1971 he was invited to join the Centre for Mental Health of the Clinical Hospital Centre Rebro in Zagreb. In 1986 he became its president. In 1988 he established the Clinic for Psychological Medicine and was its president until 1995, when he retired because of his illness. At the same time Prof. Kulenović was teaching at the Department of Psychological Medicine at the Medical School, University of Zagreb. He won his master's degree and then his doctorate, advancing from assistant lecturer to professor. He was a member of the Academy of Medical Sciences of Croatia in Zagreb.

From 1986 he was the main editor of the journal *Psihoterapija*. Together with numerous scientific and research papers he was the co-author of 15 books. He was the founder, co-ordinator and general manager of international schools for psychoanalysis and psychiatry in Dubrovnik and the School of Balint Method which is today named after him.

After his stay at the Tavistock Clinic in London in 1983 he gathered a group of family practitioners from the Medical Centre 'Tresnjevka' in Zagreb and started working in a Balint group. The group called itself 'Tresnjevka 83 – an experiment in therapeutic relationship'. This group still exists and is meeting regularly. The group developed into the Croatian Association of Balint Groups. Its inaugural meeting was held on April 29, 1989 and Professor Kulenović was elected president which function he kept until his last day of life. As a president he encouraged professional work and reseach as well as spreading the Balint method, mainly among family practitioners but also among other related professions. He describes it himself: 'When some thought, idea or teaching is beginning to apply and when it acquires followers and starts spreading round the world, reaching various environments and various cultures it is inevitable that it goes through modifications in its applications and even diversions in its theoretical orientation. For me personally, the Balint group is the most valuable and important method. In the world of developed and highly humanized social relations the need for psychological understanding is becoming an essential requirement.'

Professor Kulenović was a teacher and a leader who trained his pupils in the Balint method, and encouraged an enthusiasm for Balint in his pupils as well as helping them to become aware of the unconscious component in the patient-medical professional relationship.

Sometimes it was very hard working with him, but nevertheless, and above all, it was useful and beautiful.

Sanja Blazeković-Milaković
President of the Croatian
Balint Association

Secretary's Report 2001-2002

The year began with the Oxford Weekend at Exeter College from September 14th to 16th 2001. 40 delegates were present. These included one nurse and six medical students. Four of the medical students were from Cambridge Medical School. There, the undergraduate curriculum includes one afternoon of Balint experience, led by Drs Pat Tate and David Brodie. The meeting began with a rousing keynote address from Dr Katrin Fjeldsted from Iceland, a Balint friend for many years following her trainee year with Dr John Salinsky. There were four successful groups, which met through the weekend. On Saturday we again had a short paper session with papers given by Polly Blacker, David Kirby and Sotiris Zalidis. Unfortunately, as with many such sessions, time over ran and we will try to be more careful next year. On Sunday at noon the AGM of the Society took place. It voted to abolish associate membership of the society, allowing anyone in ongoing one-to-one client work to become a full member, but deciding to issue Certificates of Basic Balint Training (CBBT) to any member who has completed the original membership criteria of 30 hours in Balint groups, led by accredited leaders. These certificates are still in preparation.

The lecture series at the RCGP began on October 23rd 2001 with a lecture from Dr Nick Temple of the Tavistock Clinic. He spoke eloquently on "Psychosomatic Illness: A Defence Against Feeling". On November 20th, past president of the RCGP, Dr John Horder, who had been a member of one the Balints' earliest groups, spoke about his experiences and his evaluation of their contribution to general practice and the College. The third lecture on February 19th 2002, was by Dr David Bell, again of the Tavistock Clinic and leader of the only Balint group currently running there. He gave an analysis, with video extracts, of the TV series "The Singing Detective", an example of art melded with psychoanalysis. On March 19th Dr Linden West, a medical sociologist and psychotherapist, spoke on the stress felt by doctors in the Inner City as discussed in his book "Doctors on the Edge" which was reviewed last year in this journal. The last meeting, on May 23rd 2002 was very interactive, with a creative writing lecture/demonstration involving us all, led by Gillie Bolton from Sheffield. We were all keen to participate in showing how creative writing can mirror the self-exploration which may take place in Balint groups. Dr Bolton's creative writing groups seemed to have many things in common with our work.

The Group Leaders' Workshop continued to meet during the year at the Tavistock Clinic, organised by Dr Peter Graham, and led by the Society's president. This is an important institution for the promulgation of Balint group leadership skills and we are keen to keep it very active.

