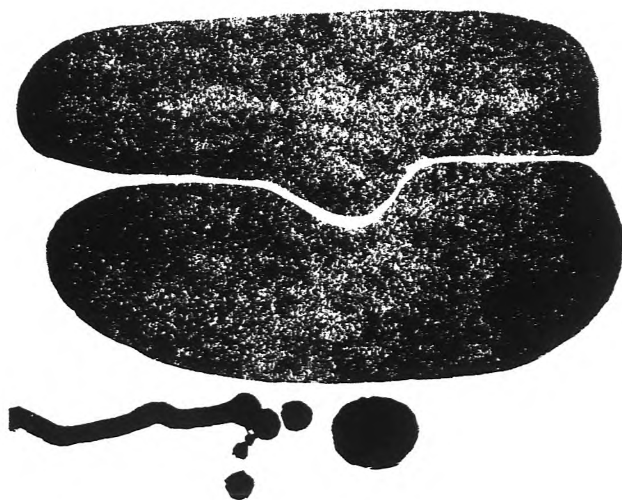
Journal
of the
Balint Society

2007



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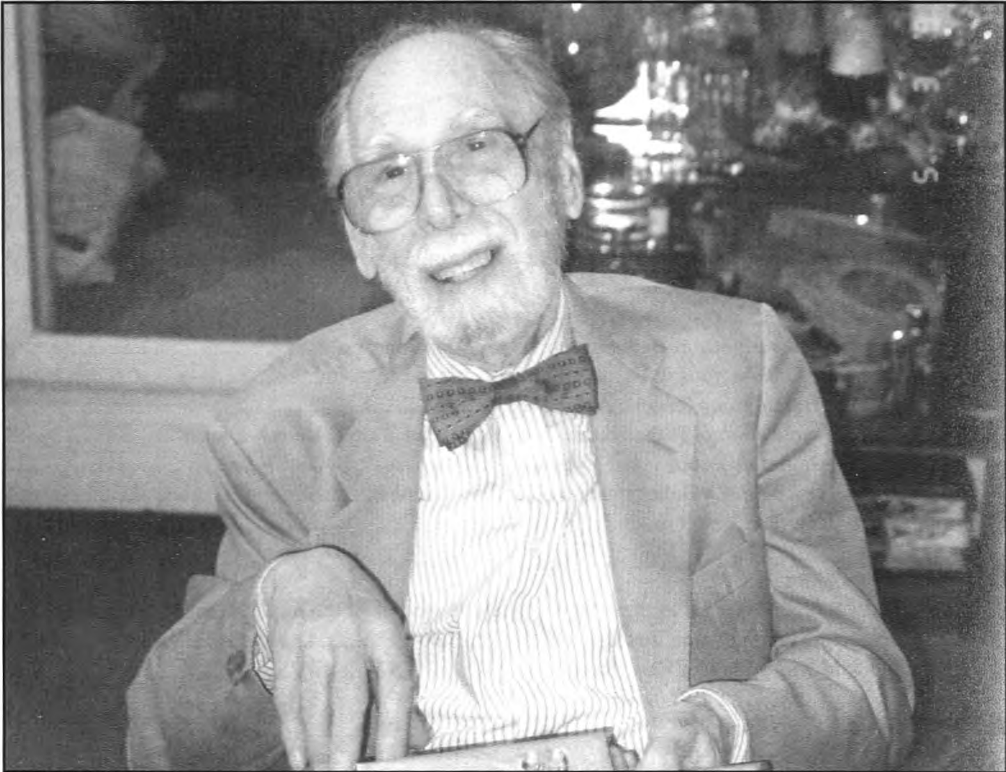

Philip Hopkins (1920-2006), founder and first president of The Balint Society.

The Balint Society:

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

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

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. Balint weekends are held each year in Northumberland(April) Whalley Abbey, Lancashire (June) and Oxford (September).

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.

Programme of Meetings of the Balint Society for the Thirty-eighth Session, 2007-2008

Lecture series 2007-2008

All 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 Andrew Elder, GP — Tuesday 30 October
'35 years on: facing ending and some thoughts on difficult beginnings'

Dr Sonia Leff, consultant paediatrician — Tuesday 20 November
'The changing needs of families'

Dr Peter Phein, psychosomatic psychotherapist — Tuesday 12 February
'Uncovering psychological trauma in childhood'

Dr Jennifer Johns, psychoanalyst — Tuesday 18 March

Dr Greg Battle, GP — Tuesday 22 April

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane. London NW3 at 8.30 pm on 13 November, 21 February and 20 May

The Northumberland Balint Weekend will be in April 2008 (exact dates to be announced)

The Lancashire (Whalley Abbey) Balint Weekend 2008 will be held from 13-15 June at Whalley Abbey, near Clitheroe.

The Oxford Balint Weekend 2008 will be held at Exeter College in September (exact dates to be announced)

The **Annual Dinner** will be held in June 2008 at a new venue to be announced.

Further information from the Hon. Sec. Dr. David Watt.

THE BALINT SOCIETY WEBSITE

The Balint Society has its own internet website. 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. See also the INTERNATIONAL BALINT FEDERATION WEBSITE: www.balintgesellschaft.de/ibf
- 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, Finnish and International Balint websites. More are coming all the time.

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

Editorial

The Leaders, the group members and the pursuit of change

How do Balint group leaders decide when to intervene in the group discussion? How do they decide what to say? Is leading a group an art or a science? Is there a leaders' 'agenda'?

All Balint leaders would agree that that the doctor patient relationship is the primary focus for a Balint group. Most leaders would see it as an important part of their role to bring the group back to this focus whenever it has strayed too far or for too long into other fields. Leaders become uncomfortable when the talk begins to generalise away from the presented patient; or when other group members bring up patients of their own with similar problems. As leaders we want to encourage empathy in our group members. We want them at least to try to put themselves in the patient's shoes and imagine how he or she might be feeling. We are pleased if they acknowledge and explore their own feelings, especially those aroused by the patient. If the patient's problem seems insoluble we are undismayed. We are much more interested in what is happening in the consulting room, in the here and now. What does the patient really want from this doctor we ask, looking hopefully at the baffled faces of our group members. What sort of doctor does he need his doctor to be? Some of us may suggest a link between the patient's present behaviour and his childhood experiences (if these are known). We might, if sufficiently confident, risk a psychoanalytical interpretation. Or remind the group of a metaphor that has already popped up as a way of understanding patient better. We might point out that the doctor is already doing a good deal for a patient who needs a doctor able to listen to her and contain her distress. We all have our own ways of steering the group in a Balint-orientated direction. There are basic principles but an infinite variety of ways of handling a rapidly moving complex discussion. Group leading, like general practice is a mixture of art and science.

But what about the group members? To what extent are they aware of the leaders' agenda? Are they happy to go along with it? Well up to a point. But, at least in the early stages, they also have a different agenda of their own. Let us change to the first person pronoun since we see ourselves as group members just as much as group leaders. When we decide to present a patient at the group we often simply want to share a painful experience. A patient has made unreasonable demands on our time and patience and threatens to keep coming back indefinitely. Someone has hurt our professional pride, made us feel humiliated or even afraid. We know that the group will listen attentively and sympathetically. They have all been there themselves. We shall feel better for having unloaded this burden; we shall be the grateful recipient of our friends' attention and concern. Who knows, one of them may even have practical suggestion for getting rid of this obnoxious patient. Or, if that would be going too far, because our patient is not really as bad as all that, a suggestion for getting him to come less often or stay no longer than ten minutes. We may want to get back in charge of a relationship that is slipping dangerously out of our control.

Another important item on our group members' agenda is how to change the patient's lifestyle. This may be on either clinical or moral grounds or a combination of both. For instance, a patient who is neglecting to look after his diabetes, or failing to take his blood pressure medication, needs to change his ways for the sake of his health. A smoker needs to stop smoking and an alcoholic needs to become an abstainer. What is a doctor for if not to make people healthier and cure them of bad habits? If the patient is not interested in looking after himself one might as well say, 'I'm sorry, there's nothing I can do for you.' Many of us also have patients who seem to expect us to collude with them in defrauding the state. They demand sick notes for extended periods and the filling in of forms that will enable them to claim additional state benefits for dubious illnesses. Surely they would be better off working, contributing to society and feeling that their lives have some purpose? Again, our fellow group members are usually sympathetic. Being doctors, they rarely if ever 'call in sick' themselves and are in no doubt about their contribution to society. Although there may be a solitary anarchist in the group who declares that people are entitled to lead their own lives in their own way and at their own risk if that is what they want

Meanwhile, what are the group leaders thinking? They may listen politely to the discussion, but their minds are on higher things. They are longing to get back to the doctor-patient relationship and the way that the patient might be transmitting some of his own feelings to the indignant and puzzled doctors. They will have observed that the presenting doctor is behaving a bit like the patient and they will be wondering whether it will be helpful to mention this to the group.

And so on. As the life of the group continues there will be a tendency for the members and the leaders to come closer together. Members who are more psychologically inclined by temperament will happily pick up the leaders' cues and talk about feelings and relationships. Those who really don't see the point may decide to drop out. Those in the middle will hopefully find that a little more tolerance and empathy may lead to a less stressful and more productive relationship with a 'heart-sink' patient.

The group leaders would like these changes to happen sooner rather than later. After all what is a Balint group leader for if not to facilitate that important little change in

personality to which our founder so memorably referred? The word 'change' might ring a warning bell here. If we try to stick too rigidly to the Balint agenda and close down all discussion that is merely 'supportive' we may be echoing our group members in their apostolic pursuit of 'change'. Michael Balint is also reported to have advised his doctors to 'be no more than half a step ahead of your patient.'[1] Perhaps that applies equally to group leaders and their group.

John Salinsky

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Reclaiming the Unconscious In Balint Group Work

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Medical University of South Carolina, Charleston, SC, USA

Introduction

Given our most systematic, professional and attentive efforts, the world around us and within always seems unexpectedly to open before us to something new, something unknown. Abhorring not knowing, we fashion a hypothesis, a belief, a myth or a silent refusal to declare our response to the novel and continue to chop wood and carry water, or in the case of medicine, to see the next patient. However, that not knowing or not being conscious catches up with us, and its shadow falls across our practice when, despite our best professional efforts, care for the patient just doesn't seem to be effective or satisfying. It is just such a case that bubbles up in the Balint group. Then, many small lights begin to flash into the darkness of patient, doctor and their relationship What has been left unspoken, unfelt, unthought, and unimagined, this shadow crossing the doctor's path, is brought into the light. What has been unconscious is, in part, reclaimed.

This paper is not an attempt to revive a psychoanalytic metaphysics of the unconscious, or in a more general sense, an attempt to propose some particular theoretical structure of the unconscious. Rather, this paper is an attempt to honor how the unconscious of the physician and that of the patient are explored in Balint group work in order to create a broader field of consciousness for improved patient care and enhanced physician satisfaction. The paper will begin with a brief review of how the unconscious entered Western thought, and next move to illuminate the particular way in which the unconscious is dealt with in the Balint group process. The Johari awareness model will be used to illustrate how the unconscious is illuminated within the Balint group.

The unconscious

All learning presupposes an unknown. When that unknown centers on the person who is assumed to have the capacity of consciousness, the unknown is called the unconscious. It is this subjective field of learning on which Balint work focuses. I will begin with the historical research of Whyte: 'words expressing awareness and self-awareness first emerged in the English and German languages during the 17th century.'[1] Whyte further notes that it is interesting to observe that 'conscious', from its Latin source, meant 'to know with'. It came, however, to mean 'to know in oneself, alone'. By 1670-1730 Whyte found that no fewer than eight writers in the English, German, French and Italian languages had '... published ideas overlapping in some degree with our contemporary conception of unconscious mental processes'.[1] These historical findings are cited to alert the reader to the far-reaching dimensions of the unconscious in science, philosophy, religion, medicine and art. What influences illness, memory, moods, sleep, dreams, intentions, imaginations, beliefs, perceptions and reason itself has long been noted as having its origins within and beyond consciousness.

Some of the more discriminating ways in which the unconscious mind has been interpreted are concisely summarized by Whyte in Table1. It would be helpful in reviewing Table 1 to analyze in what way(s) the physician and patient are oriented to the unconscious, and to appreciate how this orientation is manifest in forming what each of them considered to be their normal (rational) way of communicating and behaving.

> The mystic believes in an unknown God, the thinker and scientist in an unknown order; it is hard to say which surpasses the other in non-rational devotion.[1]

It is such 'devotion' that may put a doctor and patient on very different channels of communication. Until this non-rational devotion, this unconscious orientation, is made conscious the physician will find change in thinking, feeling and behavior impossible.

For a far more expansive, personalized and culturally contextualized history of the unconscious from ancient times to the mid-20th-century the reader would benefit greatly from a study of the Swiss medical historian, Henri F. Ellenberger's magnum opus, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, published in 1970.[2] A second book of his collected essays, *Beyond the Unconscious* followed in1993,

English physicians and the Unconscious

A group or 'school' of English physicians beginning with Sir W. Hamilton (1788-1856) and W. B. Carpenter (1813-1885) developed a doctrine of the unconscious as part of their professional responsibility in understanding the patient as a 'body-mind unity'. To these pragmatic monists there was nothing strange or challenging in the idea of unconscious factors; whether one chooses to call them physiological or mental, they were indubitably at work.[1]

Hamilton and Carpenter were succeeded by many, the most important of whom were: J. D. Morel, J. C. Brodie, H. Maudsley, T. Lavcock and D. H. Tuke. Maudsley (1835-1918) summarized the ideas of the English school in his *Physiology and Pathology of the Mind*, 1867. He said:

> The most important part of mental action, the essential process on which thinking depends, is unconscious mental activity.

Whyte points out that it is interesting that in 1874, the year Freud entered the University, Brentano published in Vienna a thorough examination of Maudsley's views. Freud attended Brentano's lectures for two years.

At this point it should be clear that the unconscious was a concept interwoven in the intellectual and medical culture of Europe and England. The social diffusion of study of the unconscious is conspicuously manifest in 1868 with the publication of von Hartmann's *The Philosophy of the Unconscious*. By 1882 it was in its ninth German edition; it was translated into French in 1877 and into English by 1884. This encyclopedic work, 1100 pages in the 1931 English translation, covered 26 topics some of which are: neural physiology, reflexes, curative processes, sexual love, feeling, morality, history, etc. It would seem apparent that the medical community long before the time of Freud was seriously considering both in England and on the Continent the unconscious as an important dimension of life and clinical practice.

Freud's legacy

Whyte contends that from 1752 to the present a shift in European philosophical and scientific thinking was evident. This was a movement toward 'process concepts' and away from 'static concepts'. He saw Darwin and Freud as products and promoters of this transformation. Whyte felt that Darwin knew he was 'extending the scope of reason by helping to make it less static'. With Freud the story was different.

> ...Freud did not realize that he was destroying rationalism by showing that reason, though essential to understanding, did not control thought or behavior.[1]

Whyte also noted that Freud's conceptualization of the unconscious neglected one of its most important aspects. Freud had remained almost silent on the unconscious mental processes underlying 'the appearance of novelty in all creation, imagination and invention.' Fortunately this shortsightedness did not hamper the routine incorporation of creative, clinical speculation in the future development of Balint group work.

It is not my intention to diverge into an extensive criticism or extolment of Freud's far-reaching influence. Many others have addressed that topic: Eric Fromm,[4] Bruno Bettelheim,[5] Calvin Hall,[6] Paul Ricoeur,[7] Paul Roazen,[8] and Liliane Frey-Rohn[9] to name a few. Rather I should note that through his work and personality he created around himself a circle of persons, several of whom would touch the life of Michael Balint and bring him into a long and productive career as a writer, teacher, executive leader and training analyst in the psychoanalytic tradition.10 Within this circle, and beyond it, an energized debate, if not overtly divisive intellectual and emotional struggle would continue over the question of the structure and dynamics of the unconscious.

Johari awareness model

The Johari window is a graphic model of interpersonal behavior ideally suited to describe and identify the dynamic behaviors of individuals and groups. It was developed in 1955 by professors Joseph Luft and Harry Ingham.[11,12] Underlying the model are several assumptions:

1. Holistic units of behavior are more important in understanding human behavior then elemental units (i.e. muscle contractions or sense organ responses)
2. Subjective factors, values, attitudes and feelings are more important than objective facts in understanding behavior
3. Behavior is influenced more by emotions and irrational striving (the unconscious) then by logic or reason
4. 'Crucial aspects of behavior are best understood by taking into account sources and determinants of behavior which are hidden from the person ...'12 (the unconscious)
5. Qualities such as acceptance, collusion, influence, conflict or trust, though not well defined or measured, are more important than quantifiable forces in understanding human behavior
6. Immediately occurring changes taking place are more important to monitor then static structural properties in persons and in groups
7. The experience of direct knowledge of a person is valued over applying labels to his or her behavior (diagnoses)
8. To pursue this understanding of persons in a relaxed and fluid way is more important than through a restricted, controlling and departmental isolation of personal behaviors.

These underlying assumptions of the Johari awareness model are isomorphic with the parameters that guide the Balint group process, and inform the Balint group leader.[13]

Figure 1 is the graphic illustration of the Johari window. A change in the area of any of these quadrants necessitates a change in the area of the other three. Q1 refers to behaviors, feelings and motivation known to the self and to others and, constitutes the basis of interactions and exchanges. 'Knowledge, skill, awareness and

FIGURE 1

	KNOWN TO SELF	NOT KNOWN TO SELF
KNOWN TO OTHERS	QUADRANT 1 Q1 OPEN	QUADRANT 2 Q2 BLIND
NOT KNOWN TO OTHERS	QUADRANT 3 Q3 HIDDEN	QUADRANT 4 Q4 UNKNOWN

pleasure are determined by the magnitude of this first quadrant.'[12] How open one is to the world, to the patient, to oneself is acknowledged in Q1. Q2 refers to behaviors and motives that are known to others but not to the self. We might call it the personal unconscious. Blind areas increase the hazards of living with ourselves and with others.'[12] However, forcing information from Q2 to Q1 is a kind of psychological assault and carefully guarded against by the Balint group leader. Q3 is the private realm, what one knows and is choosing at the time not to reveal. In extreme cases this could lead to thoughts and feelings shifting to Q2 or to Q4 so that I, and others, lose touch with who and what I may really be. Q4 is the unconscious pure and simple, an area of imagination, fantasy, daydreams and night dreams that impinge on the individual and the group. Here we might use Jung's term for Q4, the collective unconscious. The size of Q4 is much larger than the other quadrants and not so precisely defined as the closing lines of the square might indicate.

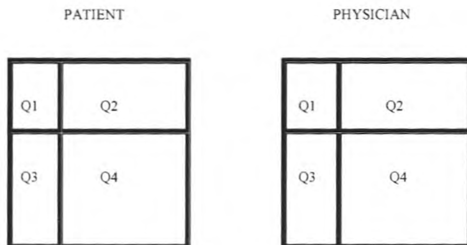
The Johari window and the Balint group

To describe how the unconscious is recovered in the Balint group, and the way in which this enhances patient care and physician satisfaction, two stages of the group will be described using the Johari window. Figure 2 pictures the initial conditions of patient and doctor in a Balint group. The Q1 area for patient and doctor is small and uncomfortable for the physician. He or she has chosen to present because transactions are limited, constricted, confused and both personally and professionally not satisfying. In the physician's presentation more is being conveyed to the group about the patient and the physician then he or she is aware of. This is another way of

FIGURE 2

INITIAL PHYSICIAN PRESENATION IN THE BALINT GROUP

PATIENT PHYSICIAN



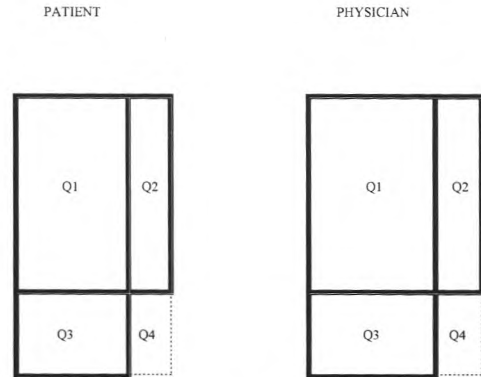
saying that the patient is always uniquely present in the group. Q2 of the patient and physician are experienced by the group beyond the physician's words or conscious intentions of communication. The physician is in some way identified with the patient, an unconscious process, and so carries this aspect of the patient, 'undiagnosed' and unconscious, into the group. Q3 and Q4 of patient and doctor are somewhat similar for the rest of the group, but certainly not identical. Therein lies the potential for growth: new insights, feelings and behaviors.

After the physician's presentation, and when the presenter has sat back, allowing the group to temporarily assume care of the patient, a new picture emerges. This new configuration of the group looks like Figure 3. The Q1 area of

FIGURE 3

FINAL STAGE OF THE BALINT GROUP

PATIENT PHYSICIAN



patient and presenter greatly expands because many in the group have articulated their own unique, picture of the patient and their own unique declarations of what they would be thinking, feeling and doing for or to the patient. Some would want to discharge her or him. Others would desire to know more about past medical history, family and social history. They are drawn to the patient. What the presenter thought her or his role as a physician ought to be is now silhouetted against other alternative roles. Q1 has now been enlarged by the group and potentially for the presenting physician. What the presenting physician was unconsciously thinking, feeling, or imagining, Q2, may now have been articulated by peers empathizing with his or her role. As well, what he or she has not shared about personal responses to the patient, Q3, may have been spoken by others in the group and will now have become part of Q1.

Concurrently with the expanding area Q1 of the presenter, is the expanding area Q1 of the patient. The group has imagined, conjectured, inferred and reasoned her or him to be more than was initially presented. What she or he was possibly hiding from the doctor, Q3, and what she may have been unconscious of in herself, Q2, or what was impinging on her due to her circumstances, Q4, has in part been brought to consciousness in the group. Both a personal and collecting unconscious have in part been recovered.

The buoyant effect of this consciousness raising on the presenter, patient and their relationship is the power of the Balint group. How the presenter decides to swim with the rising tide of consciousness is left to his or her initiative. Often the report of the presenter in following

sessions is that things just seemed better or easier on our last encounter. How the partial recovery of the unconscious affects every presenter and other group member is different on each meeting. The group's treatment of the presenter wrestles with the same unconscious currents as the presenter's treatment of the patient. Objective assessment of the case is the delusion; consensual probabilities is a more likely reality.

Discussion

Ellenberger states '...since time immemorial there have been two approaches to healing: one by use of rational means and the other by mobilizing irrational forces.'3 Too frequently Balint group work which acknowledges irrational forces and invites imaginative, clinical speculation, has prejudicially been judged to conjure up irrational forces in a cult-like gathering of doctors. I believe the above presentation of the Balint group process viewed through the Johari window should clarify how an imaginative process, honoring unconscious thoughts, feelings and behaviors, can be acknowledged and incorporated into a rational assessment of doctors, patients and their relationships. Acknowledging unconscious processes as well as conscious, rational processes is essential to the well-balanced assessment and treatment of patients and the well balanced life of the physician. Every dogmatism whether of science or religion constricts the conscious meeting arena of doctor and patient, Q1, and moves medical practice toward a devitalized ritual. Treatment by protocol without the person of the physician and the patient is sterile and recovery of the unconscious is categorically excluded.

