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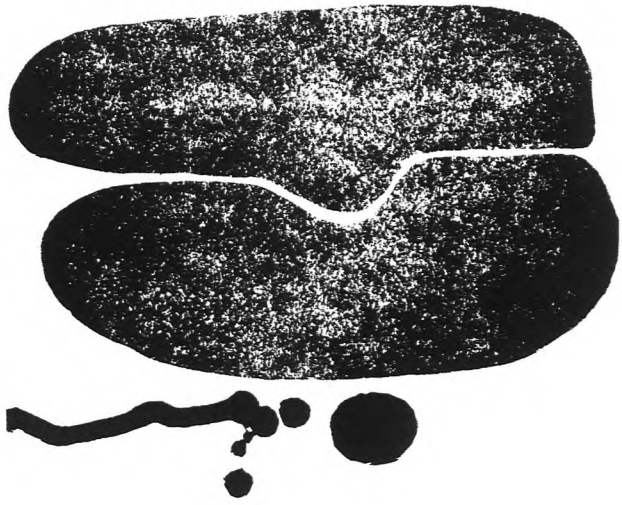
2010



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JOURNAL OF THE BALINT SOCIETY

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Editor: John Salinsky

Corpus Christi College, Oxford. Balint Weekend 2010.

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, Whalley Abbey, Lancashire and Oxford. There is a Balint study day in London in February (see 'Programme of Meetings').

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

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

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

Diary of Balint Society events 2010-2011

Please note that the lecture series will be limited to two this year because of difficulties in finding a venue.

Lectures at The Medical Society of London, 11,Chandos Place, London W1G 9EB
Time: 8:30 p.m. (with coffee from 8.00 p.m.)

Dr John Salinsky **Tuesday 26 October**
'Don Quixote, Sancho Panza and the medically unexplained symptoms'

19th Michael Balint Memorial Lecture
Lecturer and date to be announced **April**

London Day Conference at Canonbury Academy **Thursday 17 February**

The Group Leaders Workshop will meet at the Tavistock Clinic, Belsize Lane. London NW3 at 8.30 pm on 2 November, 24 February and 10 May

The Lancashire Balint Weekend will be held at Whalley Abbey, near Clitheroe, from 11-13 March 2011

The Northumberland Balint Weekend will be held at Longhirst Hall, near Morpeth from 24-26 June 2011.

The Annual Dinner will be held on 30 June 2010 at the Royal Society of Medicine

The 17th International Balint Congress will be held in Philadelphia, PA, USA from 8-11 September.

The Oxford Balint Weekend 2011 will be held in September. Date and college to be announced

The Inaugural Alexis Brook Memorial Lecture will take place at the Tavistock Clinic. London NW3 on Friday 15 October 2010

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

In the last few years we have detected an increasing interest in 'Balint' and 'Balint groups' in the medical and allied professions and this is very encouraging. The Balint Society now provides three residential weekends a year in different parts of the country. Interested doctors and psychotherapists can come and sample the Balint group experience in pleasant and convivial surroundings. Since 2009 we have also added a study day in London and there are currently plans for further activities in the North West of England. The Royal College of Psychiatrists now requires all its trainees to have some Balint training as part of their psychotherapeutic education. There are still very few Balint groups embedded in GP specialty training schemes; but most schemes have small group work of some sort in their programme and at least part of their time is spent discussing the struggles of young doctors with 'difficult patients'. If Balint is not often mentioned, his spirit is probably hovering nearby. The contribution that Balint work can make to GP training is acknowledged in the Royal College of General Practitioners' curriculum, and its recently published electronic learning programme includes a module on 'Balint's ideas' in which learners are invited to take part in a sort of virtual Balint group.

Does this revival of interest mean that there has been an increase in the number of groups for fully trained, practicing GPs? Sadly, we don't think it has. When we survey the scene we are reminded of Groucho Marx's boast that he had worked his way up from nothing to a state of extreme poverty. Although a few green shoots have sprung up in different parts of the country the number of ongoing groups in the UK can still be counted on the fingers of two hands. However, this is to reckon only those groups known to our Society. There are undoubtedly other groups which prefer, for whatever reason, not to make themselves known to us. Nevertheless, it is still exceedingly difficult to find an ongoing group for the occasional eager GP who is desperate to join one.