On May 9th the Society repeated its Balint morning at Newham General Hospital, a District General Hospital in the East End of London. About 40 doctors and nurses from all grades met in three groups to explore a few cases. The academic leaders at the hospital are keen to try to set up something more ongoing and we continue in discussion about this.

The weekend of May 11th-13th saw the second Chester weekend, led by Dr Caroline Palmer and Dr Marie Campkin. There was one group of ten but all are keen for the weekend in Cheshire to continue.

Lastly, the Annual Dinner took place on June 26th at the Royal Society of Medicine, with 21 diners listening to an after dinner speech by Dr Peter Bruggen, a retired child and adolescent psychiatrist, who spoke about many things and left a rich but fulfilling aftertaste.

During the year many of the officers and council travelled the world to conferences and meetings in other countries such as the USA, France, Sweden, Croatia and Slovenia, taking the English way of doing Balint work with them, and bringing back friends and new ideas. There was also a Balint demonstration at the WONCA conference in London, co-led by John Salinsky and Amy Ellwood from Las Vegas, USA. The International Federation Council will be meeting in Oxford this September, which is another reason why I look forward to the coming Oxford Weekend from September 20th to 22nd 2002.

David Watt

The International Balint Federation

The International Federation Council continues to meet twice a year. Each country which has a Balint Society (or an organisation which embraces Balint) can send representatives to the meeting and over the years we all become great friends. Fortunately for the Brits, our discussions are in English, which everyone else speaks with astonishing ease. What do we talk about at these meetings? Well, we exchange news of Balint activities in our different countries and we try to help each with the common problems which preoccupy those who try to run Balint Societies. These include how to attract more members; how to train and accredit group leaders; how to get recognition from those in charge of medical education. And, above all, how to encourage more people to join Balint groups! If a national Balint Society is newly formed or even aspiring to be formed, the delegates from the older Societies can give advice and encouragement.

The other very important thing that we do is to plan and organise International Congresses. These began in 1972 in London and were first held every two years in a different European city. Then there was a lull in the late 80s and early 90s when no-one seemed willing to volunteer to undergo the anxieties involved in putting on a large international meeting. There were long gaps between Montreux, Switzerland (1984) and Stockholm, Sweden (1989) and Zagreb, Croatia (1993). But then we went to Charleston, South Carolina, USA in 1994, Budapest, Hungary for Michael Balint's 100th birthday in 1996, Oxford, England in 1998 (remember that one?) and, most recently, Portoroz, Slovenia in 2001.

Next year, 2003, there will be not one but TWO opportunities to be present at colourful, exciting International Balint Conferences. The first will be in the picturesque little town of Miercurea-Ciuc (which means 'market day is on Wednesday') in **ROMANIA**. The **Romanian Balint Society** will be holding its **10th Anniversary Conference** there from the **1st to the 4th of May 2003**. The price, including transport from Bucharest airport, all meals, accommodation and excursions will be a very reasonable £250. And your significant special person can come along to enjoy the scenery for a mere £150. Those of us who have been before will testify to the warm hospitality of the Romanian Balint Society. Full details are available from Dr Albert Veress email:averess@nextra.ro

Postal address: Cry for Help Foundation, PO Box 75, RO- 4100, Miercurea-Ciuc, Romania. Tel: 40 94 812900. Fax: 40 66 171688.

THEN in the Autumn comes the **13th International Balint Congress**, the big one, which will be hosted by the **German Balint Society** and held **in BERLIN from the 1st to the 5th of October 2003**. The theme of the Congress will be 'The doctor, the patient and their well-being, world-wide' and it will be held in a historic building called the Kaiserin-Friedrich-Stiftung in the heart of the city. There will be keynote speakers, opportunities to hear about and discuss the latest Balint evaluation research and of course, Balint groups in any language you like (including English which will be the official language of the plenary sessions). The price of this one? £250 for the conference and all your meals. Hotel accommodation will be extra but not expensive. Students will be especially welcome at a greatly reduced price.

Details and application forms are available on the Congress website: www.Internationalbalintcongress.de. Or simply get in touch with me (JVSalinsky@aol.com)

I shall definitely be going to both meetings. I hope to see you there too!