Luft asserts: 'Intrapersonal and interpersonal affairs are inextricably united.' He goes on to say: '...identity and relationships are sufficiently intertwined so that it makes sense to consider them together.'12 The most central question that is always shuttling between consciousness and the unconscious in Balint group work is: what kind of doctor am I? Medical school may teach what a doctor is to do. Where, with whom, and how does the young doctor begin to sculpt consciously what he or she is to be?

It is through the transactions of the secure and supporting Balint group as the Blind, Q2, and Hidden, Q3, areas of each member are thought-by-thought and feeling-by-feeling spoken aloud by a peer that some fuller image of their individualized, personal physician begins to emerge. Concurrently, thought-by-thought and feeling-by-feeling an older, idealized image of who they thought their personal physician was begins a morphogenesis.

In recovering the unconscious, both uniquely personal attributes as well as ancient, archetypal attributes of the healer, begin to crystallize for the individuals of the group. Only indirectly are the members of the group drawn to this realization when confronting the leader's question, 'What kind of doctor does this patient need?' In attempting an answer to this question one's own hand, card at a time, will be turned over. The process continues throughout one's professional life. Q4 is a vast territory with an ever receding frontier. Recovery of the unconscious is a recovery of openness to the body-mind connection without attaching medical or psychiatric labels and hearing the symptoms speak the truth of the patient's existential condition. Recovery of the unconscious is also the physician being open to and aware of the feelings and thoughts that arise in him or her, as well as the discriminating clinical thoughts which are an immediate part of the patient encounter.

Summary

Throughout Western intellectual history, as briefly outlined above, wise individuals have admitted that insights, thoughts, feelings, images, art and science emerged from an unknown, unconscious territory. Much speculation about that territory and its living qualities has been formulated. Both before and after Freud, physicians, psychologists, and healers have attempted to understand the nature of that unconscious territory in treating the sick and suffering. Balint group work, as seen through the Johari window, has been described as a process wherein that unconscious territory in both doctor and patient is acknowledged, explored and imaginatively entertained. This incorporation of speculative, clinical reasoning enhances assessment and treatment of the patient, and allows a creative, evolving identity of the physician to emerge. Reclaiming the unconscious in Balint group work, epistemological frames clinical reasoning and speculation in a working group process that improves medical care and physician well-being.

I will close with the words of one of the earliest, medical psychologists, Carl Gustav Carus (1789-1869), privileged Dresden court physician to the king of Saxony, professor of gynecology, artist and author of many works both scientific and philosophical. From his 1846 book, Psyche, these words:

> The unconscious is the primordial source of life.
>
> ...the understanding of the unconscious in consciousness is everywhere the last and highest aim of science...[1]

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TABLE 1
THE UNCONSCIOUS MIND WAS INTERPRETED

BY:	AS:
Mystics	The link with God
Christian Platonists	A divine, universal, plastic principle
Romantics	The link between the individual and universal powers
Early Rationalists	A factor operating mainly in memory, perception, and ideas
Post-Romantic Thinkers	Organic vitality, expressed in will, imagination, and creation
Dissociated "Self-Conscious Man"	Night: the realm of violence
Physical Scientists	The consequence of physiological factors not yet understood
Monistic Thinkers	The prime mover and source of all order and novelty in thought and action
Freud (Subconscious)	Mainly inhibited memories ruled by the pleasure principle, in a state of deformation and conflict, accessible only through special techniques; also forgotten memories and inaccessible levels
Jung	The pre-rational realm of the collective myth and religious symbolisms*

***Jung also acknowledged a personal unconscious seeded by complexes, a collective unconscious seeded with archetypes and the psychoid.**

Restructuring the Unconscious in Balint Group Work

by Alan H. Johnson PhD

Introduction

In the previous paper, *Reclaiming the Unconscious in Balint Group Work*,[1] I attempted to show how the Balint group process expands the field of consciousness around the doctor, his patient and the illness: i.e. how the unconscious is reclaimed. What the first paper did not attempt to do was to articulate a new foundation or structure for this reclaimed, unconscious material. The earlier paper did point to the diverse historical foundations of various formulations of the unconscious both before and after Freud. It now seems essential to articulate a new formulation of the unconscious. Medical practice continues its unconscious slide into a biomedical mysticism or dogmatism with the eager and excited anticipation of much of society for pharmacological ways of treating diseases and lifestyle issues while evading conscious recognition and responsibility for the natural consequences to individuals, society and the environment for such treatments. What knowledge does the Balint group process bring to the practice of medicine? How does this knowledge complement a biomedical and pharmacological oriented treatment? And finally, how does this knowledge benefit the patient and the doctor? I will now try to address these questions.

A New Structure for Understanding Balint Group Work

Before directly addressing what kind of knowledge Balint group work brings to the practice of medicine, it will be necessary to define what constitutes knowing in a more general or universal sense. Without making this a philosophical treatise of unmanageable proportion, I will refer to the lucid, insightful, encyclopedic and synthetic work of Ken Wilber.[2] His thinking and extensive writing recognizes both Eastern and Western wisdom and practice, as well as the subjective and objective orientations of the arts, sciences and spiritual traditions. I believe his integral vision will allow us to create a clearer, differentiated understanding of what Balint group work does to contextualize meaningfully the events of the doctor-patient relationship: structuring the reclaimed unconscious material of Balint group work. I hope that we will honor in our thinking together R.G. Collingwood's admonition that 'all thought exist for the sake of action' and that understanding of ourselves and our world is for the sake of living a freer and more effectual self-revelation' in a 'vigorous practical life.'[3]

A diagram that appears in various permutation in Wilber's writings will immediately orient us to understanding how knowing is to be organized. Knowing has a subjective and an objective side; it has an individual and a communal side. Together they constitute four quadrants (Figure 1). These

Upper Left INTERIOR INDIVIDUAL **I** Intentional Subjective	Upper Right EXTERIOR INDIVIDUAL **IT** Behavioral Objective
Sigmund Freud C. G. Jung Jean Piaget Aurobindo Plotinus Gautama Buddha	B. F. Skinner John Watson John Locke Empiricism Behaviorism Physics, Biology Neurology, etc.
Lower Left INTERIOR COLLECTIVE **WE** Cultural Intersubjective	Lower Right EXTERIOR COLLECTIVE **ITS** Social Interobjective
Thomas Kuhn Wilhelm Dilthey Jean Gebser Max Weber Hans-Georg Gadamer	System Theory Talcott Parsons Auguste Compte Karl Marx Gerhard Lenski

quadrants may be called the 'I', the 'We', the 'It' and the 'Its', representing, respectively, the internal, personal subjective reality; the intersubjective reality of culture; the objective or empirical reality of matter and behavior; and the reality of social dynamics. Any event or phenomenon has these four epistemological frames which are interwoven and mutually determining and determined.[4] However, the attempt to reduce an event to only one quadrant's perspective produces what Wilber calls a 'flatland' and cannot be done without 'aggressive and violent rupture, distortion [and], dismissal.'[5]

Some representative thinkers and schools of thought characterizing each quadrant are listed in the four quadrants of Figure 1. I hope that these names will help us to orient better to the way in which events are interpreted or 'treated' in each of these quadrants. While patient encounter notes are to be SOAPed (Subjective, Objective, Assessment, Plan) it has been evident for some time that the objective, Upper Right quadrant, has been the primary focus of attention by contemporary medicine and that little attention has been given to the other three quadrants. Herein lies the work of the Balint group. It is as though the S in SOAP stands for superfluous Suds.

Each of the four quadrants has its own way of establishing or relating to truth. The Upper Right quadrant is looking for a correspondence or representational truth. Are sufficient numbers of criteria satisfied to earn an ICD and a DSM diagnosis? Were sufficient numbers of patient biological systems assessed to justify billing for a given level of service? Does the medical map match the territory? Then the diagnosis is true. The context of this truth is objective clinical

findings, laboratory results and consultants' reports. Within this context truthfulness is objectively and empirically established.

The Upper Left quadrant is focused not on the representational accuracy of a verbal report but rather on its disclosure of an internal integrity, believability or reliability of the subject's statements. Is he or she inwardly accessible? Is there truthfulness in this person's reporting? Can there be a meeting of minds and hearts? Then can I understand the individual perspective of this person? This question certainly evokes in a doctor the act of empathic engagement and the art of hermeneutics i.e. the philosophical orientation to the question of meaningful interpretation.[6] Here is the beginning of the knowledge that the Balint group work contributes to medicine. By attempting to create an engaged, meaningful dialogue with the patient, we enable knowledge to emerge in an intimate social/cultural context that establishes a subjective truth. The work of the Balint group is to enter empathically the subjective space of both patient and doctor and attempt to understand the meaning it holds for both. We might call this the subjective truth of the patient and the doctor.

This process naturally leads to explorations from the perspective of the Lower Left quadrant: intersubjective connectedness (or disconnectedness), mutual understanding or cultural fit (or misfit). There is no private language, so how do I understand the meaning of your words, and how might you understand the meaning of my words? Again we come to the word hermeneutics, now with its cultural overtones. How has culture defined the space in which we are now meeting and the scope of our talking? What explicit and implicit (conscious or unconscious) roles have we taken on? What has each of our subcultures, lay and medical, taught us about approaching and treating the disease and illness we imagine before us? These cultural parameters emerge as the Balint group members begin to speak of the doctor, patient and illness as they perceive and conceptualize them. Gender, race and religion naturally become more explicit. Knowing from this quadrant further refines our understanding of the context and the doctor's and patient's truth and truthfulness in a new light.

Finally we move to the Lower Right quadrant, where interobjectivity and functional fit contextualize or structure the truth that doctor and patient will exhibit, consciously or unconsciously. To understand the truth of this quadrant let me begin with a heuristic, social-systems theory axiom: 'The town drunk is an elected official.' What is implicit in this axiom is that society functions in a coordinated way to shepherd someone with an alcoholic problem into a supported role that is mutually satisfying in maintaining community homeostasis.

What about the practice of medicine? How does a medical practice treat, move along a drug seeking patient? Nurses alert the doctor that this patient's pain is most likely fabricated and variations of it have been seen often. The doctor is also informed that sweet Mrs. Nice has been waiting far too long to be seen. The doctor is now cued to discount pain, assess poorly, accommodate nurses and move on quickly to enjoy sweet Mrs. Nice. What is the truth of the patient's pain: objectively, subjectively, intersubjectively and interobjectively? The Balint group process turns over such issues in noting the immediate context of one patient's visit in a specific clinic setting with particular nurses and aids on a discrete time, day and date. This immediate social system establishes a truth that enacts more than just a cultural prescription. It is a truth of a different order which subsumes the doctor, patient and the illness in its dynamic context.

The Balint Group's Contribution to Medical Knowledge and Practice

In the preceding section I have outlined the kind of truth that each quadrant, linked in an integral system of knowing, contributes to the understanding of any event. As well I have related these various truths to the doctor-patient relationship in the general practice of medicine. What is first apparent in an integral way of knowing is that all meaning, all truth assertions, develop in a context, and that this context needs to be brought to consciousness. In the words of Wilber, 'Meaning is context bound but context is boundless.'[7] We might say that each of these contexts, objective, subjective, intersubjective and interobjective, defines a field of consciousness that provides a meaningful, truthful perspective on each event, person or object. Each quadrant provides a context for interpreting the reclaimed unconscious material of the Balint group process.

The first contribution of Balint group work to medical knowledge is to begin to clarify context. The doctor is an individual (object), a person (subject), a physician (cultural agent) and has a social role in a dynamic social process. The same things can be said of the patient and of the illness. In the case of the illness, we know it objectively as a disease, subjectively as illness, culturally as a prescribed pattern of behavior, and socially as defining how others are to relate to me and how I am to relate to others. How my cold (or Aids or autism) is to be known and treated is contextually prescribed by the quadrant from which I perceive it.

The second major contribution of Balint group work to medical practice is to help the practicing physician to see himself from this four quadrant perspective and how that is, consciously or unconsciously, directing his assessment of the patient and the illness. Is he dealing objectively with the disease? Is he treating the illness of the patient? Is he ritually addressing the cultural role being enacted? Is he socially accommodating the patient's presenting behavioral style? One, two, three or all four of these interpretations (truths) may illuminate further the doctor and his or her

relationship with the patient, and the illness. Each quadrant clarifies the unconscious perspective from which the doctor may have been operating.

When the doctor can begin to be conscious of the role, ritual, social accommodation or mental state into which s/he has drifted, there is hope that his relationship with the patient can also change. It is the doctor's professional duty to take on the conscious responsibility for this transition in his or her practice, both for the sake of the patient being better served and for his or her own deeper, personal and professional satisfaction. This responsibility certainly includes a continuing cultivation of biomedical and pharmacological knowledge. However, that knowledge has to be contextualized: consciously applied and not reflexively administered.

Summary and Conclusions

It appears to me after what has been outlined above that the reader would no longer be thinking about the unconscious only as some complex of aggressive or sexual impulses hidden somewhere in the tissue or biochemistry of an individual. Rather, the unconscious might more nearly appear to be an organizing process within matter, persons, groups and cultures that can become conscious as individuals disidentify with their habits, rituals or roles long enough to see the trail of their adventure, or their misadventure. The unconscious is not some process that lies dormant until we become so exhausted, numb or distracted that it suddenly asserts itself into our routine. The unconscious is a live dynamic pattern that is always operating, and unconscious only because: we re-cognize events and do not perceive their uniqueness; we frame events in professional terminology; we ritualize responses and habituate our behavior in culturally and professionally prescribed ways. However, suddenly to decide to be unconventional does not immediately put us in touch with the unconscious currents of our life. It is only a new way to get stuck to the other side of the same tar baby. I am as unconsciously determined by what I crusade against as I am by what I passionately run to embrace. I am as unconsciously linked to the patient I can't abide as the one who seems to brighten my day.

The Balint group is not a restructuring, political society of medical practitioners working for reform within or outside medicine. It is rather a group of physicians daily at the heart of medical practice trying to grasp more consciously what it is that leaves their best knowledge, efforts and intentions short of its mark both in the patient and in themselves. It is a conscious attempt to make peace with the patient, the illness and themselves. The Balint group's individually focused case study is an attempt consciously to reframe medical practice in realistic terms and begin to see into the unconscious and unexpressed expectations of patients, culture, society and themselves what leaves them feeling less satisfied, less competent, less helpful and less potent as practitioners.

For the classically trained psychoanalyst the dream was the royal road to the unconscious. To the Balint group leader and Balint group participants, the group process becomes a collective dreaming on the group's present case study. Dream as originally understood seem to imply that the unconscious was a destination to another place, at an earlier time, in a different mental state. The group's collective dreaming involves the entire group in the present reflecting through their projections hitherto unconscious information about the doctor, the patient and their relationship to each other and to the illness. The group process is one of free association, with neither case presentation, clarifying questions nor ensuing discussion following a prescribed protocol. Each member of the group will absorb consciously and unconsciously from the collective dream the new insights that they are able and ready to assimilate. The conscious and unconscious dimensions of the case are here and now within a group climate of trust, openness and empathic engagement.

The integral model of understanding presented here is a way of conceptualizing or contextualizing the dynamic character of consciousness and unconsciousness. This integral model is proposed in order to give some substantial structure to Balint casework, and to suggest how a more broadly understood unconscious opens doors to more effective treatment, better patient understanding and greater physician self-acceptance. The reader is now alerted to an unconscious immediately present in the slight shifting of cultural patterns and symbolic representations, social dynamics that subtly reshape or recast roles, biochemical shifts not yet detected or drifting mental states and cognitive patterns. One is always in the unconscious as well as the conscious. The unconscious is reclaimed, and becomes more structured in Balint group work by clarifying the immediate context in which doctor, patient and illness are mutually affecting each other and the social/cultural context in which they are meeting.

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4. Each of these four quadrants has many levels. These levels are organized in what Wilber calls a 'holarchy': a hierarchical order of

'holons'. Each holon has an identifiable integrity which becomes embodied in a new holon and then assumes the role of a part within it. I will cite just a few holon examples in each quadrant to help the reader grasp more fully the integral approach. Upper Left: moving from pretension, to sensation, to emotion, to concepts, to vision logic. Upper Right: moving from atoms, to molecules, to reptilian brain stem, to complex neocortex. Lower left: moving from physical pleromatic, to vegetative, to uroboric, to archaic, to rational, to centauric. Lower Right: moving from galaxies, to planets, to Gaia systems, to societies with division of labor, to tribes, to nation states, to planetary.

5. *The Eye of Spirit: An Integral Vision for a World Gone Slightly Mad*. Boston: Shambhala, 1998.
6. *A Brief History of Everything*. Boston: Shambhala, 1996.
7. ibid.

The role of the Balint group leader

by Andrew Elder

This article discusses the influence of psychoanalytic ideas on the structure and function of Balint groups and on the role of the leader in assisting the work of the group. A Balint group, when successful, can bring together the conflicting feelings and semi-chaos of daily life in a busy general practice, with a rather special atmosphere of attention, openness to feelings, and attitudes of mind which are derived from psychoanalysis. Provided care is taken in establishing a disciplined structure for the group, such an atmosphere then provides a freedom for the participating doctors to experience and think about the many important, and more personal, aspects of their professional work that otherwise may remain unnoticed and unstudied. A Balint group thus becomes a 'scientific instrument' for the observation of the doctor-patient relationship and the many facets of medical care that it determines. Such groups can have extensive application in the fields of training, research and in the continuous need for further development in professional functioning.

The article proposes that there are three key areas of relationship that need to be the focus of observation in a working Balint group, and further, that the inter-relationship between these different areas is of crucial importance: 1) *the doctor-patient relationship* as expressed to the group by the presenting doctor discussing his difficulties with a patient who is troubling him; 2) the relationship that develops *between the presenting doctor and the other doctors in the group* as a case is discussed, and 3) the relationship *between the leader and the work of the group*. Another important relationship for the leader to consider is that between him and the presenting doctor, although thoughts about this relationship would often not be made explicit in a Balint group. Alongside the attention given to the feelings expressed in these interweaving relationships, the working method of a Balint group places an emphasis on free association rather than prepared case presentation, and on the value of discovering ideas about things that are unknown or uncertain.

Background

Michael and Enid Balint both worked at the Tavistock Clinic in London during the years immediately after the Second World War. Michel Balint's book describing their work with GPs *The Doctor, his Patient and the Illness* was first published in 1957. There have been many publications since that time. My own first experience of this work was soon after starting as a GP in 1972 in a practice in the middle of London when I joined a Balint group at the Tavistock clinic. Michael Balint, whose father was a GP, came to England from Budapest and was trained as a psychoanalyst and a psychiatrist. Enid Balint was also a psychoanalyst but was not a doctor. At the Tavistock Clinic she had been working with social workers to devise new approaches to marital therapy with couples. Instead of trying to make a psychological diagnosis of what was wrong with either the husband or wife, they tried to find out what the trouble was *between* the two, *in their relationship*, or interaction. It was this thinking that they then applied in the work they developed with GPs.

Doctors and their Patients

Doctors and patients may get to know each other over quite a few years, and to some extent, develop a relationship which resembles a marriage: some becoming old friends, others more like old enemies, and often the doctor and the patient seem stuck with each other in a way that can be frustrating to both, and perhaps not healthy. For the doctors in the group it is not easy to stay focussed on the doctor-patient interaction, which is very different from their more familiar way of making diagnoses and management plans learned during medical education. A Balint group tries not to focus solely on the patient as the object of interest, but to include the doctor's difficulties as well and to explore what is going on between the patient and the doctor, much of which is not at all clear to the doctor when he brings the case to the group.

The group atmosphere

The doctor presenting a difficult case should have a feeling that the leader and the group members know what it is like to be a GP. The atmosphere should not be a critical one. A Balint group is not expounding or teaching a 'right way' of doing things, but is concerned to help the presenting doctor find out how things *are* between her and the patient, not how they *ought* to be. For this there needs to be a respectful atmosphere in which group members can listen carefully to each doctor's own way of doing things, and allow space for the doctor's feelings to be included as well. Doctors who experience being listened *to* in this way within a group become better able to listen to their patients.

At the heart of the Balint method two disciplines come together: there is a marriage between the practice of medicine and psychoanalysis; the latter not as a body of theory, but as an attitude of mind and an approach to learning. Psychoanalysis knows about human relationships and the unconscious mind, and the value of a stable setting without which it is not possible to observe these areas of life. Doctors, with their daily practice in technological medicine, are well acquainted with a variety of patients, blood tests, all kinds of scans and so on, but at the same time can quickly feel disconcerted

if a patient suddenly opens up about their feelings, or somehow always manages to leave the doctor feeling defeated. The atmosphere in a Balint group can be one which allows doctors to experiment in bringing these equally important strands of medical practice together, psyche and soma, and doing so in such a way that suits them as individuals. Listening and medicine, side by side.

Freedom and discipline

The freedom engendered in a Balint group that enables the doctors to learn in this way is dependent on the discipline of clear boundaries for the group which are agreed by the members and upheld by the leader. These will often include such things as a stable membership, meeting at the same time for a fixed length of time, in the same place and at regular intervals. A group may also agree other ground rules for its work. It is the leader's responsibility to keep comments focussed on the doctor-patient relationship, avoiding quick theories or psychodynamic lectures about what is wrong with the patient. The leader models the working method for the doctors and seeks to let ideas and reflections develop from within the group; perhaps encouraging those that seem likely to be productive, or picking up and articulating some of the conflicts and tensions within the group and bringing them forward for examination in the light of the doctor-patient relationship. In this way, the leader sets an approach which the doctors can absorb and develop in their own work with their patients.

A working group

A Balint group begins when the leader says 'Has anybody got a case?' After a little hesitation, one of the doctors will offer a new case and begin to tell the group about their problems with a particular patient: very often the doctor feels no room for manoeuvre with the patient, is stuck with the patient – 'I don't know what to do, I am in a bit of a mess, this patient is distressing me.' As the doctor describes their work with the patient, the doctor- patient relationship arrives in the room, and the way the patient 'inhabits' the doctor becomes experienced in the group. This is the *first* area of attention in a Balint group.

Freud's concept of 'free association' influenced the Balints in wanting the doctor to be as free as possible in her presentation of a case. Doctors are trained in their medical education to make formal, objective presentations of patients. In contrast, Balint groups place importance on the doctor making a freer, more subjective presentation. Partly this is a training method, a way of introducing doctors to the more personal side of their work. Talking about a patient without the comfort and security of case notes is a significant step for many doctors. The presentation of a case in this way gives a freedom to talk spontaneously, and to include the feelings that belong in the narrative account. There is then an opportunity for the doctors in the group to learn to listen in a deeper way too. One of the most important things to learn in a Balint group is the ability to listen. Doctors need to listen to their patients, but it is an active listening: not only to words, but also to bodily language, to the patterns of illness, to those remarks that the patient stops halfway when making, and then may contradict. As a doctor in a group you begin to learn about this by listening to your colleagues, the same process as listening to a patient.