Why do more doctors not want to join a Balint group? We have been asking that question for years without getting a satisfactory answer. Perhaps it would be more helpful to turn the question round and ask, why would you want to join a group?

When Michael and Enid started their 'seminars' for GPs at the Tavistock Clinic more than 60 years ago the London doctors who signed up really had no idea what they were letting themselves in for. But we do know what they were looking for.

They had mostly been principal GPs for a few years and they felt confused and dispirited by the situation in which they found themselves. The patients who flocked to their surgeries in the late 1940s were traumatised by the war and depressed by the austerity which followed. Few of them seemed to have proper textbook illnesses and those that did were quickly taken over by the superior hospital doctors. Meanwhile the majority of patients who came to the surgery or demanded home visits were complaining of symptoms that didn't add up to a diagnosis. The doctors felt fed up and wished they had never left the hospital. Some have told us that they were on the point of giving up general practice when the Balints came along and saved them. The seminars offered a new approach to General Practice which was a revelation to some and an education to many more. But it didn't suit everyone and there were many dropouts.

The emphasis on trying to understand the emotions of both patient and doctor could seem excessive, especially if you had to work it all out by trial and error without any 'expert' guidance from the teachers. But for those who really appreciated what Michael Balint called 'the psychological implication', the seminars provided a way of making sense of general practice. From now on it was not just a question of sieving out everything that didn't add up to a medical diagnosis. From now on every patient was potentially interesting. They were fellow human beings struggling to cope with life. They had emotions which made our feelings vibrate in sympathy if we were prepared to listen.

But that is all history. Now we have a more strictly regulated form of general practice in which we have to spend a lot of our energy doing the right thing. Patients have to be protected from every conceivable risk; from reckless life styles, lurking risk factors, unwashed hands, unrecorded data, erroneous prescriptions and difficulty of access to a health professional who is decreasingly likely to be anyone they know.

Some of my colleagues might say, you may make fun of it, but this is important stuff for doctors to be doing. More lives can be saved and ill health prevented. It's hard work but it makes sense. And it may keep me sitting over the computer long after everyone has gone home. Why would I need a Balint group as well? What does it have to offer me?

The answer might something like this:

A chance to turn off the computer, relax with some colleagues whom you know and trust and to talk about all your difficult patients. A chance to explore why some patients make you feel angry and then guilty. Why some patients keep you awake at night worrying. Why that woman made a complaint even though you did everything right. The revelation that everyone else has similar problems.

And one more thing which the group can offer you is the 'doctor patient relationship' as a way of making sense of our interactions with patients. You may begin to realise what a remarkable thing this relationship is. It involves giving, receiving, liking, disliking, tolerating, sharing, witnessing, watching over, puzzling

over, being there. It deals with secrets and lies, sudden truths, trust and mistrust, matters of life and death, small courtesies and generous acts that are not forgotten. Over time, if you hang around, it evolves, wriggles, changes its shape, comes to a crisis, explodes, resolves, makes a fresh start and somehow endures. It will probably survive the next reorganisation and the one after that.

John Salinsky

Ten Months of Balint

I McDougall (ST5 Psychiatry Trainee, Belfast Trust Northern Ireland), C McDonnell (Consultant Psychiatrist Western Trust Northern Ireland), S Donnelly (CPN Western Trust Northern Ireland)

Limavady, a small rural town on the northwest coast of Northern Ireland, is home to the Limavady Recovery Team, a multidisciplinary team of twelve professionals including nurses, psychiatrists, occupational therapists and social workers. It developed out of a generic community mental health team during restructuring within the Western Trust and has existed in its current form for 18 months. The main focus of the team is the ongoing care of patients with serious mental illness (SMI) most of whom have a history of psychosis. A Balint group has been incorporated into the team's working week on a fortnightly basis and it is to this that this paper relates. We will describe the use and incorporation of the group within the team, summarise the themes of 12 Balint group discussions taking place over ten months and also present the results of a survey relating to staff opinions of the Balint group.