John Salinsky, General Secretary,
International Balint Federation

The 12th International Balint Congress

Portoroz, Slovenia 2001

SETTING THE SCENE

THE 12th International Balint Congress was held from 3-7 October 2001 in the Metropol Conference Centre, Portoroz, Slovenia. Portoroz is a seaside town which lies on the side of a small peninsula on Slovenia's brief stretch of Adriatic coastline. It is a popular holiday resort with plenty of large hotels but it retains a good deal of its natural beauty. The seafront and yacht marina are surrounded by green hills, thick with all sorts of trees including some lovely cypresses. Modest houses are scattered thinly over the treescape. In the town itself there are some elegant older buildings, most notably the old Palace Hotel which is awaiting restoration and looks like a grand old lady who has seen better days. The modern hotels are mostly inoffensive, rising to about 8 stories with cheerful red tiled roofs. The Metropol, sits on a little hill surrounded by its sister hotels. It is big, round and fat with a revolving Casino sign on the top. It has no architectural merit but at least it is easy to find your way back to. Its conference facilities are excellent, the bedrooms are comfortable and from the spacious balconies there are superb views of Portoroz.

A few kilometres along the coast, at the tip of the peninsula is the gorgeous old Venetian town of Piran, an ideal place for an excursion or a meal of fresh seafood. Piran consists of a wedge shaped huddle of ancient houses with orange roof tiles. At the top of the hill is the impressive basilica of St George (dating from the 5th Century) with its campanile, modelled on the one in the Piazza San Marco in Venice. Down in the town centre, Piran has its own lovely oval piazza presided over by the statue of Giuseppe Tartini, the 18th Century composer who was born here and is portrayed carrying his violin and bow. Delicious little streets wander between the houses; each turning reveals a beguiling view, while appetising smells drift from the many restaurants. After a leisurely lunch, it is only a few steps down to the harbour where a little boat will take you back to Portoroz in 20 minutes.

As a result of the terrible disaster in the USA on September 11th and the subsequent suspension of services by Swissair, a substantial number of people were unable to travel to the Congress. Nevertheless, a total of 75 delegates managed to attend. There were 20 people from Slovenia, 10 from the UK, 7 from Israel, 5 each from Croatia, Germany, Romania and Sweden, 4 from Finland and one or two from Austria, Belgium, Czech Republic, Denmark, France, Holland, Hungary, Italy and Portugal. 17 countries were represented altogether.

This Congress was the International Balint Federation's first major event since the 11th Congress in Oxford, England in 1998. Many of the people who came to Portoroz had happy memories of Oxford and were looking forward to meeting their friends from other countries once again. The papers and discussion also formed a natural continuation of the ideas and reflections of three years ago. The theme of the 12th Congress was 'Balint after Balint' and the middle day (Thursday) was set aside for the 2nd Slovene Balint Day. On the other days the official language of the Congress was English. The morning session on each day consisted of papers followed by discussion in the lecture room. After a break for lunch and afternoon recreation, everyone had the opportunity to take part in a Balint group which met on each of the three days. On the last day (Saturday) there was also a final plenary session.

First evening: Wednesday

The Congress began with a welcome party in which delegates were invited to sample some unusual aperitifs, invented by champion cocktail mixer Alex Ogrin. Then we assembled in the lecture room which was to be our academic base for the next three days to listen to the opening speeches. Dr Zlata Kralj, the organiser of the 12th Congress (Slovenia) formally welcomed everyone to the Congress and to Slovenia. Our new president, Dr Heide Otten (Germany) said some things about Balint and expressed her confidence that we would all do some good and enjoyable work together. Finally, Prof. Dr Vojka Stula, Mayor of the Community of Piran welcome everybody and expressed her appreciation of the importance of doctors and patients talking together as human beings.

Thursday morning: first session

Dr Rubida from the Slovenian Ministry of Health gave a short speech of welcome and said that good doctor-patient communication led to good clinical outcomes. Zlata Kralj then read a paper by Prof Boris Luban-Plozza (Switzerland), the honorary president of the Congress, who had unfortunately been unable to come because of the grounding of all Swissair flights. In his paper, Boris recalled Michael Balint telling him: 'There is no need to know everything, but you must use your own mind.' The Balint method had enabled us to establish a very quick meeting of minds with the patient which eased formality and permitted greater openness.

The next paper was given by Prof Ernst Petzold (Germany) who also chaired this first session of the morning. Ernst's paper was entitled 'Our Track to the Milky Way'. Using the idea of the Milky Way as a bridge ('not a chocolate bar') he described the ways in which Balint work could make links between psyche and soma, between general practice and psychoanalysis and between

disease orientated and patient –centred research.

Next, Dr Kornelia Bobay (Hungary) spoke about 'The Balint group as an antidote to professional and human alienation'. She told us about two multidisciplinary Balint groups in which she had taken part. In one, a village priest was able to help the GP and the specialist to understand their relationships with the patient better. In the other group, a GP presented a patient who was recognised by two specialists in the group and the discussion led to the disappearance of all their stereotyped views of the patient and each other

Dr John Salinsky (UK) described an unwilling home visit to an old lady who told him the story of her life. The story was better than he had expected; and listening to it transformed his attitude to the patient.