Once a case is presented – and the doctor comes to a *natural* conclusion to whatever he wants to say – the *second* area of attention in a group comes into play: the relationship between the presenting doctor and the group as they set out to understand the doctor's predicament and offer some help. After some initial responses, questions and comments, something rather mysterious happens: the doctor who has brought the case begins to behave a little bit like the patient to the rest of the doctors in the group, who themselves take on the role of the doctor. After an early stage in which comments from the group help to open things up, the group then begins to get a bit stuck with the doctor, just as the doctor had got stuck with the patient. The doctor feels perhaps that whatever he tries, the patient blocks any progress in the treatment. And the doctor brings that frustration to the group, and the group says, well, have you tried this and that, but after five to ten minutes of suggestions from the group, the doctor is beginning to behave a bit like the patient, beginning not to want to take it any further and blocking the group's suggestions. So the conflict that exists in the doctor-patient relationship, whatever it is, then often gets taken up unconsciously and becomes re-enacted in the group. Without a leader, it is likely that the group would get caught in whatever is the unconscious dynamic that has led the doctor to present her case in the first place. Not a lot of progress is likely to be made.

The *third* sphere of attention, then, is the leader's difficult task of trying to observe and think about how the group process reflects the conflicts underlying the case being discussed. Just as a doctor in his consulting room will need to identify and feel something of the patient's predicament but also withdraw enough to think about whatever might be a helpful professional response, so also does the leader in relation to a Balint group. He must allow himself to be drawn into the group's pre-occupations (it would be hard to prevent!) but then also be detached enough to think about what he feels and comment to the group about this in a useful way. In a Balint group such comments are made in relation to the case under discussion and refer to the doctor's professional difficulties and how the group might be reflecting these, not in relation to the doctor's personal difficulties. By working in this way, the leader provides a further layer of reflection through which the group may be able to generate new perspectives to help the presenting doctor gain a *fresh view* about his work with the patient

under discussion. Much of the leader's job is to help the group stay on track and to concentrate on the doctor-patient relationship.

The focus in a Balint group is primarily on the doctor-patient relationship and only to a secondary degree on the personal life of the doctor. This means that less emphasis is placed on the (transference) relationship between the presenting doctor and the leader than would be the case if a Balint group was a form of psychotherapy for the doctor or a supervision group. The therapeutic focus in Balint work is on helping the patient, through a development of the doctor's professional capacities. Clearly such a change is likely to bring benefits in the doctor's personal life as well but these are not the primary aim of the work. A Balint group is more a place of learning through discovery and should not be a teaching group. Michael Balint referred to the group meetings as 'seminars' and the activity in them as 'research-cum-training'. So it is important for the leader to hold back his natural tendency to teach or demonstrate his knowledge and let the doctors discover something for themselves. In this way, whatever an individual doctor assimilates from the group is likely to be more enduring and consonant with their own development.

Conclusion

Balint groups can help doctors tolerate and think about much that is otherwise uncertain and unknown in their daily work. In the current climate which places a strong emphasis on evidence-based medicine and the scientific method, it may seem unfashionable to remind readers how much is unknown (and not amenable to conventional scientific enquiry) about the meaning and significance of a doctor's daily contact with her patients. Perhaps another valuable legacy from psychoanalysis to the Balint method is a belief in the value of studying things that are not so easy to know about, things that lie within ourselves, attitudes and feelings that may influence the course of professional work more than is recognised. Doctors are surrounded these days by ideas of correct medical practice, about how things *should be done* when patients are treated. In a Balint group we may learn to explore how things *really are* in our day-to-day doctor-patient relationships in order to be able to change our medical practice to the benefit of our patients and ourselves.

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Continuity

Andrew Dicker

(Keynote address delivered to the Balint Society at Exeter College, Oxford 15th September 2006)

There is a great deal of inconsequential stuff researched and written about continuity of care in general practice. The subject is topical because it has become politicised.

Most of the literature seems to be part of an endeavour to confirm that continuity of care in general practice is important enough to make it part of the agenda for planning for future provision of health services. It is perceived to be under threat because the politicians and planners prefer to listen to the people who say what they want to hear. What the politicians appear to want to hear is that the public do not mind about continuity. The politicians believe that the priority for the public is to have instant access to a competent doctor on the door-step. The public does not mind who it has to see. Intuitively it is difficult to believe that an encounter with a one-stop doctor in a supermarket can be a qualitative experience comparable to an encounter with a GP whom a patient knows and trusts and who may also know the patient's parents and children. But perhaps these are two different kinds of health service provision and the comparison is pointless.

There is also increasing evidence, mainly from non-NHS organisations which do research on the NHS, that the public is profoundly ignorant about how the NHS works – until it needs it – and it is really only doctors who regard the issue of continuity seriously. Part of the reason that doctors, or more exactly GPs, think that continuity of care is important is because it is a source of professional power. It has its origins in the personal list system, a contractual arrangement upon which GPs used to be dependent for their living. Personal lists no longer exist. Since the new contract was introduced in 2004 the patients register with a practice, not a GP. But both the patients and GPs continue to refer to 'my doctor' and 'my patients', in a possessive way, which reflects both attachment to the past and a need for the continuity of a relationship of some sort between the supplicatory patient and the powerful professional.

This is intended to be a purely personal reflection on continuity, but the extensive literature on the subject cannot be ignored. Much of it has been published by European[1], American and Canadian authors[2] – so it is not just a preoccupation of NHS GPs.

But first I think it is important to be clear about what I mean by continuity of care. There is a lot of new language invented by managers to describe new ways of doing old tasks. This language usually relates to the way in which multidisciplinary teams of professional people, working in the community, provide particular services to patients with specific needs. There are packages of care, integrated care, care approaches, care pathways, seamless care and so forth. Being multidisciplinary they are all characterised by fragmentation. The patients rarely see the same provider of care twice and continuity is often conspicuous by its absence.

The kind of continuity of care which I think is important is achieved through the quality of the relationship between patient and doctor which relies upon the duty of the doctor, in a Kantian sense, to respect individual patients exclusively as ends in themselves and never as the means to any other end. This may seem self-evident, but in the 21st century NHS it is becoming increasingly difficult to sustain. There are many countervailing pressures which constantly threaten the possibility to adhere to this basic Kantian golden rule.

The NHS Act created the statutory right of patients to access to a doctor when in need. The language of rights became popular in the consumerist polemic invented during the latter decades of the twentieth century. A plausible and practical non-statutory, but moral right to see a doctor, might be expressed in a *negative* sense as the right of patients *not* to have to see a different doctor every time they need one. This is a particularly apposite proposition in the context of general practice, and becomes a reality, if the correlative Kantian duty of respect for patients is observed by doctors as far as it practically can be. The quality of respect, sustained over time, is what I consider to underpin the possibility of achieving continuity of care. A useful source of evidence about the advantages and disadvantages of continuity of care has been published by a group from Exeter in 2003, from which I will quote selectively[3].

Michael Balint was one of the first authors to observe the stress which GPs encountered, as a result of their efforts to provide continuity of care to patients with complex needs, in 1957.[4] He was also the first person to research this phenomenon in his original groups, which provided a unique opportunity for GPs to discuss the nature of the relationships which they sustained with their patients in a demedicalised context.

Another author who has observed the effects of continuity of care on GPs is Professor O'Dowd from Dublin. In 1988 he published a paper entitled: 'Five years of heartsink patients in general practice'.[5] His observations accurately reflected the fact that there are patients who vex GPs but the language he used to describe them was harmful. Perhaps it is a reflection on the real difficulty which many GPs experience in

sustaining a therapeutic relationship with certain patients that the term 'heartsink' has been so readily absorbed into the medical vernacular. I have even heard it used in Balint groups!

There is no doubt that some regularly attending patients project a powerful transference of their helplessness and suffering. Unless this transference is used skilfully it is likely to evoke precisely the same sense of helplessness and disempowerment in the doctor as in the patient. Consequently large numbers of the most needy patients, who regularly attend their GPs, have been pejoratively labelled. They are tolerated but rarely helped. It is long overdue that the term 'heartsink' was consigned to the language of paternalism and judgementalism and ceased to be used. Heartsink GPs need to be better trained in a systemic understanding of why their patients come to see them.

A systemic approach to understanding why patients come to see their GPs when they do is critical to the possibility of fulfilling the expectations of the patient. It is particularly true in the context of chronic illness when patients may have made a considerable investment in time and effort to gain access to the doctor. It is essential that the doctor should possess the curiosity to discover why this particular patient should be in the surgery just now in order that the context of the encounter is properly understood.

There has been much written on the importance of a 'systemic approach' to consulting, although there is little objective evidence to support its value. Intuitively and empirically there can be little doubt that a GP who consistently takes a systemic approach to contextualise the patient encounter will derive a great deal more interest and satisfaction than doctors who attempt to deal narrowly with the biomedical problem which most patients bring. I would suggest that a systemic approach is intrinsic to the achievement of both successful continuity and happy GPs.

From the perspective of the patient there is quite a lot of evidence that continuity of care is not necessarily better than any other model. The evidence pertains in particular to the management of diabetes, epilepsy and antenatal care.[6] There is also some evidence that long familiarity with patients may lead to missed diagnoses where a fresh eye might be more vigilant.[7] In the management of chronic illness, GPs with long established relationships with their patients are less inclined to apply the edicts of evidence-based medicine, which may or may not be a benefit for the patient.[8] There is also some paradoxical evidence that long familiarity between doctor and patient may undermine the autonomy of the patient. This process happens when GPs conduct genial consultations but pay less assiduous attention to explánation than might be the case with a patient with whom they are less familiar.[9]

Evidence for the benefit of continuity of care, at least for those members of the public who seek it, is voluminous.[10] Research has shown that continuity of care is associated with improved communication; better secondary prevention; better diagnoses in selective areas of morbidity; better education about self management of minor illness; better adherence to clinical advice; greater patient satisfaction, (albeit a flawed concept); better quality of life; better health perception; greater trust and a more empathetic relationship between patient and doctor. And so on and so forth. The list is endless.

So much for the evidence. Because this is a personal account I am now going to resort in anecdote and gossip, which are increasingly recognised as valid sources of evidence. I grew up in a comfortable suburb of North West London during the 1950s and 1960s. I think that my family had about the average incidence of contact with our GP, and we came to take it for granted that we would always see the same doctor for the simple reason that we always did. Over the years our GP must have gained considerable insight into the way my family functioned and this was reflected in his endless capacity to seem to understand the diverse problems which we presented to him.

At that particular time in the twentieth century (and in that particular part of London) all discerning patients sought to be on the personal list of a particularly well known GP whose name was Cyril Gill. Cyril was one of Michael Balint's earliest converts and remained closely involved with Balint work for the whole of his professional life. Cyril looked after my father until he died in 1981 and continued to look after my mother until his own retirement. I last saw him in his surgery in Adelaide Road when I was in my mid teens in the mid 1960s.

In due course I went to medical school at an establishment on the South Bank of the river Thames. All the medical students had to be registered with a practice in Pimlico. One of the partners came to do a surgery every day in the medical school. I was registered with a kind and wise GP called Stephen Bryans who lived and worked in Pimlico and has now retired. During the 1970s he gently saw me through the usual succession of terminal illnesses, to which medical students are prone, usually on first encountering them.

At the end of the 1970s I decided that I wanted to be a GP and had the good fortune to be appointed to the very progressive Ipswich Vocational Training Scheme. During my time on the scheme I discovered about groups and group learning. Inevitably I acquired an interest in Balint groups. In about 1982 I attended my first Oxford weekend meeting run by the Balint Society. In those days we met in Pembroke College and the fun began with a 'fishbowl' group on the Friday evening. As the meeting foregathered for the 'fishbowl', and being enthusiastic about this new group experience, I planted myself in the circle of chairs in the middle of the room opposite the group leader. With a gradual dawning of recognition I realised that I

was sitting opposite Cyril Gill. Some fifteen years had elapsed since he had last encountered me in his surgery. He lent slightly towards me and said quietly: 'I hope your mother is well'.

In 1991 I had the unique opportunity to start a new practice in Pimlico, where I continue to work, although the practice has recently moved to Millbank. During a morning surgery in the mid 1990s I recognised the name of Stephen Bryans on my list and looking across the waiting room there was my old GP now registered with me in his retirement. For 10 years I had the privilege of looking after Stephen; a satisfactorily reciprocal arrangement in return for his sensitive management of my undergraduate diseases.

None of this is coincidence. Viewed systemically, both my encounter with Cyril in Oxford, and Stephen's presence in my surgery, were both more or less inevitable in the counterpoint of our lives. But the events contain many layers of continuity.

Continuity, whether it pertains to encounters and re-encounters over time in the surgery or to related situations and contexts, creates a connectedness. It helps to locate us in our professional lives. The psychological continuities which we accumulate, through encounters with patients over time, confirm both their and our identity. Continuity is the means by which a truly systemic approach to the work of general practice can be achieved. The counterpoint of the overlapping lives of the people whom we look after is the source of the constant curiosity which smoulders in the crucible of the relationship between patient and doctor. Cultivation of a sense of curiosity is the route to enlightened general practice. Continuity of care in general practice, driven by curiosity, is like true friendship – it allows conversations to continue uninterrupted, from one encounter to the next, no matter how much time passes in the interim.

Continuity should be construed as an art in which patient and doctor dance to the music of time. It is a partnership which requires one of the couple to steer the other to the rhythm created by the problem and in a direction which is mutually fulfilling. Like any art the skills must be learnt and practised. It is a complicated and sophisticated art which requires sustained mental and emotional effort and the courage not to abandon the process when it becomes challenging. Continuity needs to be a central theme of the curriculum for GPs, not just for those in training, but for GPs in established practice as well.

So how should doctors learn the art of sustaining professional relationships over time? Here are three things which might help. First of all, curiosity needs to be recognised as an important attribute, which lies at the core of the consultation. Without a constant sense of curiosity it cannot be possible for a doctor to maintain an interest in patients. As curiosity cannot be taught it needs to be learnt through experience and its relevance to consulting understood. The lives of patients, their narratives, are an inexhaustible source of fascination for anyone willing to listen. But listening also is an art; it is a common outcome of an inexpert consultation that patients depart feeling that they have not been listened to.

Second, a systemic approach to the stories which patients tell is helpful in maintaining continuity. This entails contextualising the encounter between patient and doctor to achieve a multidimensional perspective of the reason for the patient being in the presence of the doctor. The encounter with a doctor should itself become a part of the patient's narrative. So the story related in the consultation, interpreted by the doctor and shared with the patient, becomes a new story; a narrative in some way changed and maybe refreshed, which allows the patient and the doctor to view the problem from a new perspective. The doctor becomes intrinsic to the evolving narrative.

And third, there is the work of Balint groups. The opportunity which Balint groups provide to talk about the vexing and stuck problems which patients bring, is unique among all the models of learning and teaching about the consultation. There is no other forum for the non-judgemental, demedicalised scrutiny of what was going on in one or many consultations. Balint groups can empower doctors, who do not know what to do next for particular patients, to take the next step into the mire of their patients' emotional lives. The groups sustain the courage of doctors to remain a part of the narrative of their patients. Balint work is a powerful reminder of the intrinsic role which curiosity has to play in the consultation, because when the story ceases to be comprehensible, it is often because the doctor has not asked the right questions.

I believe that the three most important things which contribute to the successful outcome of an encounter between a patient and a GP are continuity, curiosity and kindness – all uniquely unquantifiable. But, for the sake of numbers: 98% of the population of the UK are registered with a NHS GP, and 49% of the population have been registered with the same GP for ten years or more. Almost everyone who changes from one GP to another does so because they are moving from one part of the country to another, not because they want to change their doctor. These facts speak for themselves.

A long relationship between a GP and a patient, knowledge of the patient's parents and children and close familiarity with the locality, are unique qualities embedded in the experience of general practitioners. In this age of evidence and guidelines, experience has become unfashionable and devalued. Nevertheless, it is only through experience, whether that of the patient or the doctor, that the importance of continuity can be understood.

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Mutiny on the Balint?

A reflection on the relevance of Balint, 49 years hence

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The following editorial commentary was written in response to a paper published last month in the American journal Family Medicine. Its title was 'Mutiny on the Balint: Balancing Resident Developmental Needs with the Balint Process.' The authors describe their work with a group of US Family Medicine residents (trainees) over a two-year period. Over this period, the authors sought to evaluate the residents' responses to the Balint process through discussion and a questionnaire consisting of five open-ended questions. The authors report that residents found the Balint format to be restrictive and inadequate to fully meet their needs. Particular emphasis was given to expressed needs for concrete management strategies, frustration with the avoidance of problem solving, and a need for specific professional development topics. In response, the authors evolved a hybrid that permitted residents to utilize a Balint format but allowed strategizing and problem solving. From their description, subsequent sessions focused around a specific doctor-patient relationship occurred only occasionally thereafter. In the authors' estimation, 'The residents in this study appeared to understand the purpose of Balint groups, and they expressed a strong desire to improve their doctor patient relationship skills. But, they rejected the Balint process.' The original paper is freely available at http://www.stfm.org/fmhub/fmhub.html

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The authors of the paper 'Mutiny on the Balint' in the July August 2007 issue of Family Medicine report on their experience in a residency training program of an exploration with their residents of the purposes and methods of running a residency-based Balint group. A recent study from the UK by Pinder and colleagues[1] addresses similar questions, most importantly: What is the relevance of Balint groups as a method by which we train residents in the skills of humanistic medicine and professionalism?

Nearly 50 years ago Michael Balint published his first work detailing the experiences of meeting regularly with London based general practitioners and the insights gained from those meetings.[2] Today, Balint's legacy is one of global proportions, as evidenced by a 26-year-old International Balint Federation (http://www.balintinternational.com) with at least 23 national societies from the U.K. to Australia. In the United States, Balint groups have been most commonly associated with Family Medicine residency training, but now this activity is expanding into Pediatrics and Obstetrics and Gynecology training. Internationally, Balint groups are extremely diverse. They may involve not only primary care clinicians in practice and in training, but also sub-specialists, nurses and members of other helping professions such as clergy. Similarly, there is a rich tradition of experimentation with the Balint method internationally ranging from 'prismatic' Balint, where the group may fill an entire lecture hall, to Balint 'psychodrama', where group members physically act out the roles presented in the case. In Germany, Balint group participation forms a significant and essential portion of training required for physicians to provide and bill for behavioral care. There is ongoing discussion within the European Academy of Teachers in General Practice (EURACT) regarding formal recommendation for Balint groups to be a part of routine general practice education. In summary, here in the U.S. and internationally, Balint work is diverse, thriving and continuing to inform medical education.

This international perspective is important background to a consideration of the questions raised by 'Mutiny on the Balint.' Readers might conclude from this paper that Balint has a sole focus on the doctor-patient relationship, with issues and outcomes of professional identity and safety being 'side benefit' deviations from the orthodoxy. If it is an inflexible orthodoxy that the authors and their residents intend to 'mutiny' against, I would guess that given the diversity of Balint work much of the domestic and international Balint movement might be considered to be in 'mutiny.' Clearly, as the authors of 'Mutiny' suggest, the goals and outcomes of a group of resident learners in 2007 will be different from a group of practicing U.K. general practitioners in the 1950s. There is indeed much to commend in the authors' approach of clearly defining boundaries between professional development and Balint type case-based discussion. The importance of this distinction is embraced within Balint circles, and some programs have even developed a separate group experience focused solely on professional development.[3,4]

If Balint work has become more diverse, and less insistent on orthodoxy, what then are the current hallmarks of Balint groups, and can we continue further the goals and development of the Balint method without losing what is essential? I believe we can, if we continue to uphold two constants of Balint work: specific doctor-patient relationships as the focus of Balint group sessions, and an informed focus on the safety of the group's experience.

The doctor-patient interaction remains the critical crucible in primary care where two people come together with a common focus on health, well-being and the alleviation of dis-ease. The communication and relationship between these two people is critical to the mutual understanding that is necessary to reach accurate diagnoses and proper therapies. A safe, well functioning Balint group provides residents with a flight simulator like environment where they are able to present to a group of peers an emotionally vexing relationship, where the mutual understanding has gone astray. With the group, they experience an opportunity to unpack the facts, emotions and possibilities of the relationship. Solutions, indeed multiple solutions, may emerge to the dilemma that is presented. However, these solutions arise through an exploration of a specific relationship. Through the presentation and discussion of multiple specific relationships, topics of professional identity, balance, emotional responses to patients, etc. are frequently explored in depth. A list of the ways in which Balint group participation addresses specific ACGME competencies is available on the American Balint Society website
(http://familymed.musc.edu/balint/ACGME.htm) By rooting the discussions in a specific relationship, a Balint group frees the discussion from the abstract and the theoretical, giving residents the opportunity to apply their understanding directly to their patient's care.

Safety of the group experience also remains an essential of Balint work. Unfortunately, in my opinion, much of what has been communicated as orthodoxy in the past resulted from our own uncertainty about where the boundaries of safety lay. This 'beyond here lie dragons' sort of line on the map was often drawn in reaction to fears of what harm might be done in the name of Balint. As has been described elsewhere, the safeguards maintained within a Balint group are similar to those of many other small group formats.[5] However, because the frame and contract of Balint work, especially within training settings, is on professional interactions and behavior, intensely personal explorations of the sources of members' reactions and emotions are discouraged. Leaders also act to protect the member who presents a case from excessive cross-examination by other group members, recognizing and reinforcing to the group that if the presenting member had the answers they would not have need to bring the case to the group.

A focus on specific doctor-patient relationships, the issues raised by them for our professional selves and an observance of important boundaries of safety characterize current Balint work. These basic ingredients leave a great deal of freedom for groups to work productively. Rather than a mutiny from Balint, which might leave us like the crew of the Bounty, aimless and destined for ignominy at best, we should learn from each other, setting sail together on a voyage of discovery of how we can continue better to understand and be of service to our patients.

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Re-Entry: The last task of a Balint Intensive

(or 'How to say Good-bye to the Balint State of Mind')

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I really didn't understand what was happening at the time of our residency faculty meeting, but I did realize I was somewhat uninvolved, somewhat disconnected and very uncharacteristically quiet. Anyone who knows me would begin to wonder. What I did become aware of was that the timing of this meeting was not inconsequential – it was held 24 hours after the end of a Balint Leaders' Intensive. When that realization hit me, it became clear that I was experiencing a struggle to re-enter my life. What was surprising to me was the fact that this was my third Balint Leaders' Intensive, and I had not experienced anything quite like this after my first two Intensive experiences. In fact, if anything, after my previous two Intensives, I was excited, energized and ready to apply my newly learned skills. I was like a child with a new toy. My parents just explained and demonstrated how it works. This time was different. I do recall that 're-entry' was mentioned at the last large group meeting where we all shared in the marvel that these meetings are. But I don't remember anyone really describing the sense of culture shock, the time warp or silent sonic boom that can accompany the contrast between the serenity and intimacy of our Balint groups on the one hand and the hustle and bustle of 'real life' on the other hand.

The fact that I didn't experience this in my first two Intensives is part of what made me somewhat surprised this time. Upon reflection, I have some ideas why this was the case. I am certain that I was previously less emotionally available. Part of my limits at previous Intensives had to do with disruptive things going on in my personal life, and I think that an additional part of it related to my extreme focus on the process (so I could learn to do it right). I was watching what was happening while trying to be part of it. What was different this time? I believe that I was more personally and emotionally available. In addition, I felt that I knew the basics about leading a Balint group; I felt more free to just experience it – to be more fully 'here and now', either as a group member or practicing leadership skills. Clearly, the more 'here and now' one is, the more 'present' one can be with his/her group. I am aware that I am not only trusting the Balint process, but I am also trusting the process of the Intensive as a learning and training experience. I can be fully 'here and now' during the groups and learn about what happened ('there and then') during the processing time.