During the reorganization from a generic mental health team to a psychiatric recovery team it was recognized that the pace of change with this group of patients at times be slow, staff could feel 'stuck' with cases and key worked cases would be highly complex. Generally the provision of staff support in the NHS is poor, risking unhealthy staff, low morale and a poorly functioning team. Arguably unhealthy staff lead to unhealthy, unwell patients. In order to maintain an ability to work, the care of staff within the team is vital and one way to address this was to have a Balint group integrated into the team.

Balint groups have been an integral part of psychotherapy training for psychiatrists for a number of years, but otherwise within psychiatry are generally not part of practice after training or within other disciplines. In the Western Trust a Balint group was formed for senior house officers (now core trainees) training purposes in 2005 and CM was involved from its inception. The main aim of these Balint groups is to encourage reflective learning in psychiatric trainees through an awareness of the emotional content of the interaction between health professional and their patient. The experience of the authors from participating in and leading Balint groups was that the process increased the level of empathy towards the challenging patients often presented and provided good support for junior psychiatrists in dealing with difficult cases.

This Balint group meets for one hour prior to the weekly team business meeting, in a room separate from the main meeting, on alternate weeks. Two members of the team lead the group (SD & IMD) and the average size of the group is eight to ten members. The group proceeds in a usual Balint group form with one person volunteering to present at the beginning after the opening words of 'Does anyone have a case?' He or she presents from memory as much of the case that comes to mind. A short period of time is then spent with questions from the group to clarify details of the case and then the presenter sits out, metaphorically rather than physically and remains silent until the last 10 minutes of the group. The group lasts for 45 minutes with one of the leaders keeping time.

There is a belief within the team that our own reactions to patients can reflect important aspects of their lives. In a client group who can have difficulty expressing their emotions in words, by giving consideration to other forms of communication, including unconscious ones, we can improve our patient's treatment and our understanding of their lives. Psychological interventions for patients with SMI are often limited due to the complexity of the cases, risks associated, long waiting lists or a lack of training in specific interventions. By ensuring that a psychological perspective is integrated into our thinking about patients it is possible that the team itself could add its own psychological approach in order to fill this void. If a recognition of and improvement in the therapeutic relationship is achieved, then this Balint group has been a success.

There is an atmosphere of trust and confidentiality within the group allowing an open, spontaneous, imaginative discussion to take place with a focus on what may be represented in the interaction between patient and team member. The group speculates, often through their own fantasy of the patient's background, what would lead them to interact in the way they do leading to very creative explorations of the cases presented and for important themes to be brought out.

Shown below in table 1 is a summary of the themes that have been explored in twelve of the cases over a ten month period. These are complex psychiatric cases requiring individual key-working by a nurse, social worker or occupational therapist, alongside often frequent input from psychiatrists within the team. It can be seen that topics frequently addressed in Balint groups were present, such as 'splitting' and boundary issues. However a wide variety of other ideas were discussed ranging from secrets to death and dissociation to grief and sadness.

Patient	Themes
A	Splitting
B	Stillness
C	Forgetting
D	Creating a space for patient, 'what about me'
E	Lost creativity, enmeshed mothers
F	Avoided grief, boundaries, enmeshed mother, roles in families
G	Sadness, fear, when to parent and when to let a child/patient go
H	Separation anxiety, enmeshed with mother, sexual abuse
I	Need for and lack of change, dissociation from feelings, disturbed maternal relations
J	Secrets in a house, anger, power, death, collusion, abuse, loyalty
K	The child that disappeared, sadness, the wish for a son
L	Lack of change, dissociation from feelings, recognition of feelings
M	Family of chaos, patient caring for this family, anger and duty

Table 1 Themes of case discussions

This community team based Balint group grew from AM's involvement in developing Balint for psychiatric trainees. However, there is an important difference between this group and those for trainees. Team members are involved in the cases on a long term basis and seeing patients weekly. This contrasts with the once-off A&E assessments or short ward admissions that often are discussed in psychiatry trainee Balint groups. This allows the effect of the Balint group discussion to be seen in a longitudinal way, with any speculations, fantasies or guesswork about the patient's life allowed to be explored further at their next appointment. Putting the content of the fantasies that arise in the Balint group to practical use, team members have been able to explore further areas of the patient's world, often confirming with quite astounding accuracy the group's speculations. This has allowed key workers to move forward in their work with patients helping to reduce the frustration of feeling stuck that can arise for both professional and patient.