The next two papers were by doctors from Israel. Professor Benyamin Maoz gave an absorbing account of Balint work in his country. A number of factors were contributing to increased professional stress for doctors and many were feeling threatened by burnout and, sadly, counting the days to retirement.

Balint groups provided an atmosphere of listening and tolerance in which they could talk about their relationships with their patients and their colleagues and also about their personal emotional difficulties. He reminded us that patients and doctors both need to be allowed to tell their stories. In another paper from Beersheva, Dr Amir Mandel gave a progress report on his group's evaluation of the effectiveness of Balint groups for primary care physicians and for residents. Preliminary results showed no real change in the way they take care of their patients (perhaps they were unwilling to admit that they ever made mistakes). But 80% reported a change for the better in their feelings about their patients and their work as a result of their participation in the groups. Dr Mandel's final message was that you need at least two years in a group to achieve some change: and it's better to start early because some older doctors may be beyond help

The papers were followed by some discussion in which the main themes were doctor-centred *versus* patient centred groups, the training of leaders (by apprenticeship) and the specific problems of residents/trainees ('teenage doctors').

Thursday morning: second session

After a coffee break and a chat we returned to the lecture room for the second session of papers, chaired by Dr Igor Praznik (Slovenia). Professor G Martignoni (Switzerland) was unable to be present and so his lecture, 'Memories of the body' was read by Dr Ursa Mrevlje (Slovenia). He saw the body as 'a great book' in which everything about the person is written in a psychosomatic language. The difficulty we have today is in understanding the different voices and signs in which these messages reach us. He recalled the story of Rabbi Loew of Prague who breathed life into a clay man (the 'golem') which got out of control and became alarmingly destructive. Today we can prolong life and clone new lives in the laboratory but we still need a better understanding of the links between body, mind and environment.

The next presentation was by Dr Sanja Blazekovic-Milakovic (Croatia). Her paper was entitled: 'The psychosomatic approach in general/family practice'. She described a study which compared the outcome for two groups of patients: one treated by conventional medical methods and other with a psychosomatic approach. The psychosomatic treatment group showed a significant improvement in both somatic symptoms and emotional well being compared to the control group. Although patients with psychosomatic symptoms expect a specific organic diagnosis they also need help to understand the psychological origin of their illness.

Dr Michel Delbrouck (Belgium) gave a psychoanalytical account of the causes and ways of preventing child abuse, illustrated by computer slides of various paintings, including work from ancient Babylon and from the painter Klimt. When the child's internal world is attacked or even destroyed by abuse, especially from his father, he needs support from an alternative external father figure. This figure, who is often the doctor, has the task of providing another model of good child care; he must also be aware of the shame experienced by victims of child abuse. One of his tasks is, through his own sexual maturity, to reframe for the patient that adult sexuality is not necessarily directed towards the child. He needs to work with the parents and show that he appreciates the efforts toward good parenting that they have been able to make

Polly Blacker (psychotherapist, UK) then gave an account of her proposal to provide a multidisciplinary Balint group for the staff of a hospital paediatric intensive care unit. She interviewed a large number of managers, nurses and doctors to explore their views about devoting a regular 'space' to talking in a Balint group about the emotional aspects of their work together. There was considerable resistance to the idea, mainly because each professional group tended to project their own needy feelings on to the others who were seen as unhelpful or demanding. She concluded that it might be more productive to work with the senior managers in the first instance, or, alternatively, to introduce the Balint at an earlier stage, during professional education.

Finally, Dr Stanislava Stojanovic-Spehar (Croatia) described a case in which a multidisciplinary team had great difficulty with a broken family and a physically abused 7 year old boy. She described a number of misunderstandings between family members and team members. Participation in a Balint group helped everyone to reach a better understanding in

psychodynamic terms.

The session of papers was followed by a tasting of health food preparations. We also had the opportunity to look at the posters which were displayed in the foyer. These included presentations on 'Balint groups for trainees in psychiatry' (Drs Neilsen and Thorgaard, Denmark) 'The iatrogenic patient' (Dr S. Supe and colleagues, Croatia) and 'Determinism and liberty in Balint groups' (Dr Anté Gilic, Croatia).

Friday: 2nd Slovene Balint Day Excursions

As an alternative to the Slovenian papers, the non-Slovenian speakers were provided with opportunities to see more of the region's attractions. One group went on a coach to the spectacular caves of Skocan. Another party went on a guided tour of Piran followed by a visit to a winery where they were able to taste some of the excellent local produce.