I wonder also about the others who attended the same Intensive or any other Intensive where the emotional tone develops a similar sense of intimacy. 'Re-entry' – the word itself conjures up images of the space shuttle with its narrow window for re-entry, or possibly any special place or event that you pay to attend, and once you leave, you are warned 'No Re-entry'. As in all these examples, we have gone to a different place – at least figuratively; however, it happened without our noticing or choosing to do so until we were there. It's like a hypnotic trance – we go deeper and deeper, slowly – as our group evolves, becoming more trusting, more open, with more sharing and caring. We have clearly reached a level of trust and intimacy that allows us to consider fully the nature of our connections with our patients. We face, with a clarity not usually possible, the ways our work has meaning and value to us and to our patients. It seems like a luxury to have this time to dig deep emotionally – yet it is probably a necessity to do this occasionally over the long haul in order that we keep ourselves centered in our profession.

Would a warning label be appropriate? 'You are leaving Balintville – Proceed with Caution'. We have subtly dropped our defenses, and we have done work that is often intensely meaningful to all of us. We're not numb like when we get anesthesia – we don't need someone to drive us home. However, all joking aside, we have been immersed in a process to seek deeper understanding and meaning in our complex work experiences. When we do return to our homes and work, it is very likely helpful if we do have a co-participant to accompany us.

In contrast to the Balint Intensive experience, the reality is that, of necessity, much of our lives are transacted at a more mundane level, and we have been freed from those responsibilities for a short time. I wonder if we might be helped to identify more pointedly the possibility of experiencing some re-entry symptoms. It's a complex process – the shift from one work environment to another. It is probably a very individualistic experience. But it might be helpful to explore with the large group at the closing meeting if anyone has had other times they have experienced a re-entry adjustment (I know I can think of a couple others for myself). It is easier to negotiate when it is predicted and/or expected. It is normalized – and it is just as normal if it doesn't happen.

As one of our group said at the end: Metaphors be with you!

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The Empowerment Concept and Balint Groups

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The process of empowerment involves changing from a feeling of helplessness to one of control over one's life, of one's destiny (Sadan, 1997). It is very interesting to note that the empowerment concept has been looked at mainly by professions in the social sciences, such as social work. However the concept has not been sufficiently investigated by physicians and other health professionals. By the latter, the term has been primarily looked at from the vantage point of the patients' empowerment, with little work done in the area of the health professional's own personal empowerment. This may be due to the mainly paternalistic approach in medicine, whereby professionals are busy treating patients, not necessarily empowering themselves. This particular professional stance may deny/ignore their right to investigate clinicians' own empowerment.

The language of empowerment: Parallel process for the patient and the clinician

Empowerment assumes that it is possible to help people who have failed in social situations, to help inject in them a sense of personal regard. Empowerment involves a slow, personal, system of change and growth for all groups and communities in order to find personal satisfaction and provide freedom of choice. From a philosophical perspective, it involves the right of every person to feel empowered and an important condition for individuals' very being. The language of empowerment, we maintain, involves both the patient and the clinician being in a parallel process of change, from helplessness to empowerment. We hypothesize that in treatment, the clinician tries to guide the patient through specific steps by reducing disempowerment or overcoming barriers to empowerment, when the patient may have appraised situations negatively, or solved problems inadequately. The process of discovering empowerment involves looking for empowerment barriers, like negative stigmatization, prejudices and discrimination, non-realistic ideals that may lead to isolation and loneliness or other difficult system issues. The clinician may also find him/herself in similar individual and professional situations of disempowerment.

Research related to empowerment

Foucault (1979) looks at the close relationship between knowledge and power, features that are found in systems, communities and in medicine too. The psychiatrist has the power of medical-psychiatric knowledge, his/her professional skill which enables him/her to diagnose and treat emotional problems. However, this knowledge may not necessarily help patients (or doctors themselves) to feel empowered. In studying empowerment in Balint groups, we listen to stories which are in themselves evidence of the subjective experiences of others. This is like investigating evidence in the archives of life narratives, or in the laboratory. This is the way that a social scientist investigates things. From a philosophical perspective this is different from the biological investigation, which assumes that we have to look at deeper elements in order to understand the structure as a whole. The empowerment approach looks at the meaning people give through their narrative structures (White & Epston (1990). Knowledge, in itself, may not only give power but may be seen as empowering. In this perspective, feelings and cognitions create a personal evidence-based process, which supplements medical scientific investigations.

The process of empowerment

The aim of the empowerment is to change three basic processes:

Empowerment of the individual

A person is shaped not just by genetics and environment, but also by opportunities to change his/her surrounding world. In this respect, the person's ability to make decisions, to act, to take responsibility, to fulfil his/her aims is the expression of empowerment. It is an interactive process that develops between the individual and his/her surroundings, whereby a change takes place. For example, the person with a low self-esteem becomes more assertive. Specifically, empowerment involves change and choice, to make decisions from a wide range of possible options and possibilities, and by so doing, enabling the person to influence his/her environment. It involves self-efficacy, which is confidence in one's ability to carry out a task, and internal locus of control involving one's ability to be controlled by oneself, and not by external forces. Empowerment also requires comprehending a situation. This means having the access to relevant information in order to make the appropriate decisions.

The community aspect of empowerment

This aspect of empowerment encompasses the expression of the need individuals feel for being and acting together, for trusting and communicating. In fact these two terms have a common root. Empowerment involves being part of a system or part of the community. This raises

the question of how much the individual brings empowerment into the system, or how much does the system itself empower the individual? The answer to this question may be that empowerment develops only relative to 'others' .The latter may involve a group, an organization or a team, which interactively work together.

The professional aspect of empowerment

The concept of empowerment was born out of the professional dialogue concerning the ways social problems are created. This dialogue developed because of the professional disappointment in existing social solutions. It was assumed that empowerment itself could take place without professionals, but the discussion about empowerment is professional and academic by its very nature. The discussion about empowerment then is seen to be practised within groups of professionals who aim at working in the mode of empowerment, practising dialogue, and discussing principles governing the professional practices of empowerment. According to this concept, the professional might act as a resource advisor, instructor and advocate. The discussion about different identification/ role models is also part of empowerment practices.

Balint groups and empowerment.

Balint groups have a long tradition in family medicine training in helping doctors and other health professionals improve their sensitivity, knowledge and skills in patient-physician relationships and problems involved in this process. Furthermore, the group helps doctors to reduce stress and burnout caused by patient care and/or the system. The group itself can be very effective, often empowering the presenter, allowing him/her to feel more at ease, freer in his/her relationship with the patient. This involves coming to terms with uncertainty and knowing that there are no clear answers or definite solutions, but that solutions lie many times in the paradoxes and vicissitudes of the human, complex interaction in the doctor-patient dialogue.

Historically, Balint groups have been patient and disease orientated, although recently they have moved from the patient-illness aspects, to the doctors themselves as well as their professional lives. This includes bringing up issues related to doctors' helplessness, loneliness, stress and burnout. In this context we assume that the group helps the presenter to become more empowered within him/her as well as in the team and organization in which he/she works. By gaining empowerment, this can lead to a reduction in professional stress thus preventing burnout, enabling the doctor to become a better clinician and therapist.

Balint members often talk of special cultural groups suffering from prejudices and stigmatization by the general population. For example: a Balint group of immigrant doctors spoke about the specific issues involved in the acculturation processes of their same immigrant group. The group process enabled these doctors themselves to feel empowered, helping them in turn to treat their immigrant patients' specific problems in a more professional way, without over-identification with their problems. This led to more appropriate and effective treatment by this group.

It has been noted (Maoz, Rabin, Katz, Matalon 2004, 2006), that attending Balint groups help participants to develop new ways for change in that it provides the doctor with an additional tool-a common language, a new approach to treatment and a greater sensitivity and awareness towards the system. One of these "new languages" might be the language of empowerment.

The Group

We should now like to present the results of a weekly half a year Balint group that we ran (Y.S. and S.R.) for occupational therapists (OTs) working in a general hospital setting in the Occupational Therapy Unit. The group consisted of ten professionals who worked with patients, adults and children with physical, neurological and cognitive limitations. The OTs. were also consultants to the neurological, neuro-surgery, orthopaedic and geriatric departments. The head of the unit also participated in the group after the group members unanimously and confidentially gave their permission for her to participate. This is unusual in Balint work but we were convinced that this head was an exceptional person, warmly liked, admired, respected and even loved by the other participants. The aims of Balint activity were outlined to the group who became fascinated by possible open group involvement. The group took place in the same setting in which the members worked.

Methods

Verbatim reports of the sessions were taken by one of the leaders with the permission of the participants. These were then analyzed for process and linguistic characters that concerned the empowerment language. The leaders considered first recording the sessions but this practice might have been understood by participants as a barrier to openness and empowerment. It was rejected. A follow-up group session up was carried out five months after the group ended

The group process

The introductory phase of our Balint group was short since the members belonged to the same hospital-unit and therefore knew one another. The group gathered in the O.T ward towards the end of working day, which allowed participants the time and place for themselves in their workplace. An interesting feature of this stage was to hear them talk about the diverse work environments, since each member worked on different wards and units with diverse age groups. This affected their conception and perspective of their profession, which often lead to lively discussions. For example, feelings of loneliness were found

across the board, which proved to be most comforting for the group members who had never openly discussed these feelings before. Their openness and honest expression brought much relief, as later reported by many of the participants.

In the group process, the members often saw the connection between their patients' conflicts and their own, as well as problems inherent in the specific work environments. They also took note of the development of an empowerment language and their sensitivity to empowerment barriers. This process could be achieved in the group when a place was made for an integrative discussion of the patients' problems, the problems encountered in specific system in which the participants worked, as well as the difficulties found in the wider medical system.

Examples

Presenter: I started to share at home dilemmas that we spoke of in the group. I have a problem: I find myself talking with the family about the prognosis for the child; doctors escape from this, but since we treat the child and see the family for long hours for years, we talk. What should I say?

Members: We feel the same. We feel that families depend on our professional opinion, who are we to know the exact prognosis, Is it our job to tell?! Doctors throw on to us the dilemmas about which they don't have time to speak with the families.

I feel a heavy burden put on me, do you feel the same?

The diagnosis is physical but also cognitive. The burden is emotional but also professional – who knows when to stop treating a child?

Leader: You seem to be expressing both the professional and the parental voice. Can we

Personal/group themes	*Personal Empathy: My Internal Locus of Control & Self Efficacy*	*Staff Empathy: My Colleagues and I*	*Professional Practice Empathy: What is our professional.-ideological language?*
'I always look for practical solutions, I come to the group to share emotional burden'	'sharing the burden depends on me, it's my right to do so	'Sharing helps to find solutions together'	'my ability to open up helps encourage my patients to do the same'
'Patients, families & doctors expect quick solutions and hope for clear-cut improvement'.	'Solution doesn't depend only on me; it's also an emotional process.'	'Doctors aren't always aware of what we do. How will we describe what we do in our profession?'	'We treat not only the patient but also the family, couple, they are part of the dialogue'
'I tend to appease clients and doctors; I hesitate to set my limits'.	'My cognitive schema :the need to be perfect is an barrier to empathy'	'We spoke about our professional image. We have to present cases that we treat & also professional dilemmas.'	'Sharing professional image helps me to move out of my paternalistic approach'
'I give homework to patients and ask the family to help but they do not always comply.'	'What does it say about me as a competent professional (as a parent?)'	'Compliance depends on how I share responsibilities.'	'Families and I share common responsibilities towards the patients.'
'We treat children for years, from infant to school years; we know the diagnosis is bad, we feel like parents. When should we stop treating or transfer to a different professional?	'Does saying goodbye and stopping treating depend on us or on the patient or family or the doctor?'	'We are long distance runners with our patients especially children, It's hard, frustrating, to say goodbye!'	'Is it our professional mandate to treat also emotional separation, or is it the job of the psychologist?'

further discuss the different 'hats' that you take upon yourselves?

Table and description of subjects and issues raised in the group and their empowerment components

Follow Up

This took place five months after completion of the group. Its aim was to see the effects of the group process on the group, and the impact of the content areas discussed in the group on the members ongoing daily work. We looked at the treatment changes, their attitudes towards their place of work and their outlook towards the broader health system in which they functioned.

In order to make the group interaction more relevant one of the group leaders gave a very brief talk about the language of empowerment and the empowerment concept.

The language of empowerment

Below are some of the direct quotations of the participants during the follow-up session which express their use of the language of empowerment:

The process of change is due to me, my thoughts, my feelings and my functioning.

Part of my change is due to the system in which I treat the patient.

The process of change is undoubtedly due to the discussion of conflicts between me and my patients and between me and my co-workers.

I feel that I received a lot of support, strength and encouragement from the group, from the narratives they presented in it many of which were often related directly to me.

There is a lot of stigma related to my profession, perhaps the same stigma I have for my patients.

Sometimes I cause myself to fail in my work. Now I realize that this maybe due not only to me, but the difficulties inherent in the system in which I work.

My professional role, my knowledge and skills as a professional give me much strength but it can also limit me when the system in which I work cause barriers to my functioning (for example families).

I always thought that my professional language was adequate and it explained things adequately for me, but I now realize that added concepts and language from the emotional area can help me to understand processes and maybe help me to solve issues better'

Empowerment is a slow process confounded by internal conflicts which are worthwhile discussing openly in the group.

Discussion

As has been mentioned earlier, empowerment can enrich our understanding of Balint activity. Many aspects of Balint activity related to empowerment can be seen in this paper. We should however like to note two particular points which emerge out of our presentation:

1. The concept of empowerment is not only relevant to poor or deprived groups who feel helpless and powerless to break the cycle for change. We maintain that the concept is of great importance for doctors and health professionals generally, and for our Balint activity in particular. The system aspect of empowerment for the doctor indicates that the doctor patient relationship is not only what transpires in the doctor's office alone. Doctors bring into the consultation and treatment their own personalities and personal attributes, their professions and the wider system in which they work.

   In Balint groups too the 'other' is also brought into the group which may have its effects on the group process .The 'other' can be the presented patient, the doctor's specific working environment, as well as the wider system in which he/she functions. The implication of this observation requires us, as Balint leaders, not only to be attuned to the case presented but also tune in to the 'other', which may play an important part in the underlying problems brought to the group.
2. We Balint professionals are currently dealing with the question of process and outcome measurements' of Balint groups. Measuring empowerment operatively is problematic since it is an all encompassing, integrative concept, which makes it difficult to measure and quantify. It usually is measured by the particular professional interested in measurement e.g. personal variables of empowerment. But, as Sadan (1997) says, 'If we take into account that every person needs to be empowered and that empowerment is found in every person but is also affected by the system, then the personal attributes of the individual alone is not the only component of the various levels that may influence the process.' This then makes quantitative measurement almost impossible. Therefore in Balint groups we should see empowerment as a process (gradual and dynamic) of change, a process of gaining control, power and strength, influenced by multi-varied factors. This is a basic issue which we should all think about in our Balint work.

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17th Michael Balint Memorial Lecture
Psychoanalytical Models of the Mind

Kenneth Sanders MD, psychoanalyst

Given on 17 April 2007 at the Royal College of General Practitioners

Thank you for inviting me to give this year's Balint Memorial Lecture.

General practitioners are daily occupied with work at the border between body and mind, and therefore between science and art and between the skills they have been taught and the knowledge which comes from experience. Michael Balint learned from tragic experiences in his own life and from his life in psychoanalysis that working at these borders increases the meaning and enjoyment of the practice of medicine, but is paid for by the need to tolerate the anxieties that come with it. He found in the seminars a way of enabling those of us who are interested in the humanity of our patients to carry this heavier responsibility – a way close to the psychoanalytic conversational method.

At his seminar for GPs at the old Tavistock Clinic in Beaumont Street, where I first met him, there were occasional requests from discontented members for lectures on theory – perhaps lectures like this one – which he discouraged. I think he doubted the value of theory in this context because of the contrast between the extraordinary discoveries made in the practice of psychoanalysis and the provisional models of the mind invented to make them intelligible. I will be describing one that developed in a line from Freud through Melanie Klein and the work of two of her pupils, both of whom, in different ways, distanced themselves from the psychoanalytic establishment. I think this was not accidental, but followed from a model of the mind where a conflict between family life and social life originates in the unconscious phantasies of the inner child, when the intense passions experienced around birth and infancy come into contact with the pressures to adapt to life outside the home.

From these passions of love and hate, children learn what it is for their parents and for themselves to be human, and that the organising fact at the core of family life, is the love-making of their mum and dad, a mystery that has a special cogency because of the possibility of new baby. All other social groupings, professions, religions, work forces, political parties are organised on another principle, that is the authority of senior or elected members, whose qualification for the position is of course quite other than love-making and procreation, and where qualification for membership is by examination and interview for suitability.

This fundamental duality in type of organisation is first felt with the need to survive in nursery school, as an anxious – or heartbroken – mother is waved away by the headmistress. With school and college, the necessity to train for survival and citizenship in the wider world becomes greater, but has little to contribute to understanding the life of the mind – the mind as distinct from the brain.

All this is a preliminary to the psychoanalytic model of the mind which focuses on the borderline turbulence where conflicting interests or ambitions meet. This model suggests how it was that Freud's ambition for academic recognition of the extraordinary phenomena he had stumbled across in his consulting room became an obstacle to those who loved him as the father of psychoanalysis, but who had a problem with him as a professor. I should mention another borderline, and that is the one that is troublesome to a borderline personality, one who occasionally feels attracted to the warmer but turbulent family side, but more often doesn't. Psychoanalysis can be very interesting and attractive to a healthy part of the personality, one that is sympathetic to the struggles of children and to the child within but there is always a part of the personality which cannot take an interest in the inner child, as it seems to belittle and diminish its own significance. In other words there is a split in human nature, manifest externally in the worry that our genius for blowing each other up and mindlessly exploiting the riches and beauty of the planet, will end in tears. There is a less obvious counterpart in our inner lives where the inner child's egocentricity and grandiosity – its Oedipus conflict – threatens the development of a capacity for love and admiration.

There has been a long struggle in psychoanalysis to construct a model of the mind worthy of this complexity of the mind, with its dreaming and peculiar unconscious symbolic transformations, that is so different from the predictable computer-like brain operating with instincts and reflexes. We must return to Freud to follow this struggle.

According to Ernest Jones,[1] his colleague and biographer, Freud and his contemporaries *wanted to deprive mental processes of their peculiar status among natural phenomena*. The 40 year-old Freud sought fame as the discoverer of the secret of the neuroses and as he commuted by train between Vienna and Berlin to visit his eccentric friend, the ENT surgeon Fleiss, he scribbled pencil notes on a grand Project for a Scientific Psychology, which have survived. The Project became the basis for the idea that the brain and central nervous system seek constant quietude, through the ebb and flow of an imaginary substance called *libido*. Yet he was finding in his consulting room that the mind was

of Dostoievskian complexity and while his theories were met with scepticism, case histories like the Rat man and the Wolf man were written with a poetic intensity that won him the Göethe prize for literature.

As new clinical observations were pushing investigation further and further back towards the separation anxieties of infancy, the idea gained ground that with the milk from the breast, the baby, in unconscious phantasy, sucks in a parental idea, which becomes part of the structure of its mind, an internal parent, as the milk becomes part of the structures of its body. And like the food and drink, anything unwanted can be got rid of in the urine and faeces. Perhaps depression was a state of mind where one of the internal parents had been got rid of in this way. Perhaps obsessional states betrayed uncertainty whether or no this had happened.

But the old libido theory would not cover this sort of thing. Freud, at 64 years old, surprised his followers with a new model of the mind, which this time resembled the structure of a family. There was an inner child or ego, and inner parents, and the unconscious was renamed the Id.[2] He described healthy development as 'the heir to the Oedipus complex' – a change of mind that happens in the child when the advantage of having two parents is thought to outweigh the temptation to have only one. When that happened, there appeared a structure in its mind consisting of an internalized mother and father 'somehow united with one another'. He called this structure a 'super ego or ego ideal'. But while Freud soon used only the term 'super ego' for this parental structure in the mind, others were to become interested in the difference of meaning that could be conveyed by using both terms.

The term 'Id' (*Das Es* in German, literally 'the It') Freud borrowed with permission from his contemporary the physician Georg Groddeck, who had got it from Nietzsche. Groddeck treated people with psychosomatic disorders in his private nursing home. His concept of healthy development uses the term Id as an unconscious ideal that leads the child forward to discover all it can about the world into which it has been born.

> I hold the view that man is animated by the Unknown, that there is within him an "Es" and "It", some wondrous force which directs both what he himself does, and what happens to him. The affirmation 'I live' is only conditionally correct it expresses only a small and superficial part of the fundamental principle 'Man is lived by the It'.

> Groddeck again:

> Is it not strange that we should know hardly anything of our first three years of life? Now and then a man produces some faint remembrance of face, door wallpaper or whatnot, which he claims to have seen in infancy but never yet have I met anyone who remembered his first steps or the manner in which he learned to talk, to eat, to see or to hear. Yet these are all vital experiences. I can well imagine that a child in stumbling across the room for the first time conceives a deeper impression than his elders would from a visit to Italy.[3]

Let us add, not just stumbling across the room for the first time, but tumbling out of the womb and into the world. We may imagine that the infants are unsure whether this change is for the better of for the worse, or just an exchange of agoraphobia for claustrophobia. But having inhabited a space within the mother, and not being sure whether it is a rejection or a lucky escape, the idea persists of the mother as a three-dimensional object one might live inside or outside. Perhaps this is when a split occurs in the mind of the infant: one part perhaps never emerges, or – and this is a common unconscious phantasy of dream life – having sampled outside, decides to go back inside.

Psychological illness is associated with the unconscious phantasy of life inside rather than outside the internal mother, and the border line between the two has become the focus of interest since Melanie Klein described the mind ***as*** unconscious phantasies about an internal family. These are seen as split at first into an ideally good family and a bad one, and dreams as the evidence of the symbol forming activity of the mind to which attention can be deployed when the organs of sense that monitor external reality are relatively undisturbed in sleep.

This model of a primary inner reality has less affinity with medicine than with literature, philosophy and theology; Platonic philosophy because the internal parents function as ideals of courage and love to which the inner children can aspire; theology because they seem to bear a close relationship to the concept of the gods. Theology also suggests how the gods, who vary and have varied so confusingly between kindness and cruelty, may be related to those two terms ego ideal and super ego. For the term 'super ego' has found a use to name, not a parent, but a feared authority figure that has deteriorated from the ideal father. If the ego ideal were the parental deities who presided over the welfare of the children as models of manliness and womanliness, the super ego was the grandiose big brother of life in the nursery and playground – in other words not a parental figure at all but an aspect of the child self.