Considering that the main aim of the Balint group at the outset was as a supportive measure for staff with no expectation that it would lead to any change in the patient themselves, the effect on patient treatment that has been observed has been a pleasant surprise. The case exploration and development of a deeper, more empathic approach or change in perspective has been reflected in interactions with the patient, changes in the patient's symptoms or in the management of most cases discussed.

Something for the Managers

In the current NHS climate of targets and waiting lists the time spent every fortnight in the Balint group is always in danger and it was thought that an objective measure of its benefits would not only be of interest but also strengthen the case for its continuation. We undertook a survey of the staff in the team to gauge their opinion of the usefulness of the Balint group in their work.

Our aim was to study the effect of a Balint Group in a psychiatric recovery team during a ten month period with reference to:

1) Effects on patients who are presented

2) Effects on staff members as individuals

3) Effects on the team

4) General opinions about Balint group

The survey was carried out in relation to the time period May 2008 to February 2009. It contained eighteen questions, of which thirteen were five point Likert scales, one was a yes-or-no question and five questions invited open comment. The Likert scales were reduced to nominal data of agreeing or disagreeing for ease of presentation. Open comment answers were not subject to a formal analysis but are summarized below in table 2.

Although this approach inherently has many positive biases including the active participation of the team members in Balint and the survey design by a team member, it is always difficult to have a truly objective unbiased study of any psychotherapeutic venture. Even taking this bias into consideration, the results of the survey were astoundingly positive.

Twelve Balint groups took place within the time frame of ten months with eight different staff presenting cases during this period. This is obviously short of the 20 groups that would have been expected but the losses are accounted for by holiday periods and, at times, clinical pressures. 100% of staff believed the Balint group was of benefit to patients, with 75% suggesting a change in their patient in the weeks following presentation at Balint while 25% were unsure. 88% thought that any change in their patient a positive one.

100% found Balint supportive and of benefit to staff and 100% found it of benefit in their management of cases. 92% suggested that the Balint group had changed their practice. 92% thought that the Balint group had a positive effect on the team with 100% believing it to be a productive use of staff time. 100% found Balint group a safe place to discuss cases, a positive experience both when presenting and when involved in the discussion.

Table 2 shows some specific comments from staff in relation to the four areas considered in the survey.

Topic	Comments
Effects on Patients	**'Creates a focus more on the person', 'Our change creates opportunity for patient change', 'She said – something has changed here'**
Effects on Staff	**'Aware of emotions', 'Breaks old patterns of thinking', 'Shares frustrations', 'Greater depth of understanding', 'Brings up issues that may be missed'**
Effects on Team	**'Increases trust and strengthens the team', 'Develops a team ethos', 'Very interesting to hear the ideas of others'**
General Comments on Balint	**'Ensures a psychological perspective', 'Brings up issues that may otherwise be missed'**

Table 2 Staff comments from survey

What has happened in these ten months?

The team has strengthened during the time of the Balint group and there has been a general improvement in team morale with this being seen through subsequent improvements in the care of many difficult patients. Presenting a difficult case within a supportive environment can be a cathartic process for the presenter with the knowledge that there has been a multidisciplinary discussion reducing their anxieties further.

We have seen in the group that the transference and countertransference processes that the patient engenders in their key worker and the interactions with them become represented in the Balint group. The trusting space created in the group allows a reverie and at times free association within the team to develop and we could even go as far as to suggest that there is a connection with the patient's unconscious created. This trusting space allows all possibilities to be discussed and acts as a preparation to hear what has until then been unspoken. When the worst possibility has already been suggested it is then much less a surprise to hear it is true.

The group process in itself validates the thoughts of the members within the team allowing a confidence to grow in the knowledge that feeling an emotion about their patient may well reflect a very important aspect of the patient's life. Having the speculations of the group verified when a patient openly begins to describe what has been discussed is a huge experiential learning process for the team, allowing further trust and confidence in the group and the team to develop as a whole.