Saturday morning: first session

The morning started with a talk on the Slovenian lace making school of Idrija. Ms Metka Tratnik gave a fascinating talk about how the lace is made, illustrated with some beautiful photographic illustrations. Later on, in the foyer we were able to examine the real lace for ourselves. Lace making involves application, the ability of people to work together and the weaving together of many different threads to form an interconnected and meaningful pattern of relationships. The comparison with Balint work comes readily to mind and this was the reason why the organisers had chosen a traditional Idrijan lace pattern as the symbol of the Congress.

Then the first morning session of papers began, with Dr John Salinsky (UK) as moderator. The research and evaluation theme was resumed by Dr Chris Mace (UK) who described the work of his team in examining the structure and process of current Balint groups in the UK. He noted that groups for established practitioners tended to be more traditional, concentrating on the doctor-patient relationship and more often having a psychoanalytic psychotherapist as a leader. Groups for trainees, on the other hand were more likely to be led by GPs and to include discussion of other matters of professional concern to the members

Next, Dr Ioan Bradu Iamandescu (Romania) spoke about patients with severe drug allergy syndrome. He told us that the fear of further exposure to the allergen could, in some patients, result in a psychosomatic syndrome very similar to the genuine immunological reaction. He suggested that the Balint group might be useful in helping these patients, their families and their physicians to understand the phenomenon better.

This was followed by a paper from Dr Dorte Kjelmand (Sweden) who returned to the question: 'Do GPs benefit from Balint group participation?' She told us about the continuation of the work which she first described in Oxford in 1998. She has now completed an evaluation of the attitudes of a group of 26 GPs who had been in a Balint group for more than a year, compared with a control group (also 26) who had never had this opportunity. She had used both quantitative and qualitative methods in the questionnaire .On a number of outcome measures, including feeling in control of the work situation, awareness of feelings and a more positive attitude to somatising patients the Balint trained GPs scored significantly better. They were also more likely to be 'holistic' in their approach.

The next speaker was Dr Stanislava Stojanovic-Spehar (Croatia) who told us the story of a young woman patient who was very socially withdrawn and unhappy. Over a period of years, and with the help of her Balint group, Stanislava was able to do therapeutic work with the patient which enabled her to overcome her difficulties and find fulfilment in a personal relationship.

Dr Ena Grbic (Croatia) described her personal experiences of participating in Balint groups. It was clear that the leadership and culture of the group were crucial in determining whether the members found it supportive and helpful. Ena had been put off by her first group which spent too much time analysing the doctors themselves. Later in her career, she sought the help of another group with a very difficult and frustrating patient. This group provided the space she needed in which to learn about her relationship with the patient without too much 'dissecting of the soul and probing of guilt'.

The final paper in this session was given by Dr Ari Lauden (Israel). He described a compulsory Balint orientated course for students called 'Emotional Processing'. The students had 8-10 sessions in small groups in which they discussed their emotional experiences in the wards under the guidance of one or more group leaders. The subjects raised included helplessness, levels of emotional connection with patients, anger and frustration, conflicts of loyalty and dealing with death and dying. There was evidence that the students appreciated the group experience and found it useful.

Saturday morning: second session

The second session was chaired by Dr Heide Otten (Germany). We began with Dr Anita Häggmark (Sweden) who presented a follow up of her report to the Oxford Congress on the Balint group leader training in Sweden. The program enables GPs, nurses, psychologists and psychotherapists to train together. The course runs one day a month for two years and it consists of lecture/seminars, group sessions and supervision. This year nine leaders have graduated and the evaluation has been very positive. The course will continue in 2002.

Next, Dr Jean Gillis (Belgium) told us about the Belgian 'Group Post-Balint' which has been running successfully for 20 years. All the participants are Balint veterans and some, but not all, are group leaders. In the group, members take

turns at leading as often as they want to. The presence of at least one psychoanalysed member maintains 'psychoanalytical listening'. The group has been used for leader training and research as well as a forum for members to discuss their cases with old friends.

After hearing about the joys of senior Balint work we were treated to two excellent contributions from students. Monika Pixius from Aachen, Germany, told us about the anamnesis groups at her medical school through which students were able to get to know patients better and to see each patient as a whole person. Then Mojka Böhm (Ljubljana, Slovenia) described how she and her fellow students worked in groups of six with a mentor. Each student was asked to a patient to visit at home and report back to the group. She found the experience of the home visit rather daunting at first. However she was welcomed by the patient (who had suffered a stroke) and his wife and she soon began to appreciate the problems of both of them and to understand more about their relationship.