In Orwell's *1984*, Big Brother made lovemaking a punishable offence. Those who depose their ego ideal and elect themselves to this office all show the same characteristics of grandiosity, while the creative ideal languishes in misery like Shostakovich in the time of Stalin. This is the phenomenon Klein called *projective identification*,[4] and from her experience of analysing small children she conceived the idea that the frustrated child in unconscious phantasy projects an angry part of itself 'equated with faeces' into the inside of the mother, transforming

her from ideal parent into authoritarian super ego. Klein's model describes healthy development as avoiding confusion between good and bad by splitting the two views enough to keep all positive feelings about the mother and father in one compartment of its mind, and all the bad temper and paranoia in another, until hopefully there is a thoughtful questioning of this tidy arrangement, and with a move to bring the two worlds together, when the so-called good, but maybe complacent, children recognise their complicity in these negative activities. This conflict between positive and negative views of the experience of dependence in childhood, and the anxiety associated with it, may I think be recognised in the context of external reality in ecological anxieties about the deterioration of the beauty of the planet – our mindless exploitation countered by worry that the bounty of Mother Nature on which we depend will dry up.

This was how things were left before some of the pupils of Melanie Klein discovered that this so-called splitting and projective identification had more to offer. Wilfred Bion proposed that the mother with her baby at the breast provided more than security and love. He wrote about the maternal reverie of the nursing mother being in unconscious communication with her infant and helping it to think about its sense impressions of external reality and its internal body sensations[5]. He described the infant experiencing the mother's mind as a container, as is her breast into which it was invited to place those painful and passionate feelings which it had assumed it could only evacuate as meaningless. In the container of her mind, equated with her breast, these confused passionate feelings are changed into a form which can be used as the stuff of unconscious symbolic thought, rather than meaningless faecal waste that needed to be got rid of. This positive concept of projective identification was needed to balance Klein's description of it as an intrusion into the mother's mind and body. For the intruder there is no access to the container of her mind and breast, and therefore no symbolic thought, no ego ideal, the distinction between adult and infantile is lost, there is only a narcissistic .hierarchical world with the super ego (Big Brother or Sister) in charge.

Donald Meltzer wrote about the psychoanalytic process as being one in which the thoughtful part of the personality can exercise a choice. He imagined the infant's anxiety at the time of birth as it emerges into the light, countered by amazement at the beauty of the mother's face and breast and the experience of mutual love at first sight, until having been cleaned up and drunk its fill and fallen into a sleep, it wakes from its dreams to the pangs of hunger, a dirty nappy and doubt about the faithfulness of the mother. But with a clean up, a feed and maternal help in thinking, hope is restored, until the next cycle.

Meltzer writes of the aesthetic dimension of mental life having its origin here, later extended to the beauty to be discovered in the wider world, but that the transition from the inside to the outside, which involves integration of the good and bad inner children, is a threshold that is not crossed without turbulence and struggle, and a shift in a view of the world and the self in it.

A clinical note may illustrate this. Mrs A, an intelligent lady in her late thirties, regretfully understood in the course of her analysis that she would not succeed as an actress but had meanwhile discovered a talent for journalism. With hope renewed, she moved from a dismal rented room to a brighter furnished bed-sitter, and then, with her parents' help, to her own two bed flat. She became pre-occupied with the decoration and furnishing of the flat, and spoke about white sofas as being aesthetically ideal, were they not so easily soiled as to be impractical. We discussed the white sofa in connection with the comfortable but utilitarian analytic couch on which she reclined, as a symbol of a mother's lap and breast and therefore mind. Would making further use of the analysis spoil our apparently amicable relationship? The subject of her reputation for witty remarks came up. To her surprise one of her friends had been seriously offended by what was in fact not a witticism at all but simply an offensive personal remark. For a week or two she seemed puzzled by what I thought was a move towards integration, as the cynical remarks about the analytic world with which she had previously enjoyed tormenting me, now made so-called free association distinctly embarrassing.

Meltzer wrote about infantile and adult sexuality – from the point of view of the infant. On the outside of the mother, joined to her now not by umbilical cord but by nipple in mouth, the infant may in some infant way conceive that its existence has followed from mother and father being analogously 'joined together' in a love-making, The father this time restores the mother after her rough usage by the needy children, as a milkman who refills the emptied breasts, a hero who, with Herculean courage, cleanses the Augean stables of her rectum of all the faecal projections, and at her genital fertilises the eggs and attends to the need of the as yet unborn babies. This lovemaking between the parents remains a mysterious area, which has a 'private' sign on the door, and resists intrusive projections. The development of adult healthy sexuality comes secondarily from identification with internal parents' lovemaking. Infantile sexuality leads to confusion, associated with the intrusive form of projective identification, linked with anal masturbation, with hostility to the internal father as the guardian of mother and her orifices, and violation of the mother herself by the intrusion. The structure not only of mental illness but of character seems to be related to the time of life spent in retreat into the paranoid atmosphere of the imagined hierarchical interior world of the

mother's rectum, compared with time passed outside drinking in ideals of love and beauty at her breast, while at the borderline between inside and outside are the uncertainties of birth. Donald Meltzer's book *The Claustrum* is recommended for further details.[6]

I am going to conclude with three pictures which may make clearer than all these words, these three states of mind: the insider's paranoia and problem with authority, the borderline situation where emerging from the interior is of uncertain wisdom and, finally, outside but equipped with ideals and ready for adventure and discovery.

First, I like the story of the three little pigs looked at from the point of view of three infants who don't want to be born, in which case the big bad wolf, who blows down the house of straw and wood, becomes a competent obstetrician who succeeds in delivering two of them while the third remains bricked up inside, strangely triumphant and convinced to the end that daddies eat their babies.

Next, the borderline or threshold between the paranoia of life inside while submitting to the inevitable emergence into the daylight is nicely drawn in this report from someone who alleges he does remember his birth:

> My first interview with Dr James Winter was under dramatic circumstances. It occurred at two in the morning in the bedroom of an old country house. I kicked him twice in the white waistcoat and knocked off his gold spectacles, while he with the aid of a female accomplice stifled my angry cries in a flannel petticoat and thrust me into a warm bath. I am told that one of my parents, who happened to be present, remarked that there was nothing the matter with my lungs. I cannot recall how Dr Winter looked at the time for I had other things to think of, but his description of my own appearance is far from flattering. A fluffy head a body like a trussed goose very bandy legs and feet with the soles turned inwards-these are the main items which he can remember.

These ironic words were written by Dr Arthur Conan Doyle in an opening paragraph of a short tale about family doctors called 'Behind the Times' which I recommend to you.[6]

My third story is about Christopher Columbus who, on his third crossing of the Atlantic wrote in a letter to the King and Queen that in his voyages 'neither reason nor mathematics nor maps' were any use to him compared to certain prophecies of the Old Testament.[7]

Groddeck's word for an inner inspirational force, muse or godhead was the It. The psychoanalytic model tempts us to call it the breast and Columbus may have agreed, for writing of his conviction that somewhere under the Atlantic Ocean was the Earthly Paradise of the Holy Scriptures, he added:

> I am therefore forced to conclude this about the world. I have found that its shape is not a true sphere as scholars have told us but more like that of a pear which is completely round except towards the stalk where it protrudes considerably: or that it is like a round ball with a protuberance on one side like a woman's breast.

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A Narrative Approach to Clinical Supervision

by Helen Halpern MB BS MRCGP MSysPsych.
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(Talk given to the Balint Society on 21 November 2006)

I'm aware that a number of people here tonight may already know quite a lot about the topic that I am addressing. From your previous experience, reading and conversations you may already have strong views, and if the idea of narrative is related to stories and how we understand them then I hope this evening we can explore how our different narratives interweave. I suspect that we will find areas of difference, places where our stories touch at tangents and also intersect. My plan for this evening is to talk briefly about the concept of clinical supervision in primary care, to outline the context and theoretical bases for how one particular model has developed and how we teach it.

I'd like to tell you a little bit about my personal narrative now to explain how I became 'indoctrinated' with these strange ideas. On the psychiatry attachment as part of my GP training, I was lucky enough to be encouraged to take on my own psychotherapy patient and to have supervision from a psychoanalyst who also facilitated the psychiatry team's group supervision. I found it baffling and fascinating. In the practice where I was a GP registrar there were regular team meetings to discuss 'difficult' cases with an outside facilitator, who I now know was a family therapist. And, of course, there was a strong Balint influence both from the presence of Andrew Elder in the practice and from the GP training group. After finishing my GP training I continued to attend a Balint group, run by Alexis Brook at the Tavistock for a couple of years, and when in the mid 1990s a course was advertised there called 'Working Systemically with Families and Teams', I was intrigued. I knew that I worked with families and teams but I had no idea what 'systemically' meant, so I decided to follow my curiosity and find out. The course was designed for people working in primary care and was run by Caroline Lindsey and John Launer. I met many thoughtful and creative GPs on the course, and my consultations with patients started to change. I was hooked. Some of us who attended that course went on to do the full training in family therapy, and throughout this I certainly struggled with thinking about how to apply this work to primary care. How could all these skills be used when consulting with patients and were they relevant to helping GPs think about their consultations? For me, a narrative approach seemed a good fit. Patients often bring us their problems in the form of stories, and as clinicians this is also how we frequently talk about problems related to our work. We can use Tom Andersen's definition of a problem to re-frame it as a 'stuck story', one which we have been thinking about in a fixed way. A conversation in which someone helps us to become curious about how this situation came to be defined as a problem can help us to form new descriptions. Through work with John Launer we have developed a narrative based model which seems to be helpful to practitioners in providing supervision in different aspects of work within primary care.

Some professions (counsellors, nurses, therapists) already have a history of clinical supervision using particular models. The idea of GPs having clinical supervision is relatively new. Although he never used the term, was Michael Balint actually the first person to write about the concept of supervision for GPs? The narrative-based model is still in the process of being developed as we continue to learn and discuss ideas through courses and workshops. Part of my learning and development comes from the opportunity to present this account to you tonight. It is only an account, my account, to try to make sense of where we are now, based on my therapeutic family of origin.

I'm going to outline the background and framework to this particular model of clinical supervision, but first I would like you to think about what you understand by the term clinical supervision and the different situations in which this might take place. Could you spend a couple of minutes discussing this with someone sitting near you.

What is clinical supervision? There are a number of different definitions but I am going to use the term to refer to supervision as an activity intended to promote reflective professional practice and ultimately to improve patient care. In our model it is more than just the processing of the emotional aspects of the work. The actual task of supervision may vary depending on the context for which it is requested. I see the different contexts as being: GPs 'supervising' patients, colleagues, as trainers, mentors, educators, coaches, members of healthcare teams and as appraisers.

As we trace the unfolding of the Donaldson report and the implementation of its recommendations, some form of clinical supervision may become part of our culture. I think it's really important that a system of supervision for a particular profession develops from the people who work within it so that it properly suits its own context. In our case this means that we can continue to ensure that the developmental aspects of our work can be prioritised, and that it does not become purely a tool of clinical governance and assessment. I'm

now going to say something about clinical supervision in primary care.

Let's start by thinking about how clinical supervision helps practitioners.

It allows them to go beyond purely functional, automatic practice. It addresses complexity and the uniqueness of each encounter. It helps develop inner and outer resources for reflection, and it develops professional behaviour in terms of competence and confidence.

Brigid Procter has described a model of reflective practice which involves the clinical supervisor taking on different roles. She sets out three tasks of clinical supervision:

1. Normative – setting a professional standard or bench-mark, challenging departures from accepted professional ethics, co-monitoring of competence and practice and is therefore concerned with performance.
2. Formative – learning and development of good practice through personal and professional development to allow the unknown and the unspoken to become apparent.
3. Restorative – caring for the carer in a safe and confidential relationship, letting off steam, recharging batteries; this may contribute to preventing burnout.

The experience of a helpful supervision may be a parallel story with that of patients who may leave a consultation without being cured but may have found a new way of managing their illness or the injustices they have suffered.

The ideas in our model have been developed from multiple sources, but especially from family therapy, systemic and narrative approaches. I'll try to explain how this has occurred by giving some historical and contextual background. Some of you may be very familiar with this so I'll just give a brief resumé. It is interesting to reflect that those of us coming from a systemic background and those from a more psychoanalytic approach may now be finding ourselves in a similar place, but the journey and the philosophy underpinning our ideas have been different.

We need to start by going back to psychoanalysis because psychoanalysts were the first group of people to use the idea that talking about problems made a difference to patients and also to colleagues. Please forgive me if I misrepresent the psychoanalytic paradigm but my understanding is that their approach would generally be: 'What is really going on here?' 'What lies beneath the surface?' The work is that of 'finding fundamental truths'. Those of you who have a background in this way of working, including psychodynamic and Balint group work, will be familiar with this way of thinking. It's the idea that there's always some deeper truth underlying what seems to be going on. Among psychoanalysts themselves this way of thinking is changing and indeed many systemic therapists use psychoanalytic concepts to inform their ideas. The difference is that these would be used to make hypotheses which may be more or less useful to the client, rather than being interpretations of underlying truth.

Following the Second World War a lot of people in the mental health world such as psychiatrists and psychologists became interested in ideas from quite different areas to psychoanalysis. These included communication theory and cybernetics (the way that mechanical, engineering and robotic systems, even some biochemical systems – such as the Krebs cycle – are regulated) and how these ideas could be applied to communication and feedback in human systems. They became particularly interested in systems theory, which postulates that things are interactional, and that people within a system all mutually influence each other. This led family therapists to work in ways which tried to help families solve their difficulties by focusing on interactions between family members, rather than just looking at what went on inside individual people.

Probably the biggest revolution in family therapy came in the 1970s and 1980s with four psychoanalysts working in Milan, Italy, (Palazzoli, Prata, Boscolo and Bertrando), who devised a way of working based on asking questions. They found that giving interpretations and advice to people was less helpful than working with them to address the question of people's belief systems and how things were being understood. In this frame we would be interested in what people believe reality to be rather than what it actually is and how perspectives on this differ between people in different parts of the system. This approach also takes the position that questions themselves stimulate people to think differently about their problems and to act differently in relation to them.

The next very major influence that has become strongly incorporated into systemic thinking was that of the feminist movement, which draws attention to the importance of gender, culture and power.

We can now move on to post-Milan and the influence of social constructionism. This is the idea that what we believe to be reality is defined by social or cultural convention. To get an idea of what this means it may be helpful to think of the changing views on homosexuality or marriage over the last century. Social constructionism is very similar to the idea of narrative, which comes from the arts and the interpretation of text and is how we become increasingly interested in the threads building up a story and how different parties contribute to this. It's also connected to the whole area of post-modernism, in which all stories are considered to have equal validity. The only concern is with the surface phenomena. This leads us to a sometimes confusing and uncertain position about what is true, where reality is constructed from stories in conversations between people where meanings may be drawn out and altered. John Launer uses

the metaphor of continually weaving a tapestry rather than unpeeling an onion. The way knowledge is laid down influences how we think. We can construct stories and test them against the constraints of a real, though ultimately unknowable world. The Guardian book of Notes and Queries suggests a definition of post-modernism as: 'today's interpretation of yesterday's vision of tomorrow'. All theories are stories and represent the best efforts from different standpoints at making sense of an uncertain world. How useful these stories are depends on feedback from others and from our own experience in how they help us to deal with the world. As David Campbell has written, a pilot is more successful with the concept 'the earth is round' whereas an architect might find the concept 'the earth is flat' more helpful. If we accept some things as 'true' it may stop us from looking at other possibilities. We need to maintain a position of curiosity as there may be multiple 'truths' For example have a look at this optical illusion which shows an old woman and a young woman. Can you see them both and can you see them both at the same time?

I think these ideas are important for us in general practice as we see patients and their families response to illness and life difficulties within the influence of other, wider networks e.g. the effects of poverty, housing, the changes in the NHS and the political system in which we work. We have to work with explanations which are an interaction of our beliefs as doctors and the patient's beliefs, as meaning is constructed in the course of the consultation. This is important in respect to power issues in the relationships between ourselves, patients and the people we work with. This frame of thinking gives us a role where we can collaborate with people to help them develop different stories about themselves. It takes into account different cultures and beliefs. It forces us to acknowledge that qualities are not embedded in people but are how people show themselves in response to how other people treat them and to the context in which they live. It may help us, as doctors, to understand our own varied roles and set them in a social and political context and it can free us from the position of being the sole interpreter of reality and from an inflated and unrealistic sense of responsibility for what happens in the consultation. I think it fits well with primary care. This context also reminds us that to stay 'real' we need to acknowledge our medical expertise when appropriate, and that some things are not stories (poverty, illness and death). Some things cannot be changed by conversations and some experience may even be beyond language.

To work in this way it then becomes increasingly important for us to manage our own uncertainty. We can never know the end of the story as we are simply part of an episode, and what is true may change over time. We have to rethink our ideas about change. Our role may simply be to shift a person's perspective or to shake things along a bit to create a new version of the story which makes better sense for them at that time.

Applying theory from systemic or narrative approaches also provides some ideas about how problems are best addressed and what may help to promote change. It suggests that people don't always find other people's solutions or interpretations of a situation to be helpful, and that asking questions to help the person think about alternative stories may be more useful and more respectful. It allows people to question their current realities and choose the best way forward for themselves. It also forces us to confront our own role in relation to determining what reality is for others and the constraints on what we can do.

For me this kind of approach offers a bridge between a rather rigid medical model and some of the philosophical ideas I suggested earlier, between the apparently hard world of scientific facts and the worlds of explanation and meaning in people's stories.

Before we get into the nuts and bolts of the narrative approach to clinical supervision, I'd like you to think about this case which was recently brought to a clinical supervision workshop. The GP, who is a non-principal, had several consultations with a 45-year-old window cleaner who had fallen and injured his ankle but was continuing to request medical certificates long after the ankle should have healed. The GP felt uncomfortable about providing the certificates and also uncomfortable at challenging the patient about this. The consultations seemed to follow a repeated pattern of the patient coming as an emergency and the GP, who was already running late, getting him out of the room as quickly as possible. In addition the GP also had concerns that one of the partners in the practice had given this patient a sick note on the basis of a telephone conversation.

I would like you to get into groups of two or three with people around you.

I am going to give you two rules:

You can only ask questions.

Just for the purpose of this exercise you cannot ask questions about the GP's feelings. (These are not rules intended always to be used, but purely to assist learning what may be a new technique for some people.)

Please spend five minutes writing down some questions you would ask this GP if you were providing supervision on this scenario.

Some possible questions:

The GP-patient system

- Are there differences between the GP and the patient which make it easier or harder to talk about the problem?
- What does the GP think would happen if the medical certificate was refused?

The GP-practice system

- Who else in the practice might agree/disagree about giving medical certificates to this patient?
- Is there any kind of practice policy on

medical certificates?

- What systems operate in the practice about booking appointments?
- Is there a choice of which GP the patient can see?
- Is the GP worried about a clinical governance issue with the other GP who gave a certificate without seeing the patient?
- Are there differences (age, gender, ethnicity, status in the practice) between this GP and the other GP which make it difficult or easy for this concern to be discussed?
- What might the GP say to explain the problem to an interested non-medical visitor from another country?

The GP's belief system

- Does this GP have particular views on the GP's role in giving medical certificates?
- Does this GP have particular opinions about the welfare state?
- What other options does the GP think are possible?

The patient's belief system

- What explanations does the GP think there might be for this patient's request?
- What else does the GP think it may be helpful to understand about this patient e.g. who else is in his life, how has he managed previous episodes of illness?
- How does the GP think this patient might view him/her?
- What narrative does the GP think this patient might have about these encounters?

Between us we have generated a huge range of questions. As I move on to explain some of the theory of the narrative approach to supervision you may find it interesting to see how you think these questions fit in.

Exploring the consultation has been a constant source of fascination to some of us. While the original courses at the Tavistock focussed on consultation skills and interactional skills, they have now moved towards a focus on supervision alone. This is partly pragmatic; in the context of the current political climate in the NHS this is what the London Deanery will support financially, as well as recognising that practitioners want to talk about cases and work-related issues that press their buttons. As the Tavistock courses evolved, Caroline Lindsey and John Launer drew up a kind of mnemonic for their approach to the work. They called it the seven Cs as it consists of seven words each beginning with the letter C. These have also changed over the years to adapt to new explanations of the concepts involved. The current set of seven Cs that we now use for teaching is as follows:

Conversations – The conversation in itself is the working tool. Simply through taking place, effective conversations between people can create a new understanding of reality.

Curiosity – about your patients, colleagues and about yourself. One of the skills of clinical supervision is in the appropriate use of curiosity to listen closely and choose questions that may help move people on in their narrative. The task is to be tuned in to what the supervisee (or the patient) needs so that the conversation is carried on within an ethical framework. This means focusing questions and not simply asking them through 'idle curiosity'. During a supervision conversation many ideas may occur to the supervisor, and the aim is to reframe these hypotheses inside their head into questions. This is one of the skills we practise in the workshops as well as learning how to ask appropriate questions, when to pursue them and, importantly, when to drop them based on feedback.

Contexts – the networks, culture, faith, beliefs, community, values, history and geography etc. We encourage people to be particularly aware of ideas of differences between them, especially those that may relate to how power is understood e.g. (age, gender, experience, sexuality, culture...) How might these differences be affecting what can and cannot be spoken about? What is the context/purpose of the supervision? Is the supervisor or the supervisee accountable to anyone?

Complexity – how things interact with each other. This includes a dimension of time. It helps the move away from simple cause and effect explanations. It looks at different perspectives and definitions and how these relate to each other.

Creativity – how you can create a story which makes better sense for people. This includes using yourself, your intuition and sensitivity to fine-tune the conversation. It involves paying close attention to language and non-verbal cues.

Caution – knowing when to stop, when to be straightforward, how to balance an appropriate level of challenge with being too bland.

Care – being respectful, considerate and attentive to your patients, supervisee and to yourself, working within an ethical framework.

We have also developed some Rules for how to give effective supervision.

1. The supervisor is not considered to be in a position of authority over the supervisee. There may sometimes be exceptions to this depending on the context of the supervision, for example a trainer and registrar, or if the GMC has recommended remedial supervision of a practitioner.
2. The supervisor's role is to help the supervisee reflect on and expand the narrative they present in a non-judgemental way.
3. It is not necessarily expected that the conversation will lead directly to any solution, but it may simply help shift the dilemma or narrative in a more helpful way for the supervisee.
4. The supervisor should not offer advice unless specifically requested by the supervisee. If the

person supervising is asked to give advice they may wish to think with the supervisee about how advice has been for them in the past, and what the effect might be of any given advice in terms of permission and constraints

5. The conversation does not at first set out to explore the supervisee's feelings, although their emotional response may become an important factor to consider.
6. The supervisor asks questions rather than offering interpretations.
7. Each question that is asked should be based on the response to the previous question. This helps to build up an interactional picture based on feedback.
8. In general the supervisor should not ask a question if they think that both they and the supervisee already know the answer, as it does not help move the narrative forward.
9. The supervisor needs to pay close attention to the language used by the supervisee and to track this. This means unpicking the details of the person's own words and teasing out their meaning.
10. The supervisor notes non-verbal cues and body language and uses them to help frame subsequent questions. For example the supervisor might comment that 'When you were talking about the meeting with your partners I noticed that you looked very uncomfortable; can you say more about that experience?'
11. The supervisor will necessarily base their questions on their own knowledge and experience but needs to be wary of making assumptions and imposing these on the supervisee. Indeed one of their roles may be to challenge the supervisee's assumptions.
12. The skill of the supervisor often involves working 'on the cusp', offering enough challenge to the supervisee to help in the exploration of new ideas, but not so much that the supervisee becomes excessively defensive or anxious.