Conclusion

The incorporation of a Balint group into this community mental health team has provided not only a supportive measure for staff and their development but appears to have had a subsequent beneficial effect on patients with psychiatric illnesses. In an indirect way this has provided a form of psychological input for patients in whom this is often difficult to access.

It has truly validated the strength of the group process and the unconscious communications held within the matrix of transference/countertransference and the therapeutic relationship that can be communicated through a Balint group. Interestingly, a recent public enquiry of another area of care within this trust highlighted the importance of staff's recognition of these unconscious communications, further strengthening the case for the continuing development of Balint groups in mental health services.

Our admittedly crude method of survey has highlighted some important issues for consideration, but clearly further more scientifically rigorous methods of studying the process of Balint groups would be greatly valuable.

To end with an interesting question from a team member,

'He opened up and told more of his story; was it because I was now able to hear it?'

Balint Groups in the Medical School of the Pontifical Catholic University of Goiás: Report of an Educational Experience

Daniela Londe R. Taveira[1]; Fernanda Gerst M. Freitas[2]; Lara Cerveira de Souza[3]; Polyana Naves Adorno[4]; Iracema Carvalho[5]; Lorenzo Lago[6]; Rita Francis G. R. Branco[7]

Pontifical Catholic University of Goiás, Brazil

Introduction

Medical students need a special training as part of their curriculum, to develop a holistic view of health and a capacity to critically analyse the bio-social-psychological and cultural aspects of illness.[3,4] The medical course of the Pontifical Catholic University of Goiás, is a modern school and its political pedagogic project (PPP) has as its central focus the medical students and the communities in which they practice during their course. This medical course is very new and it was founded in the second semester of 2005.

The medical students have an early and active involvement in the problems of the community and its environment. They see the people in health and illness and this provides the background for a new didactic methodology based on two main axes. These are:
The Theoretical Practice Integrated Axis and
The Personal Development Axis.

Where these axes meet they learn about the multidisciplinary approach and the doctor-patient relationship. (Figure1). The teaching methods we use are problem based learning (PBL), skills laboratories with role play and Balint groups.

Objectives

The objective of this text is to present the educational experience of the Medical School of Pontifical Catholic University of Goiás about Balint groups and Balint theory as integral part of the curriculum.

The report of an educational experience

Balint published his theory about the doctor-patient relationship in his well-known book The Doctor, his Patient and the Illness in 1957[1]. The Brazilian psychoanalyst Danillo Perestrello introduced Balint groups into a medical school in 1958, in Rio de Janeiro. The practice of Balint groups on medicine courses in Brazil was forgotten for years after 1960, although a few experiences of Balint have been reported from universities in Rio de Janeiro, Recife, São Paulo and Goiás[2]. During the 1990s, the Federal University of Goiás, included Balint groups in their programme of clinical semiology for 4 hours a week, increasing to 8 hours in 2001. The

Figure 1: The Theoretical Practice Integrated Axis and The Personal Development Axis as the cycle of medical course of Catholic University of Goiás. There are 5 circles around the axis: the first, second, third and fourth student years and the two intern years. All of the studies are along the two axes.

experience was very successful and the medical students showed evidence of an improved doctor-patient relationship.[5] The educational experience in the Pontifical Catholic University of Goiás is very different and aims to give medical students a good foundation in understanding of the doctor-patient relationship and a holistic view of human illness. This programme has been running since August 2006. Balint groups are continued until the third semester of the medical course and this

1. Medical student of Pontifical Catholic University of Goiás
2. Medical student of Pontifical Catholic University of Goiás
3. Medical student of Pontifical Catholic University of Goiás
4. Medical student of Pontifical Catholic University of Goiás
5. Professor MD of the Personal Development Axis – Medical School/ Pontifical Catholic University of Goiás
6. Professor MD of the Personal Development Axis – Medical School/ Pontifical Catholic University of Goiás.
7. Professor PhD of the Personal Development Axis – Medical School/ Pontifical Catholic University of Goiás and Balint Group Leader.