These words of appreciation from the students brought the final session of papers to a close on a very hopeful note.

The small group meetings

The Balint groups met each evening at 4.30 or 5.00 p.m. There were five groups and all were conducted in English as there proved to be insufficient numbers to support a group in any other language. This was fine for native English speakers but posed a considerable challenge to many of the delegates and I am full of admiration for their bravery and perseverance in overcoming the language barrier and making themselves understood. My group had members from at least nine different countries. Our first patient was an unhappy lady who had been summarily divorced by her husband. She seemed to have no life of her own except for her frequent visits to the surgery. She was very grateful for the doctor's efforts to help her and embarrassed him by kissing his hand .The second patient was a man who insisted on sprinkling the consulting room (and the doctor) with holy water before starting to describe his problem. Finally we had a patient tormented by psychosomatic digestive symptoms and depression who seemed impossible to understand and yet... through the magic of the Balint group, by the end of the session there seemed to be some hope for her too.

On Saturday, before the final small group session, there was a meeting of group leaders and representative members from each group. It emerged that there were some interesting differences in leadership style. (This was also noticed at the Oxford Congress in 1998). In some groups the leaders were more active in questioning the presenter about his feelings. In another group, it was observed that the leaders were happy to contribute accounts of patients of their own with whom they had had similar experiences to the presenter.

I am told by my reporters in the different groups that, in the final session after this meeting, there was a tendency for all the leaders to revert to a quieter, more conservative style.

Greek dancing

I must tell you about one other group activity of a totally different kind which we were able to enjoy. On Saturday afternoon, Dr Monika Voncina (Austria) took a band of enthusiastic pupils out on to a hotel terrace, overlooking the sea and taught them how to dance in a ring to traditional Greek music. Everyone who took part found this music and movement refreshing and exhilarating. And it was quite easy to get the hang of. Greek dancing reappeared later on at the Farewell Party (see below).

But first we had the **Final plenary session** on Saturday evening. The chairs in the lecture room were rearranged so that everyone could sit in one big circle. I chaired the proceedings and did my best to notice and respond to everyone who wanted to speak. Many people made recommendations for the next Congress in two years time (Berlin 2003) Here are a few of the comments that were made:

It was good to have one Slovenian leader and one leader from a guest country in each group.

There was a request for the next Congress organisers to provide a list of delegates with country of origin, address and contact numbers form the beginning. (The list for this Congress did appear about half way through).

It was suggested that people might have been able to mix with each other socially a little more if they could have eaten lunch together at the Congress.

The papers had been of great interest but it would be nice to have them presented so that papers on related themes were placed together. A short period of discussion after each presentation was preferred. Visual aids (pictures, graphs, electronic presentations etc) were appreciated and there was a call for all papers to include these if possible. It was probably better not to have papers read by other people in the author's absence as this was a very difficult task. English people were asked to try and speak more slowly!

Some people would welcome fewer papers and more discussion. The student forum was warmly approved. In future congresses the students could be asked to participate more fully and give papers. There was a proposal to create an international scientific board. Posters were encouraged and one-minute poster presentations suggested. There should be one session for evaluation and one for new Balint Societies to present themselves .It would be nice if presentations from the National (host) Society could be translated at least in summary. Everyone agreed that sitting with people of many different nationalities gives one a wonderful feeling.... But it's hard to think and speak in English in a big group.

There was a request for all the Proceedings of the Congress to be published. The Greek Dancing was wonderful and should be repeated.

Warm thanks were expressed to Zlata Kralj and her colleagues for all their hard work in organising the Congress and bringing us all together for such a fruitful and happy few days.

The farewell party: dining, dancing – and singing

On Saturday evening, we gathered in the dining room of the Metropol for a celebration of our reunion and our achievements. There was an excellent buffet dinner and plenty of good Slovenian wine. There was dancing to the music of a versatile and tireless two-man orchestra (keyboards and guitar). After the meal our Greek dancing teacher, Monika Voncina led us all out onto the floor and proceeded to get us all moving and shaking, more or less rhythmically, with arms linked, sometimes in a circle, sometimes in a long snake winding in and out and round about…After that there was an outbreak of furious scribbling in all parts of the room. What was going on? The Swedish delegation had decided that we should compose the words of a Balint Anthem to be sung to the tune of 'Lili Marlene'. When the creative lyric writing was finished the words were copied for everyone, the band was taught the tune and the massed choir of the International Balint Federation cleared their throats and sang. The second performance was recorded by Michel Delbrouck (with the good singers nearest to the microphone). The CD will be available shortly, but meanwhile here are the words:

THE BALINT SONG FOR 2001
(Melody: 'Lili Marlene')

We are all together for a Balint week
Gathered in Slovenia, a place that's very 'chique'
Coming from Holland, I soon made friends
And in some lace I put some pins
Balint après Balint - Balint après Balint

Talking of our feelings makes me very glad
Along with my patients I can be so sad
With sexuality and incest-
and broken hearts, the talks are best
In groups with old Balint – in groups with old Balint

In Michel's heart a black hole will take place
It will be filled in golden Berlin days
When he shall meet the Balint girls
From Northern lands, he'll start to dance
Alors Balint Alors! – Alors Balint Alors!