For the last few years the London Deanery has been putting on 1-3 day courses on clinical supervision. These have been mainly aimed at GP trainers and appraisers but also some primary care nurses, managers and administrators who are involved in clinical supervision. The work has now been taken up by other Deaneries around the country and is extending to hospital doctors and even dentists. To give you an idea, last week John Launer and I taught three separate groups each of about 16 people. Two of these groups were an introduction to clinical supervision and the third was the ongoing Tavistock workshop for people who have attended a basic course and wish to extend their skills.

So what do we actually do? We offer a mixture of theory and practice. I'll tell you about the Tavistock workshops, as I am particularly involved in these. There are five, three-hour workshops per term at fortnightly intervals. People can join for one term but most stay for at least a year, and many have chosen to continue for a second year. In the workshops we generally divide the afternoon into two parts. In the first half we discuss a theoretical concept and practice skills based on this or from the micro-analysis of video. We make use of reflecting teams, people who are not directly involved in a piece of work but use their detachment from it to comment and contribute to the pool of ideas. We also focus on our own narratives and how the stories that we bring may impact on those of the people with whom we are working. This involves looking at people's own families of origin and the organisational systems in which they work, with a particular emphasis on factors that may affect how they interact with other people in the context of providing clinical supervision. Then we have a tea break, and in the second part we have small group work on case supervision. The cases people bring range from stuck patient consultations, difficulties in teamwork, frustrations with the wider healthcare service and dilemmas about career choices. The more experienced people are encouraged to help those less experienced in this model of supervision and they, in turn, are supervised on their supervision skills.

It may strike you that clinical supervision can involve taking on different roles and being able to change from moment to moment as the story emerges and a new narrative is being constructed between supervisee and supervisor. A systemic approach offers the possibility of engaging with multiple and changing contexts in medicine. It is like using a lens to zoom in and out, shifting focus from wide-angle to microscopic. It involves maintaining curiosity and allowing a range of points of view to be brought out. I find it exciting and challenging. I get a real buzz from seeing how people can manage to find new ways of looking at old stories. Sometimes the work involves helping people to tolerate an unsettling sense of uncertainty and confusion but sometimes things which had seemed to be a problem just dissolve.

I hope you have found this interesting, perhaps confusing, and that it will leave you with some new ideas and questions. Thank you for listening.

Coda:

I have used the ideas of many people in putting together this talk and apologise for any unacknowledged references.

Where the Wild Winds Blow

Diana Bass, psychoanalytic psychotherapist, London

(a paper read to the Balint Society on 24 October 2006)

This paper is written from the work that I do as a student counsellor and psychoanalytic psychotherapist in a university counselling service in a large London teaching hospital. A proportion of the medical and dental students who approach the service for help are from families of South Asian origin and this paper is about some of my experiences in working with these young people. The students usually contact the university counselling service themselves, although this referral may have been prompted by suggestions from friends or tutors. In the first meeting it often becomes clear that they have been struggling with emotional difficulties for a considerable time, sometimes years. It is often not until their difficulties begin to have an impact on their academic performance that they seek help.

For this paper I am writing about a specific group of young people, on the whole British-born, highly motivated, and high achieving, but who present in a state of paralysing internal conflict. These unconscious conflicts are evident in all the students we see and are based in the transition from adolescence to adulthood. The theme of this paper is about the amplification of these transitional conflicts in these particular students who are at the same time negotiating the differences between the culture of their family of origin and that of their present environment. This crisis is often triggered by but can also itself be a causative factor in an external event, typically failure of an exam or relationship. In the consulting room it becomes clear that what is absent is an internal structure or language in which these emotional experiences can be acknowledged and thought about. The experience of guilt and shame are particularly resonant, associated with a feeling of failing to cope on their own, and that they have somehow let down both family and community. Feelings of emptiness, dislocation and suicidal despair are common. Their overriding emotional experience is of not being able to get it right. This predicament is often felt powerfully in the counter-transference, and there have been times when, in the grip of this, I have doubted my own capacity to understand and be of help in any way. At the same time it seems important to acknowledge that there will be times when I will indeed get it wrong, misunderstand or become confused. This situation might be understood to be arising from the crucible of colliding worlds. I am aware that this is a very large topic and I can only touch on some of the issues involved.

It was an interesting experience writing this paper. I found myself thinking about how, as a white psychotherapist, my words might be received and understood. I wondered about my place in the hierarchy, whether I would have the right words, language, and attitude. Would assumptions be made about my life and experience which would somehow invalidate my words? I wondered about having a place in this discourse. I realised that these thoughts mirrored many of the anxieties these students have had to face throughout their lives. The title of the paper reflects the difficult situation in the consulting room in which I and the student, at a personal, professional and institutional level, are exposed to powerful and often contradictory forces in which it is vitally important but extremely difficult to keep ones footing. The image of the place 'where the wild winds blow' I had in mind was a high mountain pass, perhaps an ancient migration route, the lands of the past and those of the future spread out below.

With young people in late adolescence issues of identity are paramount. The struggle to integrate the experiences of childhood and adolescence are particularly daunting and difficult when there is an underlying sense of a fractured self. Defences against painful areas of conflict can manifest in different ways and lead to developmental breakdown at this stage of transition. This breakdown often reveals an underlying traumatic situation in which psychological development has been stunted or curtailed. The issue of appropriate psychological treatment for students training in medicine can be seen to mirror the dilemma of their parents, who want to prepare their children in the best way they know how for life in a difficult, challenging and competitive world.

Working with a therapist from a different ethnic and cultural group sharply delineates the issue of identity, and challenges both therapist and patient. To confront the fact that we are not the same, is to face head on the pressure to take refuge in the powerful projective mechanisms of splitting, denial and denigration which are designed to protect us from the feelings of exclusion, vulnerability and aloneness which we all contend with throughout our lives. To feel that we are part of a powerful and superior social, cultural or religious group can be a comforting fantasy when faced with doubt and uncertainty. For the group to serve its function, outsiders must be feared, denigrated and rejected because they carry the hidden, disavowed parts of the self that cannot be acknowledged because of the ensuing pain and guilt about the psychological damage inflicted on the self and others. This sense of occupying the moral high ground, which we see employed to devastating effect around the world, is a powerful weapon based on the false dichotomy of good and evil. Evil exists in any sense of complacency about our own goodness. We can think we know this, but to work with these conscious and unconscious dynamics in the heat of the session can be both challenging and

confronting. It can be extremely painful and shaming to suffer the narcissistic wounds which can result from encountering, confronting and acknowledging our own prejudices and fears of difference.

It would seem that some of these young people have become stuck at the point of negotiating the necessary emotional separateness from their family of origin to enable them to create a stable enough adult identity. This separateness is necessary to allow them the internal space to discover the reality of their own individual feelings, thoughts and emotions. It is this internal space, a place to think, that allows the individual to base their decisions and life choices on a clear perception of their own strengths and weaknesses, fears and desires. This interior dialogue with internal and external reality is dynamic throughout life, constantly in flux, under pressure at different times from both within and without. When anxiety and emotional pain become too much for the individual to bear, this process can become stalled or break down. In the same way parents who are themselves emotionally overwhelmed or traumatised, may not be able to provide sufficient psychological containment or emotional safety for their infant to learn how to tolerate the pain and anxiety of separation without resorting to desperate measures of defence. These psychological defences, particularly those erected against traumatic memories of rejection, separation and loss, if internalised, can impair the growing child's ability to process and digest events in a way that leads to psychological development and growth. Any process of change which threatens to trigger these profound anxieties can markedly interfere with the ability to think, to learn, and to remember.

The young people I refer to in this paper have as a common thread, the experience of immigration in their family's recent past. Coming from an ethnic minority means that a history of immigration is something that can also be visible to others. The drive to immigrate to achieve a better future requires both energy and confidence and the full impact of the losses involved can be denied.

As an immigrant myself, I am aware that this transition is profoundly meaningful and can be traumatic at an intra-psychic, social and cultural level, and that this effect is even more powerful if the host culture is ethnically and linguistically different to the country of origin. 'Losing one's place' physically and emotionally, no matter what the eventual gains, is akin to a major bereavement. These are children, often the first-born to parents who, even if they were financially secure, were often far from family and friends, trying to survive and find a place in a strange and sometimes hostile society. In cases of arranged marriage, it might be that the intimacy between a couple that is necessary for painful feelings to emerge, and not be felt of as shameful, has not had time to develop before children are born. This can mean that there was little time or opportunity to mourn for the life left behind. This pain is often unconscious until it surfaces in these young people, going through their own life-changing transition, often at the same age that the parents' immigration took place. They feel suddenly lost and uncertain, lacking signposts and the tools to think about why this is happening to them, like an immigrant in a foreign country. They may need at that point the support of a counsellor or therapist in a safe setting so they can explore the sources of their pain and breakdown, and make the relevant connections, without feeling they are adversely affecting or hurting the people around them.

A considerable proportion of these students are also at a financial disadvantage, having parents who have struggled to bring up and educate their families in situations of considerable poverty and deprivation. Often these students are and will be in the position of supporting family members both financially and emotionally. There is always mental pain involved in unconscious conflict becoming conscious, even more so if there is a fear of rejection, or parental figures are felt to be emotionally fragile. There can be protective fantasies in families that there are no differences between family members, or between the generations, that cultures can be transposed and conflict avoided. The reality is that each generation must struggle again to find their own truth, to make their own accommodation between their internal world and the external environment. This process is halted when there is a terror of the re-emergence of unprocessed traumatic states. Reflective capacity has to be shut down and emotional curiosity has to be curtailed. These students have had to use their intellects to hold themselves and their families together and when this defence starts to crumble panic can set in. They want, in the psychoanalyst Bion's term, knowledge without experience.

The problem is that when things go wrong, they are left without internal resources. In their attempts to deny their emerging selves, their curiosity, their liveliness and desire, these young people may sabotage their opportunities, resort to self-harm, attempt suicide, or starve themselves, They can become deeply depressed, shutting down their own minds and perceptive processes in the face of so much pain. Success can also offer as big an emotional challenge as failure. To become more educated or higher in social status than one's parents, especially if they are perceived as emotionally fragile, can trigger powerful unconscious anxieties about being destructively competitive or triumphant, or abandoning one's own unmet infantile needs or those of the dependent parents. A student told me that in his family emotional distress was not allowed. If you failed an exam and there was nothing physically wrong then it was perceived to be because you were either lazy or stupid. I have often had to bear feelings of being incompetent or

stupid in the counter-transference as the feared vulnerability is split off and projected in a desperate attempt to rid the self of doubt and uncertainty.

Many of the people I see come from traditional family and religious structures with arranged marriages as the norm. Although this is not in itself a negative factor, sometimes there are reports of destructive, violent and abusive marital and family relationships. These situations have continued because of the fear of isolation and community ostracism if the silence and denial are broken. A high proportion of these students are eldest children, and this has often meant that they have been born to young mothers, torn between duty and desire, whose wish might not have been to leave home and family and who have not yet built a secure support system. In psychic terms this can lead to situations where the hope and longing for a brighter future is embodied by the new infant. From birth the infant is filled with the hopes and dreams of the parents and remains unaware of its own feelings and states of mind. The child thus becomes the agent of the parents need. It is driven to be, in the psychoanalyst Sandor Ferenczi's term, a 'wise baby', whose intellectual and social precocity is unconsciously aimed at supporting the parent. This reversal of roles can be at enormous cost to the ordinary emotional development of the child. They learn to deny their natural dependency and vulnerability and their own need for support and understanding. One student who had to drop out of his course, and whose future at medical school was in doubt, told me how he had to protect his mother and younger siblings from his father's violent and abusive behaviour. He recalled how his father would beat him and lock him in a cupboard when he was young and seen to be naughty. At the same time he was also aware that his father, now living apart from the family, and who was ill, unemployed, and felt humiliated, was also vulnerable and needed his support. 'I am on my own with this', he said, 'they don't even know about my difficulties at college, how could I tell them about this, I am so ashamed. There is no way I can turn to my family for support. They are waiting for me to qualify so that I can make their lives better, so they don't have to struggle so much, but I don't know if I can keep going, I feel so tired. I will have to pay my mother's mortgage and for my younger brother to attend university. The school don't seem to take into account in their decisions what I am struggling with, how I am the head of the family, how I can't afford to fail at this. What I need is a sort of guardian angel – but with brains.'

At an unconscious level, becoming a doctor, with the implication of real knowledge and power about human beings, can be seen to offer a solution to the burden of being the emotionally-receptive, care-taking child. Another student reported a recurrent dream he had had throughout childhood whenever he was ill: 'I had this crushing awful weight on me, like the whole world was pressing on my shoulders, on my chest, and I couldn't breathe.' The difficulty comes when the illusion breaks for these young people, often during their clinical placements. There is a painful realisation that becoming a doctor, although it may bring some status and financial security, will not really provide the omnipotent knowledge and power that was needed to solve their own and their family's difficulties, and that caring for others does not take away the need to care for oneself. They start to experience symptoms of anxiety and depression as their own psychological deprivation and pain start to surface. They are often surrounded by students who are well supported both financially and emotionally by their families, and this can increase their sense of shame, deprivation and envy, as well as fears for their future capacity to fend for both themselves and their families.

With all this in their background, the therapist can feel under enormous pressure, as was the child, to bypass thinking and feeling, to find a solution, and to act in some concrete way. There may be a pull towards intervening in an inappropriate way on the student's behalf with authority figures, or taking on an overtly maternal or directive role. These counter-transference feelings can be a useful guide to the student's predicament and can indicate how they feel overwhelmed by feelings of responsibility. As one young woman said, 'I had never really thought about what things were like in the family, or what my mother was struggling with at the time that I was born and how that might have been affecting me.'

An immediate issue which permeates the therapeutic work from the start is the conflict that arises from needing or accepting any help at all. Even when there is seeming compliance with attending sessions, sudden conflict can arise or the student can abruptly terminate the sessions. Inevitably this is a common experience when working with adolescent issues. But with these particular students any exploration of family circumstances or history can feel like an immense betrayal. When students come from cultures where any questioning of or challenge to adults and authority figures is discouraged, the underlying protest can be difficult to detect, leading to a false impression that all is going smoothly. As one student told me after many months, 'I am aware of a part of me that is always there, arguing in the back of my mind with the things you say, but I never say them.'

In some religious groups, depression and distress can be understood as resulting from a lack of faith, and for some students this can add to feelings of guilt and despair. Religious fundamentalism can feel like a solution, providing a rigid container, a second skin for a fragile and fragmented sense of self. However a reflective religious belief can also offer a much-needed sense of belonging and identity at a time when confusion prevails, a way of getting

something right when caught between different worlds. It has felt very important in the therapeutic encounter to be extremely aware of the hurt and misunderstanding that can arise if these issues are approached in an insensitive or unthinking way. There are enormous differences between being devout, being a fundamentalist, and being drawn to radical political activity, but these are often confused and conflated in the media and in people's minds and this confusion can find its way into the consulting room. Religious belief can sometimes be used as a defensive retreat and be used as a way of shutting down the struggle with uncertainty and retreating to a black and white world. It can also be used to ensure compliance in family members who might otherwise question a rigidly authoritarian parental stance. When one's own parents are experienced as weakened and denigrated by the majority culture and preoccupied with their own struggle for psychic and economic survival, then something which offers a strong and proud identification with background and culture is welcome as well as offering an antidote to isolation and loneliness. I have also experienced religious dogma used defensively in psychotherapy sessions as a powerful and intimidating weapon when it is harnessed as propaganda to shut down any exploratory thinking. I then become the person in the room who feels useless, excluded, without vital knowledge.

Many of these young people have direct experience of racism but it is significant how often this is denied, rationalised or explained away. It seems to come as a shock that I might perceive it that way. Perhaps they are protecting me, denying the emotions and actions that difference can arouse in people, afraid, like all of us, of being in the presence of a malevolent or destructive mind. Racism in the abstract is different from the personal experience of having one's personality and humanity obliterated. It is hard to be hated, and they play it down. One student told me of his depressive breakdown at 15 when, as he described it, 'something went wrong with his mind', and he had to take several months off school. He had been the only Asian boy in his year, and it was only after he came to medical school and had other Asian contemporaries and sought therapy for his anxiety levels that he could find the emotional strength to face what it had felt like to endure being called a 'Paki', and that he could never achieve his dream of becoming a prefect or house captain, no matter how hard he worked, or what his achievements were. He hadn't been able to discuss it with his parents because he knew they had sent him to that school to achieve the best education, and his white friends wouldn't have known what he was talking about; their preoccupations didn't match his own experience. He therefore internalised it, perceiving that the something wrong was in him.

Another student was shocked when his parents suddenly objected to his relationship with someone from a different ethnic and religious group. He felt that they had brought him up to be westernised and to think for himself. He came for psychological help in a confused and very depressed state of mind. He described how he spoke and felt English, but was not always perceived as such by others, and now he faced conflict with those whose support he needed the most. His parents had been proud of and encouraged his integration, yet were perhaps surprised themselves at the strength of the feelings that tied them to their culture and their fear of losing their child who was, as he became an adult, suddenly different.

After a period in counselling, during which he failed some exams for the first time, he described how he was starting to feel more grounded'. He had slowed things down, and as a result of exploring his internal conflicts felt more internally integrated. He felt that he was different from his parents but had been able to have a dialogue with them, as they had become less certain that they knew what was right for him. Having had a supportive family environment in the past he was able to make good use of the counselling and recover relatively quickly compared to some of the more traumatised students that we see.

As I have tried to show during this paper these young people and their families have suffered from both the trauma of immigration, and also the impact of social inequality. These factors are often compounded by poverty and hardship which can have significantly adverse effects on parental care and family relationships. They may also come from extended family cultures where both the requirement and models for a more differentiated, individualistic Western mindset are scarce or absent. This in itself becomes a source of conflict and pain as it becomes very difficult to express themselves freely and fully either at home or in the surrounding culture. Intelligence, application and focus on the future has been what has held these young people together until the point where their conflicting internal experience and lack of a positive reflection for their multiple identities gives rise to psychological symptoms which threaten to overwhelm them. Coming for psychological help takes enormous courage and in itself poses another dilemma, as it risks the student being put back in touch with emotional needs and aspects of themselves which have been jettisoned as burdensome or as threatening to stability on their and their family's journey towards a better future.

Young people who come from violent or broken homes can be afraid of their own anger and aggression. Valuable energy is used to repress that hostility which then becomes inwardly directed, leading to self-destructive thinking and behaviour. If this anger and pain can start to become slowly experienced within the safety of a therapeutic relationship, then the resultant release of tension and anxiety can allow

these young people the mental and physical freedom successfully to pursue and reach their chosen goals. At the same time it may help them to be able to acknowledge the areas of their lives and family relationships which may not change significantly, but in which they are far more conscious of the decisions and compromises they may choose to make.

My final thought is that whoever we see in our consulting room is of a different culture from us. All our patients have their own history, belief systems and ways of negotiating the world, and it is difficult to encounter difference, to feel excluded, to bear not to know, and to find out about each other. It is a hard thing to do for both parties, for when we are anxious, we tend to rely on our basic assumptions. As a therapist it is the constant activity of encountering and addressing these assumptions that is both the challenge and the pleasure of this work. There is both risk and freedom in sharing one's innermost thoughts with a stranger, and never more so when difference is obvious. In a mutual exchange, encountering and challenging the ideas we have about each other's background, culture, and ways of thinking, can help show how we are all diminished by the fences we erect between us and our common humanity.

Reflections on themes in *Death in Venice* and their relevance to elements of the doctor-patient relationship in General Practice

by Sophie Park, winner of the Balint Society Essay Prize 2007

Introduction

As part of our General Practice vocational training scheme (VTS) programme, we recently travelled to Venice. Whilst there, we were asked to read *Death in Venice* by Thomas Mann and reflect firstly on Mann's metaphorical work and its possible resonances in our roles as clinicians, and secondly on how the aesthetic quality of our environment and encounters in Venice had relevance to our roles as doctors. During *Death in Venice*, Mann develops a number of themes in relation both to an author's life (and death) and also to the city of Venice. Some of these themes are equally relevant to an individual practising the profession of medicine. In particular, this reflection has allowed me to explore our 'professional role' and consider the dynamics and interactions between patient and doctor.

These elements within the consultation are becoming increasingly recognised as one of the most important and challenging aspects to becoming a good physician. Reflecting on topics such as life, death and the integration of our professional and personal selves may feel too intense within everyday practice, but they are integral to our reasons for becoming doctors and the method by which we choose to practise medicine. A large proportion of our work, especially in general practice, does not revolve around science and pharmacology, but around human relationships and interactions. How we use these and are affected by these daily encounters is important to consider in order to be a healthy doctor.

I shall first use illustrations from *Death in Venice* to give examples of certain themes or issues commonly encountered in medicine. I will then look at one method of aiding our regular reflection on these topics called the 'Balint technique'. The plot of Mann's short novel is relatively simple. Aschenbach is a well-respected and successful author. He is professionally highly regarded, in particular as a result of his epic work 'Intellect and Art'. His life has very much focused upon the academic traditions in life, and his achievements reflect this. Perhaps reflecting Mann's own existential philosophies (Gaarder 1995 and Luke 1988), Aschenbach has largely chosen to suppress the emotional and sexual temptations that life invites, and concentrates on perfecting his writing. This makes subsequent events all the more agonizing for him. He decides to take a holiday, 'a necessary health precaution', and eventually arrives in Venice. At his destination, a hotel on the Lido, Aschenbach notices a Polish boy named Tadzio. Aschenbach becomes infatuated by his god-like beauty, and increasingly indulges his attractions towards the boy. When a cholera epidemic strikes Venice, Aschenbach's obsessions overcome both reason and logic. He decides to conceal the epidemic from the boy and his family for fear of their leaving, and pursues him until his own inevitable death.

Death, Decay and Mortality

Mann draws on many themes relevant to both the novel's setting, Venice, and also to his central character's journey. Throughout the book, one of the most prominent themes is death. From the outset, there are constant references to the inevitability of decay and mortality. We first encounter Aschenbach in the Northern Cemetery. Here he meets for the first time a character whose detailed description appears repeatedly throughout the book, each time with reddish hair and decaying coloured features. The man is an observer or shadow of death. When Aschenbach sees the stranger, it stirs in him a 'kind of roving restlessness, a youthful craving for far-off places'. Death is coaxing him to travel. Yielding to this impulse, he travels and arrives eventually in Venice, a sinking, decaying city about to harbour one of Europe's most dramatic (and scandalously managed) cholera epidemics As the story progresses, Aschenbach succumbs more and more readily to his journey's fate and decay. On arrival in Venice, he already seems aware of his close proximity to death, and appears to accept, even enjoy such a position. For example, he is driven across to the Lido in a gondola, '...a vehicle evoking lawless adventures ... and death itself ... the last silent journey'. He observes that 'the seat of such a boat, that armchair with its coffin-black lacquer and dull black upholstery, is the softest, the most voluptuous, most enervating seat in the world'. The gondolier cons him into accepting an extravagant, longer journey, despite Aschenbach's protestations, all the way to the Lido. Aschenbach, however, quickly recognises the advantages of his misfortune and concludes that '...even if you ....despatch me to the house of Hades with a blow of your oar from behind, you will have rowed me well... It was wisest to let things take their course, and above all it was agreeable to do so.' Similarly later, repelled by the 'odorous' streets and 'mercantile spirit of the sunken queen of the Adriatic', he attempts to leave Venice, but is inwardly delighted when his attempt is thwarted by the loss of his luggage.