SEMESTER OF THE COURSE	BALINT TRAINIG	OBJECTIVES
3rd Semester	Balint groups and the study of the theory (the doctor as a drug; the organization of the illness; the offer of the illness; the apostolic function and the collusion of anonymity.	To understand illness from Balintian perspective To understand the apostolic and the therapeutic function To understand transference and countertransference
4th Semester	Balint groups and the study of the theory (Psychotherapy in the medical clinic; the patient and the illness, the doctor and the patient, the doctor's defensive patterns)	To develop a therapeutic relationship with their patients To understand the patient's perception of the illness To listen the patient (a therapeutic listening) To understand the doctor's defensive patterns To develop good defensive patterns
7th Semester	Balint groups as "coping" (texts about burnout, depression and suicide; drugs in medical practice)	To understand all the factors of stress in medical life To develop coping strategies to preserve their mental health in conditions of stress
12th	Balint groups as "coping" (texts about medical identity)	To understand the complexity of medical identity To develop coping strategies to preserve their mental life in the face of stress

The differences between Balint learning experiences in the Federal University and Catholic University from Goiás are:

Federal University of Goiás	**Catholic University of Goiás**
Balint group experience of 4 hours a week were not a separate discipline	Balint group experience of 15 hours during each semester of the course a as a separate discipline during four semesters of the medical course
Pupils did not study the theory, they just took part in the Balint groups	Pupils study the theory and they take part in Balint groups
Balint groups as one circle with pupils and a leader	The students are divided into an observing group and a participation group (this is the real Balint group), configuring the GV/GO didactic technique (figure 2)

is an important part of their experience. Balint training is on the curriculum as an important part of the Personal Development Axis. Balint training is developed during four semesters of the medical course as shown in the schedule:
The groups in both universities were run in accordance with the 'essential features' published by The Balint Society (UK) in 1994. A survey of the students of the three groups showed that the Balint experience was very important in improving the doctor-patient relationship, helping students to understand both doctor and patient and the health/disease process and to help relationships between students (Schedule 1).

Figure 2: Balint Group with medical students in the Catholic University of Goiás. Balint group in the middle with observers in an outer circle.

Schedule 1: EVALUATION OF BALINT EXPERIENCE

QUESTIONS	GROUP 1 (32 students)	GROUP 2 (44 students)	GROUP 3 (46 students)
Did you already know about Balint theory?	32 pupils – NOT(100%)	44 pupils – NOT (100%)	44 pupils – NOT (95.45%) 02 pupils – YES (4.55%)
Had you participated in a Balint group before?	32 pupils – NOT(100%)	44 pupils – NOT (100%)	46 pupils – NOT (100%)
Did you believe that Balint experience helped you?	31 pupils – YES(100%) 01 pupil – NO(3.23%)	42 pupils – YES (9.,24%) 02 pupils – NO (4.76%)	43 pupils – YES (93.02%) 03 pupils – NO (6.98%)
How did Balint experience help you? (a) It helped me to understand the patient better. (b) It helped me to improve the doctor-patient relationship.	 27 pupils (84.38%) 23 pupils (71.875%)	 32 pupils (72.72%) 32 pupils (72.72%)	 39 pupils (84.78%) 35 pupils (76.08%)

(c) It helped me to understand the doctor better.			
(d) It helped me to understand the health/disease process.	25 pupils (78.125%)	26 pupils (59.09%)	33 pupils (71.73%)
(e) It was an influence in my own life.	22 pupils (68. 75%)	18 pupils (40.90%)	26 pupils (56.52%)
(f) It assisted me to improve my personal relationships	20 pupils (62.5%)	14 pupils (31.81%)	28 pupils (60.86%)
	17 pupils (53.125%)	17 pupils (38.63%)	28 pupils (60.86%)

Conclusion

The Balint experience in the medical course of the Pontifical Catholic University of Goiás provides a great opportunity:

- to develop an effective doctor-patient relationship,
- to learn about transference and countertransference and to use them as a therapeutic instrument;
- to reflect on defensive patterns in the consulation and to construct good defensive patterns [6]
- to reflect on the stresses in medical life and the problems of depression, suicide, drug abuse and burnout syndrome and to develop coping strategies.