Strolling by the seaside, wand'ring through Piran
Balint folk are gath'ring, according to our plan
Talking of patients – everywhere
We are so happy, they're not here
They're far away at home - they're far away at home!

Although Balint lovers, we must be aware
Not to build a tower pointing in the air
That, like a 'Babel', will fall down
In different language we may drown
Babel is not Balint : Babel is not Berlin

And to follow that..
What more can I say? I'll see you all in Berlin

John Salinsky

United Colours of Balintians?

Marie-Anne Puel (editor of the *Bulletin de la Société Médicale Balint* [France])

What kind of publications do the Balintian Societies provide for their Balintian members? Let us begin with the Beginnings. Our grandmother, the old English Balint Society has been publishing once a year (for about 30 years) the *Journal of the Balint Society*, whose front cover is made of a white and white glazed paper, unlike the inclination of the late lamented Queen Mum who used to cover herself in many colours. It is the most Royal publication with original articles, news, minutes of meetings, historical articles, reports of talks and lectures.

With regard to colours, our grandfather, the Belgian Society publishes *La revue de la Société Balint Belge* whose front cover changes its colours every two months. It is the most traditional, serene and warm publication. It adds some advertisements and pictures to the articles and many francophone authors can be read all along the pages. This review is written in the Belgian language, closely related to the French language, as in the French bulletin. Unlike the USA and England who are "two peoples separated by a common language", Belgium and France are different peoples almost united by a slightly different language. In France, we publish two " *Lettres*" and two *Bulletins de la Société Médicale Balint* every three months, one at each season. The white and blue newsletters contain mainly information and the yellow and blue bulletins mainly original articles (when yellow and blue doesn't mean Swedish, it means the South-West of France).

Now, turning to the most "European" family members, Germany and Romania have the ability to communicate in two languages. Our little German child who grew up speedily, fed by two remarkable mothers and perhaps some shy uncles and baptized *Balint-Journal* is a bilingual boy already expressing himself in English and German.

His older brother the *Buletinul Asociatiei Balint*(apologies for the missing accents which my French computer cannot reproduce) with a white and blue front-cover has been speaking Romanian and English for a long time already.

Going back to the source, our venerated ancestors put out a biannual letter *Balint info* in Hungarian of course ...which is, as you all know, a very simple and easy language, but last but not least the Master's language!

Our special congratulations go to the newly born baby in our family the *Boletim da associacao portuguesa de grupos Balint* and to its young parents who were born at the same time: a first in medical history!

Please remember that, *The Doctor, his Patient and the Illness* has just been translated into Portuguese which is a considerable achievement. Like all unruly children, the *Boletim* allows itself the freedom to publish every so often. Good luck to them all!

P.S. Of course, I forgot a lot of publications: let me know yours in order to complete our palette and our international family. Of course, many countries publish their " Congress book" with the contributors'papers. And finally let us remember the two 'grand public' books which have just been published: " *What are you Feeling Doctor?* by John Salinsky and Paul Sackin (Radcliffe Medical Press Ltd, 2001) and *Michael Balint:le renouveau de l'École de Budapest* by Michelle Moreau-Ricaud (Érès, 2001).

One word for "Le dictionnaire international de la psychanalyse" (Calmann-Levy Avril 02) sous la direction d'Alain de Mijolla (cf articles Balint (groupe), Balint (Michael) et Balint (Enid)

ANNOUNCEMENT

THE 13TH INTERNATIONAL BALINT CONGRESS

1st- 5th October 2003

will be held at Kaiserin-Friedrich-Stiftung, Berlin

Theme: 'The Doctor, the Patient and their Well-being World Wide'

The Congress will provide opportunities to:
Share your ideas and experiences
Hear about the latest Balint research and evaluation studies
Take part in Balint groups with colleagues from all over the world
Meet friends old and new
See the sights and enjoy the cultural events of one of the world's most exciting cities

Further information from the Congress web-site: www.internationalbalintcongress.de

Or the secretary of the International Balint Federation, Dr John Salinsky
JVSalinsky@aol.com
32 Wentworth Hill, Wembley,
Middlesex, HA9 9SG
Tel: 020 8904 2844

Programme of Meetings of the Balint Society for the Thirty-third Session, 2002-2003

Lecture series 2002-2003

Joint meeting with British Association of Psychotherapists — **31 October 2002**
37 Mapesbury Road, London NW2
Demonstration Balint group led by Dr Mike Courtenay

All other lectures are held at the Royal College of General Practitioners
14 Princes Gate, London SW1 1PU
Time: **8:30 p.m.** (with coffee from 8.00 p.m.)