Mann is expressing a rather pessimistic view of life, an inevitable and decaying journey towards death (Luke 1988). He suggests that each person contains the seeds of their own doom, and as we travel life's path, whichever route we choose, our inevitable physical decay and death ensue. The setting of Venice reflects these ideas, firstly and most obviously, with the remnants of Venetian power and success gradually descending into the sea. Secondly, there are the winding and confusing navigational challenges of the Venetian streets. Numerous routes appear to reach one destination, and likewise one can wander for hours and never achieve one's intended goal. Venice does encourage one to abandon control and opportunistically enjoy passing temptations!

Fate and Doctor-Patient Beliefs

Such a pessimistic belief system surrounding life and death may not be held by most patients and doctors. Death, however, will be encountered by doctors more than by most. We face constant reminders of our own and others' mortality, and it is, therefore, important to consider and challenge our own philosophies and how we choose to cope with this exposure in our professional role. The Doctor in our present society is 'the familiar of death', if not to 'cure us', but to 'witness our dying' (Berger and Mohr 1967). If we as medical professionals are, however, to be able to achieve more than the red-haired character observing and coaxing Aschenbach towards his fate, we need to consider our own beliefs, emotions and coping mechanisms surrounding life and death, prior to recognising and helping others with theirs.

We may not adhere to the concept of life as one long 'fateful decay'. We do, however, need to consider the associated concept of acceptance. On a daily basis, a large proportion of doctor-patient encounters will involve social, environmental and relationship problems which are not directly remediable by either party. Recognising and accepting such situations is difficult for both doctor and patient. From the physician in particular, these situations require a skilled use of empathy and 'technical rationality' to approach and manage elements beyond their immediate control (Schon 1983).

Whatever our philosophy, acceptance of death is particularly important for both doctor and patient. Medicine has now recognised this need through a new speciality, Palliative Care, dedicated to acceptance and quality of death. Most practitioners, however, come into daily contact with issues surrounding death, and need therefore to address associated topics. In order to facilitate the most desirable of deaths, both doctor and patient need to have accepted its reality. Historically, the medical profession have been very poor at recognising and accepting the imminence of death and non-recovery (Christakis 2000). This may in part be due to a sense of failure, and maybe also a fear of losing control. The power and control once held over patients' lives by medical professionals was phenomenal. In a paternalistic, male dominated profession, the doctor played a much larger role in prescribing and performing methods of treatment and management. Patients' undoubting trust in such a system now rarely exists. In a public health capacity, we still invite patients to endure our recommendations such as screening programmes, for their individual and society's greater benefit. In general, and particularly in general practice, we now actively encourage patient autonomy in management decisions. We therefore need, more than ever to remain sensitive to the health beliefs and desires of each individual patient during their consultation.

The illusion of appearance

Patients, of course, do not always openly reveal their desires, beliefs and preferences during their first consultation. Particularly in our Western culture, there is a strong tradition of disguising age and ill-health from the public eye. Whilst there is constant pressure to keep consultations short, it is important to remain aware of the rapid judgements we often make of individuals and their massive implications for that patient's future treatment and experience. If a patient is projecting a particular 'illusion' of appearance, it is important to question why. Is it to conceal ill-health and frailty, perhaps due to fear of displaying weakness or even denial of a particular problem; or alternatively is it an over-exaggeration of 'need' in order to highlight a 'cry for help'? We must maintain our curiosity and self-awareness, to ensure initial facades and deceptions do not obscure important clues to presentations and diagnoses.

Patients are not alone; doctors too are guilty of concealing human flaws from colleagues and patients. Medical colleagues can sometimes very convincingly employ Aschenbach's 'elegant self-control concealing from the world's eyes until the very last moment a state of inner disintegration and biological decay'. The spectrum between a well and fully functioning doctor and an incompetent professional worthy of 'whistle blowing' is massive, but unfortunately help is seldom sought or offered between these extremes. The medical profession, as a body, has in the past concealed many difficulties and problems, which have only recently been presented to the public. Many problems, previously ignored and hidden by the profession, have now been revealed. The quality beneath the aged veneer has been discovered to be of variable standard, much requiring attention. The medical profession has, as a result, witnessed a massive shift in public perception, both in social standing of its members, and in its general purpose from profession to service.

In Venice, there has been a similar masking of underlying decay. The illusion of beauty is probably even more apparent today than in 1912 when Mann conceived his novel. Venice is still a beautiful and attractive city with a vast

array of galleries, shops and cafes. Yet beneath the romantic glamour and carnival masquerades is the reality of damp and degradation of a sinking city. During our trip we saw St. Mark's Square completely flooded in seawater and the waves of the Grand Canal lapping under the doors of grand-looking museums and houses. We learned, that the population of Venice has reduced over the last ten years from 150,000 to 50,000 (Buckley 2002). The 'hourglass' is 'dripping its last few grains of sand', yet for tourists, the facade continues to be upheld, be it for reasons of pride, denial or financial gain.

In *Death in Venice*, it is not only the city whose ill-health, decay and age are concealed behind an illusion of beauty, but also some of the individual characters. As his infatuation towards Tadzio develops, Aschenbach becomes acutely aware of his own aging and decay; the 'contention between his soul's desire and his physical capacities .... (and) bodily inadequacy'. At the beginning of his journey Aschenbach is repelled by the 'false youth' of a man on the boat masquerading with painted face among young men. By the end of the book, Aschenbach has allowed himself to adopt a similar appearance. He rejects 'a sense of shame and moral hopelessness', and allowing a logic of dentistry to excuse any 'moral disapproval of cosmetics', masks his own grey hair and skin with paint.

There is a secrecy and conspiratorial charm associated with the deception of beauty, which becomes increasingly appealing to Aschenbach. He describes Tadzio as being 'entirely beautiful'. His 'ringlets of honey coloured hair', and 'sweet divine' expression evoke 'Greek sculpture of the noblest period'. On closer inspection however, he notices that Tadzio is in fact anaemic, appears 'sickly and will 'probably not live long'. Aschenbach is filled not only with 'pure concern on the boy's behalf', but also with 'a certain wild satisfaction' in thinking he may outlive the boy. The conspiracy extends to the city itself when later, Aschenbach learns of the cholera outbreak in Venice. He fears if the knowledge of disease spreads to Tadzio's family, they would surely plan to leave. So, instead of sharing the news with other holiday-makers, as is his first instinct, he chooses to say nothing. 'The consciousness of his complicity in the secret, of his share in the guilt, intoxicated him'.

Conflict between the emotional and intellectual self

The association and attraction of guilt and secrets for Aschenbach, principally surround his sexual fantasies about Tadzio. Perhaps because he has oppressed such feelings in the past in pursuit of 'Intellect and Art', we initially feel a sense of relief at his discovering the delights of romance. Indeed, many of the emotions he experiences would, in usual moderation and circumstance, be acceptable. We learn that in the past, 'Aschenbach did not enjoy enjoying himself'. 'Only this place bewitched him, relaxed his will, gave him happiness'. As Aschenbach indulges further however, he loses control of his rationale and logic and displays increasingly addictive, pitiful behaviour. Mann illustrates this addiction using words we would generally use to refer to substance abuse. 'Drunk with excitement ... lured onwards by those eyes, helpless in the leading strings of his mad desire, the infatuated Aschenbach stole upon the trail of his unseemly hope'. His journey can only lead to destruction.

Aschenbach's moral dilemma and inner conflict begin to worsen. He experiences both enjoyment and abhorrence from his behaviour as he is torn between his former moral character and current emotions. 'As he continued his undignified pursuit ... along streets in which the disgusting mortal malady wound its underground way, then indeed monstrous things seemed full of promise to him, and the moral law no longer valid'. Aschenbach betrays common sense, conceals the cholera and abandons any concerns of being discovered by Tadzio's guardian. He recognises that his former 'professional' self would consider such behaviour as 'criminal', but continues. He has enough self-awareness to realise the conflict, but 'at the same time he sensed an infinite distance between himself and any serious resolve to take such a step (to tell of the cholera outbreak). It would lead him back to where he had been, give him back to himself again; but to one who is beside himself, no prospect is so distasteful as that of self-recovery.'

Aschenbach demonstrates very well the conflicts and moral dilemmas between the intellectual and emotional worlds of an individual. When we first meet him, he has reached the pinnacle of intellectual excellence within the world of literature. He has reached a respectable position in society by intellectualising and formalising art. He confesses that in order to do this, he has learned to 'cool and curb' his feelings in order to achieve perfection. 'Perfectionism' is what 'he had come to see as the innermost essence of talent'. In order to achieve this he has had to overcome his feelings, 'for he knew that 'feeling' is apt to be content with high-spirited approximations and with work that falls short of supreme excellence'.

The idea is clear, that in order to achieve highly within his 'professional discipline', he believes he is required to suppress emotion. '"Good!" thought Aschenbach, with that cool professional approval in which artists confronted by a masterpiece sometimes cloak their ecstasy, their rapture.' It is not that the emotions do not exist, but their existence is being ignored and suppressed in order to achieve something more highly respected; something more academic and rigorous. Aschenbach has, however, attributed his artistic 'inspiration' to emotion, 'that element of sparkling and joyful improvisation, that quality which surpasses any intellectual substance in its power to delight the receptive world'. One could, however, argue that inspiration is the result, not of emotion, but science. Might that 'creative

spark' actually be the result, not of emotion, but 'reflection in action'? (Schon 1983). Indeed, this 'intuition' may be the result of scientific cognitive dissonance and experimentation between fields of knowledge; an individual contemplating (consciously or otherwise) the similarities between two different fields and applying one logic to another, may class his new and unique interpretation as 'inspiration' (Schon 1983).

Rather than recognising the necessary interplay between the intellectual and emotional worlds, Aschenbach struggles to find an exclusively 'right' path. He has for most of his life favoured the 'intellectual' through an academic-focussed career. On indulging his emotional and sexual fantasies about Tadzio, he explores a total submission to emotion rather than the mind. He then rejects academic 'complications' as 'injurious' and corrupt, stating that 'there is nothing to which a noble and active mind more quickly becomes inured than that pungent bitter stimulus, the acquisition of knowledge'. As he follows this path towards emotional bliss, he realises that this will result in 'naïve inquisity'; that a topic approached in such a way will become over-simplistic and cause a subsequent 'resurgence of evil'. He sadly concludes that either path, when pursued singly, leads to an inevitable 'decay' and 'degradation'. Aschenbach will not consider any compromise between the two poles, and rejects any integration between the two (Luke 1988).

In medicine we too have to reconcile the balance between intellect and emotion. There has traditionally been a tendency to favour the scientific or 'knowledge' approach over the sympathetic or intuitive. Accordingly, the 'specialist' holds much greater power and status within his department than the practising majority (Schon 1983). This represents a difficult dilemma within a profession, especially with regard to training future professionals. New trainees seeking role models will tend to look to those with highest status, and consequently adopt those traits of an individual with essentially scientific values (Schon 1983). This causes self-perpetuation of a particular set of values and practice, and can create a mismatch between a perceived role of excellence and a profession's code and values (Schon 1983).

This is particularly relevant in General Practice. GPs are not specialists in one particular field of academic knowledge. This has until recently impacted on their perceived position in the 'medical hierarchy'. GPs may often feel inadequate because they are not specialists, but specialists rarely feel inadequate because they are not GPs and unable to help patients who do not require specialist help (Enid Balint 1993). This position is changing, and with the advent of initiatives such as GP led problem-based learning in medical schools and the 'new contract' addressing the interface between service need and provision between primary and secondary care, the perception of the 'general professional' role may change.

Using emotion with intelligence

The integration of 'softer skills' are a key element of successful General Practice, and most GPs aim to balance the use of knowledge and emotion within the consultation. Whereas the traditional biomedical patient 'history' contains very little 'emotional' content (Botelho et al 1990), recognition of the importance of emotions within the context of the consultation can increase the understanding between the two parties, as well as improving professional self-worth (Brock and Stock 1990). We should initially recognise the interplay between physical, emotional and mental aspects of an individual. As GPs with a good awareness of a patient's context, we are well placed to recognise the influence of emotion on ill-health. This often requires sensitivity and curiosity to reach beyond a patient's physical complaint. Such a balance is also required in the physician in order to be operating in ideal form. Once these are achieved, we can begin to address the dynamics between physician and patient.

Mann recognises the importance of emotion in the professional expertise of an author and writes of the importance of sympathy in order to appeal to a reader. 'Readers imagine they perceive a hundred good qualities in (a piece of literature) which justify their admiration; but the real reason for their applause is something imponderable; a sense of sympathy'. He then describes the disadvantages to the author of using sympathy, and the possible subsequent effects. 'By art one is more deeply satisfied and more rapidly used up' (Mann 1897). 'It engraves on the countenance of its servant the traces of imaginary and intellectual adventures, and even if he has outwardly existed in cloistral tranquillity, it leads in the long term to over-fastidiousness, over-refinement, nervous fatigue and over-stimulation, such as can seldom result from life full of the most extravagant passions and pleasures'.

So, how can we in Medicine achieve a sense of sympathy for the patient, without taking on the life's burdens of each individual patient? Repeated exposure to human mortality and morbidity must inevitably have an effect on an individual, and we have all met doctors who have detached themselves completely from their emotions in order to cope with such exposure. In traditional days of medical paternalism (and indeed still in many specialities), an entirely intellectual and 'scientific' discipline was practised towards patients. By denying the existence of human personality and emotion, the practitioner 'protected' himself from their effects. To a certain extent we all adopt a 'professional identity' as a tool to deal in a recognised and pragmatic manner, without indulging in the emotional traumas of an individual. Indeed if we did not, and became affected by the experiences and behaviour of patients on a daily basis, we would soon become exhausted and useless in our role as doctors.

Appropriate use of empathy can help to achieve an effective emotional element to a consultation. In clinical practice, empathy is the skill used by physicians to decipher and respond to thoughts and feelings in the physician-patient relationship (Brock and Salinsky 1993). Unlike the sympathy discussed by Mann, which is an emotional response to someone's misfortunes (Nightingale, Greenberg, and Wolf 1980), empathy requires a cognitive component (Brock and Salinsky 1993). Whereas some do not view emotion as a form of cognition (Savage 2003), others do. For example Rosaldo views emotions as 'thoughts [which are] felt' (Rosaldo 1984). Similarly, Mitchell analyses cognition into semiotic (relating to language), practical (relating to embodied knowledge) and emotional (relating to feelings) (Mitchell 1997).

In a consultation, empathy consists both of understanding and response. The former tends to come more naturally to the physician, whereas the response requires training and experience (Brock and Salinsky 1993). The origin of emotion can be considered in many ways, be it a socially learned response, an irrational problem or a vital human capacity (Savage 2003). Whether we choose to categorise emotion as relativism, rationalist or romantic (Savage 2003), it exists in the doctor-patient relationship. There is no doubt some patients can evoke in us as practitioners a very strong emotional response. We can either choose to ignore this, or to recognise its existence and learn to understand and use it in the consultation. Rather than being something to avoid, counter-transference may provide important insights (Davidson 1986). These interpersonal relationships, or 'swampy lowlands' of clinical practice rarely respond to rational intervention (Schon 1987), and require careful understanding and skill.

One technique used by our General Practice Vocational Training Scheme to address these emotional elements of the consultation, is the Balint group. Michael Balint, a psychoanalyst, worked with GPs from the 1950s examining 'the relationship between the doctor and the patient, [and looking] at the feelings generated in the doctor as possibly being part of the patients' world' (Balint 1993). He then sought to 'use this to help the patient' (Balint 1993). This technique used ideas of transference and counter-transference between doctor and patient (Stein 1982), although the use of these technical terms in the group was discouraged. He proposed that the physicians' 'emotional response to a patient is an indication of the patients' own emotional state. In order to tap into what the patient is experiencing, the clinician must first be able to accept and recognise what he/she is experiencing towards the patient.' (Stein 1982). Therefore, using this technique, a doctor can recognise and experience an emotional response within a professional context, reflect upon it, and apply a constructive intellectual response to the consultation.

The doctors discuss their patients in a small group with an experienced leader. The participants describe their encounters with patients to the group. In particular, this may be a consultation which the doctor found difficult or unsatisfactory. The consultation is described to the group from memory. The group listens, non-judgementally, and may gain clues to the consultation from the way and order in which it is described. The group then explores or fantasises about the patients' motives and experiences in order to support and increase the understanding of the doctor (Clifford 1998). The group response may even reflect the initial transference between patient and physician (Searles 1955).

Through the use of this method, the doctors may gain an insight into the patients' emotional state and needs, and consequently improve the quality and benefit of their consultations. Secondly, it can encourage the physician to improve their awareness of 'what is going on inside as well as outside themselves' (Balint 1993), and consequently improve their approach towards patients and sense of personal well-being. By addressing and experiencing our emotions within a professional context, the line between our personal and professional selves may become blurred. While this allows us to use our own humanity in the consultation, this does require a greater degree of risk in exposing ourselves in a professional setting to the reality of our own emotions. Care must, of course, be taken to maintain a more permeable line between our professional awareness and personal emotion.

Conclusion

Unfortunately, Aschenbach failed to recognise the importance and potential benefits of integrating emotional and intellectual knowledge within his personal and professional life. Witnessed repeatedly by the observer of death, he follows his assumed mortal fate. Although his journey ends unhappily, the many questions posed to the reader by Mann in the short story allow us the opportunity to realise a better balance ourselves. Having reflected upon the relevance of some of these themes to medical practice, I have learned to appreciate the hidden problems behind a patient (or doctor) mask; to consider the role of fate (or inevitability) and intervention in the management of incurable disease and death; and the vital importance of the use of empathy in the consultation. Although we already use the Balint group at VTS sessions, I now have a greater understanding, both of how the method works to engender empathy and reflection, and also its potential impact on medical practice.

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Book Reviews

Why Do People Get Ill?
by Darian Leader and David Corfield.
Hamish Hamilton London 2007. 376pp.
Hardback. £16.99

In the emerging brave new world of the NHS, where chronic disease will be managed in community-based polyclinics and acute illness will be treated in super specialized hospitals, this book is a welcome addition to the small literature warning against the dangers of fragmentation of care and in favour of listening to the patient. Darian Leader, a Lacanian psychoanalyst, and David Corfield, a mathematician and a researcher in the department of biological cybernetics at the Max Planck Institute, have reviewed a great number of psychosomatic research papers, both classic and contemporary, and have written a fairly coherent psychosomatic theory of developing somatic symptoms and diseases that is essential for active listening.

According to their theory, falling ill has something to do with what they call the bacterial model of illness, in which what threatens us is always seen as something external. Every life event involves some change, either for the better or worse, and it has been claimed that it is change of our external environment as such that predicts illness. We tend to use the word stress to describe the effects of these changes on us, but the authors believe that a diagnosis of stress can be regarded as the modern way of avoiding listening and finding out more about a patient. This diagnosis replaces the richness of an individual story with a blanket concept that can be used to explain just about anything from anger to grief to frustration and depression. The authors believe that it is an inability to register this change, to elaborate it mentally and symbolize it, that increases vulnerability to falling ill. They believe that listening to the patient in a way that is sensitive to the meaning of the impact of life events on his or her health can go a long way towards making him or her feel understood and recognized. Listening and speech is very important in psychosomatic medicine because the very mechanisms involved in somatising imply in some cases a difficulty or even impossibility in elaborating problems through speech.

But who is going to listen? The authors are rather concerned about the medical profession's unwillingness to listen to its patients. Increasing bureaucracy and workload allow less and less time to listen to the individual. The management of chronic disease, that incidentally is gradually becoming a central concern of general practice, often has the unfortunate consequence of putting the patient on a conveyor belt and making him or her the object of a series of pieces of localized expertise. This movement away from biography and particularity towards fragmentation has created a gap in medical provision that is filled by a wide range of alternative and complementary therapies.

The authors recognize that just because we have a theory explaining the importance of psychological factors in the development of illness, it does not give psychological methods of treatment the exclusive recipe for a cure. A somatic problem more often than not requires a medical treatment. However, it may be helpful to be aware that patients tend to fall ill at certain symbolic moments. The authors identify four such periods that are likely to be registered at some level as a symbolic event. The postoperative period after transplant operations; the time when patients have finished a course of treatment, however successful it might have been, and are told: you are well now! At last you are back on your feet! Periods of waiting for an operation or medical treatment, and the symbolic moment of retirement. The authors believe that if therapy can matter here it does not necessarily mean psychotherapy, but simply the possibility of speaking with someone, if the patient so wishes. It is less insight into unconscious processes that can be hoped for, than the possibilities of identification and recognition, reinvestment in the body and an opening of the pathways of speech and dialogue. The authors believe that it would be ideal if all patients were to receive an opportunity to speak about themselves on their first medical visit or when hospitalized. Such work requires skill and sensitivity, yet there are just not enough trained practitioners available to do this. Dialogue is what so many alternative therapies offer. It is the principal way of recognizing someone else's experience. The authors are not advocating the usurping of medical procedures and medication by speech. Far from it. But these practices may be most fruitfully conducted within the broader context of a dialogue. Perhaps it is this emphasis on listening and being listened to that protects the small number of doctors who participate in Balint groups from job dissatisfaction.

Sotiris Zalidis

Psychosomatics: The uses of psychotherapy
by Peter Shoenberg.
Palgrave Macmillan 2007. 272pp.
paperback, £17.99

Peter Shoenberg is a consultant psychiatrist in psychotherapy at University College Hospital and will be known to members of our Society through his work with students at that medical school. He and Heather Suckling presented this interesting work at an evening meeting of the Society in 2004. Since Michael Balint's own days as consultant at UCH, there has been a distinguished line of psychiatrists who have developed a strong tradition of introducing students to psychotherapy

during their training, and Peter Shoenberg has been active for some time in continuing and developing this work. Of greater importance from the point of view of this volume is his key role in the Psychosomatic Workshop which meets monthly at UCH to discuss cases of psychosomatic interest. He has succeeded admirably in producing a book which brings together contemporary psychoanalytic thinking on the relationship between psyche and soma with up-to-date clinical information about the various conditions he discusses. It is his even-handedness, openness to different therapeutic approaches and lack of dogmatism about competing theories that gives the book its particular appeal. Experienced practitioners, as well as students and registrars wanting an introduction to the subject, will find it instructive and highly readable.

The book will be of considerable interest to GPs as well as to other professionals in primary care; counsellors, psychotherapists and nurses mainly, although most of the cases are drawn from specialist practice. It is clearly written, well-researched and gives an excellent historical summary of thinking about psychosomatic medicine. Case illustrations are generously placed throughout the text and allow the reader plenty of opportunity to think about the ideas presented in relation to different clinical contexts. The standard of editing and presentation of the book is unusually high and includes a very full list of useful references, a glossary of terms, as well as notes to most chapters. This seems to indicate a rather sensitive approach to the needs of readers from different disciplines, and indeed the author's attitude throughout the book is an inclusive one and one that emphasises (as well as demonstrates) the need for a complex multi-layered approach to the understanding of individual patients with psychosomatic illness.

Most practising GPs – certainly those with a Balint approach – would accept that the interplay between body, emotions and mind is important in nearly all GP consultations. Patients arrive in our rooms with a whole variety of symptoms and complaints and we need to be able to travel freely between body and mind as we consult. Indeed, this is so integral to our setting, we may barely notice that we do so. As Peter Shoenberg reminds his readers, 'a psychosomatic illness can happen to anyone'. This is familiar territory for GPs and can lead to the term 'psychosomatic' feeling slightly foreign, an imported usage. Although the word was first used by Coleridge, its main subsequent use has been within psychiatric and psychoanalytic nosology. I hope this does not deter non-Balint GP readers – for whom the term is sometimes used to mean 'nothing much wrong with them' – from engaging with this fascinating book.

After opening chapters on the 'scope of psychotherapy', 'stress' (excellent on the patho-physiology of stress) and 'somatisation', the book takes the reader through the major clinical areas that often attract psychosomatic interest – skin, gastro-intestinal disorders, headache, cancer, gynaecology etc. These chapters are full of succinct summaries of current and past research studies, presented in a highly digestible way, and thought provoking, for instance in highlighting a growing body of research demonstrating connections between adult attachment patterns (secure, avoidant etc) with a predisposition to develop certain illnesses. Those who have become interested in why 'the eye' is so often missing from the 'psychosomatic' canon, are bound to notice that it is absent again! Of course no author can include everything! It is however helpful to have included two chapters on disorders of eating (obesity; anorexia nervosa and bulimia nervosa) which sometimes are not included under the 'psychosomatic' rubric. The section on anorexia in describing medical approaches, family therapy, psychoanalytic views including Kleinian, classical and self-psychology, but giving at least as much space to a fascinating (and rather moving) case history is a good illustration of the book's general approach.

One of the later chapters has the rather nice title: 'Developing a Psychosomatic Imagination'. This describes well the spirit and usefulness of the book. The chapter itself focuses mainly on the value of introducing students to psychosomatic thinking, drawing on the author's experience from his post at UCH. However, a 'psychosomatic imagination' is exactly what we need as GPs, and is, of course, what Balint groups can help us develop. If you are feeling 'over-quoffed' at present, this book will give you a much-needed boost and refresh your 'psychosomatic imagination'.

Andrew Elder

Yes, Health Minister: 40 Years inside the NHS working for children.
By Sonia Leff.,
The Book Guild 2006. Hardback. £15.99

Sonia Leff's book is a memoir taking the reader from her postwar childhood in cosmopolitan north London, through her medical training, her work in child health both in the London borough of Camden, and in Lewes in Sussex, and her secondment to the Department of Health in 1990. She describes her work with humour and inspiring optimism. I particularly enjoyed the contrasting descriptions of multicultural inner city London and rural Sussex, having spent my own school years in Lewes, and now working in general practice in Kentish Town in Camden. Her dedication to the founding principles of the NHS is clear, with a vivid and impassioned description of a "great cooperative venture" from its early decades through to changes under the current Labour government. She champions the work of the school health service, since its inception in the first decade of the 20th century, recognising that

a nation's greatest investment is the health of its children.

The drive to improve the health of children in the UK, particularly in deprived city areas, both through local initiatives and through national reports and government legislation is seen within the context of a society changing rapidly, with liberalisation of social attitudes and changes in family structures. Her outlook extends beyond a medical perspective to the wider political dimension, acknowledging global poverty and nuclear proliferation as very real threats to the wellbeing of children and families. She has an international perspective, reflecting her family's origins in Lithuania and her husband's family in India. Sonia Leff speaks with acute awareness of the needs of the families with whom she has worked. She recollects memories of deprived childhood friends suffering from inequality, and describes the relative poverty of her own family's migration across Europe. Her great-grandfather emigrated from Lithuania to Britain, and her grandfather despite a school scholarship was required to leave school early to help in the family picture framing business. Her parents were members of the Socialist Medical Association in the 1930s, campaigning for the NHS, with the hope and expectation that cooperation and planned development would eradicate poverty and disease. She herself grew up in a cosmopolitan community of North London, and proceeded to medical training. It was while at medical school that she encountered the work of Michael Balint, attending weekly his voluntary groups. She describes how these helped her learn to see the actual person behind their disease, to embrace uncertainty, and explore the link between illness and personality, sexual life, work, and family.This patient centred approach was a marked contrast to most of the medical curriculum in the 1960s and members of her Balint group went on to work in psychiatry, community child health and with victims of torture. It is this holistic approach that has informed her practice of medicine throughout her working life, seeing children and families as individuals within a social and emotional context. It has been a career committed to the wellbeing of children, identifying the fundamental importance of the continuity of emotional experience from home and school and community. There is still much to be done to improve the lives of children in our communities, but this book reminds the reader how much has been achieved, in the NHS, through social change, and through the inspirational leadership and motivation of individuals like the author.

David Price

Obituary:
Philip Hopkins FRCGP FACC
Founder of the Balint Society; Editor of the Journal for 25 years

Dr Philip Hopkins died on 31 December 2006. He will be especially remembered and honoured by Balint enthusiasts in Britain and around the world. He was a member of one of Michael and Enid Balint's original general practitioner groups in London and was a champion of the Balint group and the Balint method for the rest of his life. In 1969 he was the prime mover in the foundation of the Balint Society and served as its first president. He was editor of this journal for 25 years and a family doctor for 52 years.

Philip was born in Abertillery, South Wales, on 1 November 1920. His family were of Russian-Jewish descent and his father was a dentist. After having his tonsils out at the age of seven, Philip decided that he wanted to be a doctor. He was trained at Guy's Hospital Medical School (1939-1943) and spent some of his nights as a student fire watching on the hospital roof during the Blitz. After qualification he married his first wife (June) and, following house jobs in London, he did two years of National Service with the Royal Army Medical Corps in Egypt (1946-48). Here he learned orthopaedic surgery and also discovered that the young conscripts were missing their wives and girlfriends back home. He began to realise that medicine was about understanding feelings as well as mending broken bones. When he returned to London he initially considered a career in surgery but was inspired by a meeting with a local family doctor to change course and enter general practice as an assistant to Dr Arthur Rees in Hampstead. When Dr Rees died, Philip took over the practice and bought the house which became 'Hopkins House', his family home and his surgery for the next 55 years. His early years here were spent building up the practice and looking after his growing family. He was already interested in writing about medicine and in 1954 he was awarded a gold medal by the Hunterian Society for a prize-winning essay. He also became very involved in left wing medical politics, becoming president of the Medical Practitioners Union (1960-63) and accompanying their deputation to the Soviet Union and East Germany. He was also a founder member of the Royal College of General Practitioners who awarded him their Fellowship in 1969.

In 1952 came the first meeting with Michael Balint who was to become such an overwhelming influence on his professional life. Like the other pioneer Balint GPs, Philip answered one of Balint's advertisements in the Lancet for doctors interested in 'discussions on the psychological problems in general practice'. Some of those who were attracted in the early days did not stay long, but by 1954 a nucleus of committed GPs including Philip had become the group who supplied the material for *The Doctor, his Patient and the Illness* (1957). It is intriguing (but probably fruitless) to try and guess which of the anonymised doctors, represented as A, B, C and so on, was really Dr Hopkins. However, Philip receives special thanks from Michael Balint in the preface for having read the proofs of the book and drawn the author's attention to some passages that were unclear or ambiguous. The future editor was already honing his skills! He was also a member of the group that produced *Six Minutes for the Patient*. His chapter is a protest against the main conclusion of the book: for Philip six minutes was nothing like enough. Indeed he continued throughout his professional life to do a long interview with a patient every afternoon between surgeries. Philip was an enthusiastic and prolific writer. He published numerous papers about Balint work and Psychosomatic medicine. In addition he edited and published the proceedings of two International Balint Congresses held in London These were *Patient-Centred Medicine*, the proceedings of the first International Balint Congress, 1972), and *The Human Face of Medicine*, a record of the fourth Congress in1978).These books, copies of which are still available, are valuable documents of Balint history. Another interest which he developed during this time was cryosurgery in which he became an internationally recognised expert.

The 1970s were an eventful period for Philip. His first marriage ended in divorce and he later married Susan with whom he had a son (Michael). In 1975 he developed cancer of the oesophagus and underwent a total of 17 operations. On several occasions it seemed that he would not survive, but thanks to his determination and strength of character he pulled through and was able to resume his practice. He was a much loved and appreciated GP trainer who introduced many young doctors to the joys of family medicine and the benefits of Balint. In 1987 he gave the seventh Michael Balint Memorial Lecture in which he drew attention to the need for Balint style teaching in British medical schools. During his long stewardship of the Journal of the Balint Society he commissioned and published a wealth of brilliant and thought provoking articles as well as writing a regular editorial in which he observed (usually with dismay) the current state of the NHS. Throughout the 1980s and 90s he was a regular attender and group leader at the Balint Society's Oxford weekends. He loved to come on my regular guided tours of the city even though he must have known the route and the commentary by heart. He was always a good companion. His last major speech was his address to the eighth

International Congress in Oxford (1998) entitled: 'Who was Dr Michael Balint?' If anyone could do justice to that question, it was Philip.

At the age of 70 Philip was obliged to retire from the NHS on grounds of age, although ironically he continued in post as his own locum for several years. After that he continued in private practice as long as his health permitted. Sadly, following a general anaesthetic in 1998, he suffered brain damage and his memory began to fail. He retired from work in 2000 but continued to enjoy life and to take an interest in the affairs of the Society. Philip died in 2006 on December 31st, the same day as his hero, Michael Balint. He will be remembered by many people for many reasons. As founder of the Balint Society and indomitable champion of the 'human face of medicine' he was a Huxley to Balint's Darwin and will always have an honoured place in the history of our movement. His patients will remember him as a doctor who listened to them, understood them and was there for them day and night.

His friends will remember him as a warm, friendly, hospitable man with firm convictions; a man who was always interested and always willing to help. He leaves his loyal and loving wife Susan, his four children and six grandchildren all of whom will miss him a lot. The Balint Society is also mourning the loss of a father. He was an inspiring teacher, a good friend and a brave soldier.

John Salinsky

Secretary's Report 2006-2007

The year began as usual in Oxford, from 15th to 17th September 2006. The weekend began with the society's newest departure. Friday was a day devoted to group leadership training. Sixteen participants were divided into two groups, led by Andrew Elder and John Salinsky. The model was of switching leaders each session, with half of each session devoted to the discussion of the group itself and the leadership. This exhausted the participants who then continued that evening with the regular Balint weekend, with 32 attendees divided into 3 groups over the weekend. The AGM of the Society followed at 12 on Sunday, at which nine new members were admitted and Dr Jane Dammers was elected to Council. It is the last year of Dr Lenka Speight's tenure as president.

Group leader training continued through the year at the Balint Group Leaders' workshop at the Tavistock Clinic. This met three times and groups described included Don Bryant's tribulations with clergy groups in Kent and David Watt and Paul Julian's new groups at Newham University Hospital for FY2 doctors. Because the Friday followed by the Oxford weekend had been so tiring, we had a full weekend group leaders intensive in Whalley Abbey, Lancashire from June 15th-17th 2007, organised by Dr Caroline Palmer and led by Andrew Elder. Twelve leaders or potential leaders attended, each leading the group at different sessions.

There was also another Balint weekend in 2007 in Morpeth, north of Newcastle, organised by Jane Dammers and her colleagues. It took place from 20-22 April and drew more than 30 people, many from the local area which has a very vibrant Balint community, but one or two from far away, including Michelle Moreau-Ricaud from Paris. We hope that this may also be come a yearly event.

The Balint Society Lectures Series had five lecture/seminars at the RCGP in London, most of which are published in the Journal. Attendance varied, from six to more than 50 at the 17th Balint Memorial Lecture, which included a customary reception, and tries to bring more people in from outside the Society. Council have recently discussed trying to advertise the whole series more widely to interested organisations with which we have contacts.

The official functions of the year ended with the Annual Dinner at the Royal Society of Medicine on June 26th, attended by 26 members and friends. Pat Tate gave a wonderful after dinner speech on being good enough as a doctor.

The Council is looking forward to the International Federation meeting in Lisbon September 1st-5th and to the Oxford weekend 28th-30th September.

David Watt

The International Balint Federation

Heather Suckling

Membership:
The International Balint Federation now has 21 members from 20 countries. The two most recent members are the Australian and Russian (St. Petersburg) Balint Societies.

All members of the British Balint Society are welcome to attend the international meetings. These are advertised on the website **www.balintinternational.com** and most of them are conducted in English.

Ascona Prize:
This biennial award for medical students' essays was shared by four students this year. Two of the winners are British: Swapna Reddy from the Royal Free and University College Medical School and Shi Zhuan from Edinburgh University. They will be presenting their work in Lisbon. The other prize-winners are Lala I Adrian from Romania and Markus Rinschen from Germany.

Events 2007-2008:
Paris 25th -27th October 2006:
Sadly, the planned meeting of the Council in Israel was cancelled because of the political situation, although the Israelis held an educational meeting that was attended by some overseas visitors. The French Balint Society came to the rescue of the IBF Council and arranged a meeting in Paris instead. It was a very pleasant weekend, we enjoyed excellent hospitality from our hosts and, thanks to Eurostar, travel was very easy for the five members of the (British) Balint Society who attended. Special thanks are due to Marie-Anne Puel who made the arrangements at short notice.

Potsdam 23rd-25th March 2007:
The Spring Council meeting was held in Potsdam, Germany.

Council (Business Meeting)
The meeting began with a short tribute to Dr Philip Hopkins who died in December 2006. He was one of the founders of both the (British) Balint Society and the International Balint Federation. Elections were held for the Officers of the Council who will take up their posts in September 2007. The results were as follows:

President:	Henry Jablonski (Sweden)
Vice-Presidents:	Benyamin Maoz (Israel) Donald Nease (USA)
Treasurer:	Michel Delbrouck (Belgium)
Secretary:	Heather Suckling (UK)

There were four candidates for the post of Vice-President and it was a close contest. The unsuccessful candidates were thanked for their interest. They are Sanja Blazekovic (Croatia) and Albert Veress (Romania) who work hard both for their own societies and for the IBF.

It was decided that the IBF would apply to become an 'Organisation in Collaboration' with EURACT (European Academy of Teachers in General Practice). Three representatives were elected: Heide Otten (Germany), Andre Matalon (Israel) and Stanislava Spehar (Croatia.)

We have subsequently heard that the application was successful and the IBF is now confirmed as an 'Organisation in Collaboration' with EURACT. This will increase our influence internationally.

Supervision Group:
Following the business meeting, Benyamin Maoz led a supervision group where group leaders presented problems experienced in their Balint groups. It was agreed that this is a very effective method of educating and supporting Group Leaders.

Social activities:
The German Balint Society entertained participants to dinner on the Saturday evening and on the Sunday many took the opportunity to visit the beautiful palace and gardens of 'Sans-souci'.

Dubrovnik, Croatia 4th-8th 11th June 2007:
The annual Muradif Kulenovic School of Balint in Dubrovnik lived up to its reputation of providing excellent presentations and groups as well as a delightful social programme. The theme this year was **'Patients at Depression risk'**. The social programme included a concert in the historic Rector's Palace and a full day's boat trip to three islands, with a swim in the Adriatic.

Future events:
For further information about future events please see the IBF website
www.balintinternational.com
for a full list of activities.

15th International Balint Congress, Lisbon, Portugal, September 1st-5th 2007:
The theme, 'Medicine, Evidence and Emotions...' celebrates the fiftieth anniversary of the publication of Michael Balint's seminal work, The Doctor, his Patient and the Illness. The programme has been finalised, and it is hoped that there will be a large contingent from the United Kingdom. Participants are guaranteed an informative and entertaining experience.

WONCA Paris 17th-21st October 2007:
The programme includes Balint groups in English and French to be held on 18th, 19th and 20th October 2007. You will be very welcome to attend these groups.

IBF Council meeting Spring 2008:
The Israeli Balint Society has invited the Council to meet in Israel, if the political situation allows, but if not the German Balint Society has offered to hold the meeting in Potsdam. In either case, there will be a programme of workshops to which all will be welcome.

16th International Congress September 2009:
The Romanian Balint Society will host this in Romania. Further information will be available in due course.

Heather Suckling
heathers@doctors.org.uk
General Secretary

Balint Weekend at Longhirst Hall, Northumberland April 2007

by Jane Dammers

The weekend was a consolidation and celebration of the work we have been doing in the North East over the past seven years. The weekend was very lively, attracting thirty participants, about two thirds of whom were local people, some already in Balint groups and some novices who came to find out what it is all about, as well as friends and colleagues from around the country. We all worked hard and also had a good time socially in lovely surroundings, well looked after by the staff at Longhirst Hall.

Esti Rimmer gave a short introductory paper, 'Illness, Madness and Meaning – the impact of NHS reforms on Primary Care Teams and their Patients', in which she contrasted how quality now seems to be defined by recording data and jumping through hoops, whereas the real work of general practice necessitates dealing with uncertainty and doubt and reflecting on feelings and relationships. We worked in three groups, each jointly led by an experienced GP and therapist; we also had the opportunity to observe a fishbowl demonstration.

On Saturday afternoon some of us enjoyed a fantastic walk along miles of sandy beach at Druridge Bay on the Northumberland coast, while others visited Woodhorn Colliery Mining museum which documents the history of coal mining in the region. George Welsh from Byker in Newcastle entertained us on Saturday evening with endless Geordie stories and Country and Western style music – a relaxing respite from all the talking.

The organizing group felt very well supported by Andrew Elder, David Watt and John Salinsky who came up from London, helping to lead groups and facilitate the fishbowl – a big thank you to them. We hope to be able to have another event next year. We will try to get more Balint case discussion back into GPR teaching in the North East if we can.

Jane Dammers for the organizing group
Jane.dammers@ncl.ac.uk

Report on Group Leaders' Intensive Weekend Workshop at Whalley Abbey, Lancashire June 2007

By Caroline Palmer

In June, 11 of us met at the comfortable retreat and conference centre in the rural Ribble Valley under the capable, caring and perceptive eye of Andrew Elder to explore the problems of group leadership and to try to improve our group leadership skills. We were a diverse group, with leaders including experienced venerable Balint group leaders mainly based in London, and others who were just setting up their first on-going group. We also had some people who had co-led groups at residential weekends and others who were experienced group members but were only just aspiring to a group leadership role.

It was intended to be an intensive weekend and was modelled on the one-day intensive leadership skills workshop that was held in Oxford last September, on the day preceding the annual Oxford weekend. At Oxford it was felt that the leaders' workshop itself had been too short, that it unintentionally may have resulted in a feeling of divisiveness into 'Us' and 'Them' during the week-end, and that three days exclusively doing Balint group work at a stretch was intellectually and emotionally exhausting. It was therefore decided that the leaders' workshop should be set up as a 'stand alone' event, held at a different venue and time of year.

The five group sessions were divided so that the first half of a session was devoted to a case and the second half was spent on discussion of the group process and leadership. As there were ten of us eager to improve our skills, the maths division was fortunate and we all had a chance to lead or co-lead a group session, albeit a rather large group, with varying degrees of success, but which proved to be a highly educative experience. During the weekend it was felt that the appointment of an observer could be useful, to watch both the group process and the leadership function. This development definitely helped the participants and leaders greatly to understand the dynamics of the group, and the observers seemed to appreciate the experience.

At the plenary session, most participants felt that it had been an enjoyable weekend and that some lessons had been learnt, but that it had not been a truly 'intensive workshop' and that it may have been a somewhat missed opportunity. People largely felt that we were just beginning really to engage in the group process work by the end of the weekend when it was time to go! We wondered if a longer meeting over, say, three days would help achieve this focus, or if engaging usually occurred in 'the last chance saloon' session, so would actually defer the process yet further.

We discussed whether the process could be accelerated, perhaps by doing some trust-building exercises first, and/or having the first group led by the experienced leader of the weekend, so that we might be comfortably introduced to the group, find our feet, imbibe some wisdom, but also perhaps retain in our heads a model for the role of group leader.

We seemed to need to be given explicit permission to take risks with the group.

We recognised that if we had felt more grown up and assertive, more able constructively to criticise each other, and resilient enough to stand honesty, we might have made fuller use of the opportunity the weekend provided. We felt that seeing different leadership styles modelled was a useful way of evolving as leaders ourselves; we realised that we needed to play with and practise different ideas in the group, so that we could adapt, assimilate and create our own persona as a leader.

We wondered whether it would be helpful practice, to have 'plants' in the group of people playing the role of difficult group members, e.g. problem-solver, generaliser, disruptive attention-seeker (but thought we might have enough of these in the group in reality anyway)! It was at times tempting, with a group of such experienced Balinteers, to let the group run on autopilot, let oneself off the hook as a leader and think that no leading was required anyway.

We also thought it could be useful to have two or three observers sitting outside the group who could intervene and say to the leader, 'Stop! Try this intervention', or even, as on 'Supernanny', feeding ideas to the leader through an earpiece perhaps to try in the group. It was recognised that the timing of interventions can be crucial, and that it can be frustrating when, once you've worked out what you want to say – your 'pearl of wisdom' – the moment has gone, the discussion has moved on and you've missed your chance. It was noted that the group leaders' evening workshops held in London often use audiotapes of group work; that listening to these can also be very helpful in analyzing useful interventions and highlighting the crucial points in the process.

It was also felt by some that more dissection of the leadership role might reduce the spontaneity and creativity in a group, detracting from the emotional value and content which is so central to the process, while on the other hand a definite structure might lead to increased confidence particularly in less experienced leaders. For some of the less experienced leaders, such as myself, there was often a confusion of focus between the content of the case and the

working of the group, with attention flipping in and out between the two. There is also the problem that a presenting doctor's feelings and case may be genuinely difficult and troubling to them, but that at this kind of workshop it may feel that these feelings are being used mainly as a teaching tool and so a means to an end.

We felt that it had been a good weekend in highlighting our needs, and that the discussion of possible ways of addressing these was perhaps the most useful aspect of the weekend. We hope these ideas can be followed up and specifically built on at a future leaders' workshop weekend possibly in the North East next year. We concluded that we felt that a balance of intellectual and intuitive/emotional skills was important in our Balint group leadership work, just as it continues to be crucial in our doctoring work. We needed help in fostering both aspects of the function!

Pictures from Lisbon September 1-5 2007

Bristol
Restaurante
Cafetaria - Bar
Pastelaria Regional
Queijadas e Travesseiros
Pastéis de Feijão

The Balint Society Essay Prize 2008

The Council of the Balint Society awards a prize of £500 each year for the best essay on the Balint Group and the Doctor-patient relationship.

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

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

Length of essay is not critical.

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

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

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

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

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

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

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by 1st May 2008 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

The Balint Society

(Founded 1969)

Council 2007

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Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr John Salinsky by email: *JVSalinsky@aol.com* as a word file.

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

References

References may be in the Harvard or Vancouver style. 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.

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