Dr Shake Seigel, GP and former president of the Association of Course Organisers — **26 November 2002**
'The life of a "new style" Balint group in Staffordshire'.

Dr Mike Brearley, psychoanalyst and former captain of the England cricket team — **25 February 2003**

Lesley Caldwell from the Squiggle Foundation — **25 March 2003**

The 15th Michael Balint Memorial Lecture will be given by
Dr Henry Jablonski, psychoanalyst and Balint group leader, Stockholm, Sweden. — **14 April 2003**

All meetings are PGEA approved
Further information from the Hon. Sec. Dr. David Watt

The Balint Society Prize Essay, 2003

The Council of the Balint Society will award a prize of £500 for the best essay on the Balint group and the doctor-patient relationship.

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2003** and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

International Balint Award 2003 for Medical Students

For more than 30 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verità' (the mountain of the truth) in Ascona. Owing to their influence on medical training in medical schools these seminars are acknowledged as the "ASCONA MODEL" (WHO), and their main purpose consists in Balint teamwork, examination of the doctor/patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. An award of **SFR 10'000.** will be made to the author of the best description.

The criteria by which the reports will be judged are as follows:

1. **Exposition:** the presentation of a truly personal experience of a student-patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. **Reflexion:** a description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. **Action:** the student's perception of the demands he (or she) felt exposed to, and an illustration of how he then actually responded.
4. **Progression:** a discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st March, 2003** to the following representative:

Dir. Dr. med M. Tomamichel, Via Simen 10, 6900 Lugano.

The presentation of prizes will take place at the Monte Verità Centre, in Ascona, Switzerland on the 14th June 2003.

Information can be obtained from: Prof. Dr. med. Dr. h.c. B. Luban-Plozza,
Foundation of Psychosomatic and Social Medicine,
Via Monescia 2,
6612 Ascona.

The Association for Psychoanalytic Psychotherapy in the NHS (APP)

welcomes you to a Conference organised by its Primary Care Section.

Making the Most of Brief Encounters in Primary Care

At The London Voluntary Sector Resource Centre
356 Holloway Road, London N7
on Friday 15th and Saturday 16th November 2002

Brief encounters are the essence of primary care – for GPs, psychotherapists, counsellors, practice nurses and health visitors. This two day Conference will think about brief therapy not just as a treatment modality, but also in terms of the wide range of encounters that characterise work in general practice. Here, the intensity of occasional 'meetings' in the surgery can be more important than the length of a treatment. Making a virtue of necessity is a significant part of the culture of primary care. Some encounters will be therapeutic, others less so, but what makes the difference?

The conference is for professionals working in primary care who are interested in understanding more about the brief encounters in the surgery and new approaches to brief therapy that may result from an increased awareness of the emotional world of primary care. It is hope that the conference will reflect this emphasis by starting from a basis of experience and moving towards thinking more about the nature of these encounters and how to make them more therapeutic.

The programme will include lectures, workshops, live supervision fishbowls and small group supervision. Speakers and group leaders will include Jeremy Holmes, Andrew Elder, Jan Wiener, Roger Higgs, Catherine Crowther, Jane Dammers, Hilary Graham and Sotiris Zalidis

Applications from GPs, nurses, counsellors, psychotherapists or other practice staff working together in surgeries will be welcome.

Application forms are available from Mrs Annabel Thomas, Conference Administrator, PO Box 707, Gerrards Cross, Bucks, Sl9 0XS. Tel/fax: 01494 581539. Email: app@athomas99.freeserve.co.uk

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Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to the Editor, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG, UK. Email: JVSalinsky@aol.com

Style

Articles should be typed on one side of paper only and double-spaced. Abbreviations must be explained. Research papers will be peer reviewed to assess their suitability for publication.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

We welcome the submission of articles on 3.5 inch computer disk. Authors should supply the name of the file on each disk and send a hard copy in addition. Better still, you could send them by email to **JVSalinsky@aol.com**

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.

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