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Building on the work of Alexis Brook: further thoughts about brief psychotherapy in primary care

Andrew Elder

Abstract

This paper describes the pioneering work of Alexis Brook in exploring the value of psychotherapists working alongside GPs in their practices. It starts by describing two seminal papers published by Brook in 1967 and 1976 which illustrate his emphasis on the importance of a collaborative approach between professionals, and on an understanding of the natural advantages of GP practices for mental health work. The author then describes briefly some of the more recent developments in counselling and psychological therapies in primary care. This perspective allows the differences to be drawn between the current approach in which general practitioners are encouraged to relinquish their role in mental illness, and the approach adopted earlier by Alexis Brook and his co-workers where psychotherapeutic skills are used to help professionals in practices develop their own resources. The paper concludes by arguing for a much-needed re-appraisal of the theory and practice of brief psychotherapy in primary care, one which would take full account of the psychological characteristics of the setting and build on the earlier insights and approach of Alexis Brook and his colleagues.

Appreciation

I was fortunate to have the opportunity of working with Alexis from 1995 onwards when, with Sotiris Zalidis, we established a multi-disciplinary case discussion seminar for eye professionals at the Tavistock Centre (Brook et al 1998). Alexis had a charming personality and it was a delight to work with him. Particularly, I recall Alexis's encouragement during the early stages of the project, his patience, and the priority he gave to careful planning and discussion at every stage. But perhaps, most of all, I remember his quietly determined persistence in the face of inevitable setbacks, and the confidence-at-depth he had in the value of such work. In the seminars he was always encouraging and had an apparently effortless way of responding to very distressing cases with great tact. The warmth and humanity of his approach enabled people quite unused to psychological ideas to feel safe enough to explore their work together. He never used technical psycho-analytic language and was often able to find a telling and evocative metaphor to illustrate his points. Alexis had a great gift for bringing colleagues together from different disciplines and did not like to restrict his thinking within conventional professional boundaries. Perhaps this is why he seemed to feel at home in the GP setting - the only medical discipline that isn't confined by the body-mind divide, and whose professional focus can be directed to the whole person.

Although the subsequent rapid growth in counsellors and psychotherapists working in primary care has some connection with Alexis' early example, it is important to recognise that his approach had little to do with increasing the availability of particular treatments (psychological therapies) and a great deal to do with the value of psychotherapeutically-trained listening close to the natural flow of life (and its difficulties) that comes through a doctor's surgery every day. This stands in stark contrast with many of the more recent developments in mental health policy and to the implementation of the government's Improved Access to Psychological Therapies (IAPT) programme, in which there is little recognition of the role GP practices play in maintaining the mental health of individuals and communities. The Depression Report (Layard 2005:10) includes only two sentences about primary care. 'At present 2¾ million patients come to GP surgeries each year with depression and anxiety. Most receive drugs or nothing.' This is a grossly misleading view which only the shortest time spent sitting-in on a GP's surgery would correct. Alexis was keen for all professionals who work in a doctor's surgery to understand and learn to harness the natural strengths and advantages of their setting for mental health work.

Alexis as Innovator

In 1967 a paper appeared in the Journal of the College of General Practitioners modestly entitled, 'An Experiment in General Practitioner/Psychiatrist Co-operation' (Brook 1967). This experiment entailed Alexis spending an afternoon every fortnight at two general practitioners' surgeries offering himself as a consultant to the doctors. During his visits he would see any patients referred to him for one or two assessment interviews and then discuss them with the GPs. Nothing similar had been carried out in the UK before. This was the first report of such an experiment in this country.

The 1967 report bears all the key elements of Alexis' approach to working with GPs (and no doubt to other professional groups as well). The paper describes the psychiatrist as being at the service of the GP, not going as a specialist with expertise in a particular treatment but as a consultant to the doctor, who in Alexis' own words 'should feel absolutely free to accept or reject any of the psychiatrist's formulations as he saw fit.' Such an attitude clearly conveys an unusual degree of respect for the professionalism and role of the generalist 'whose particular expertise can so easily be overlooked' (Balint et

al 1993: 17), and is often thought not to have a role in mental health at all. But most important, the conclusions Alexis reached after this first consultation with a practice in 1967 remain the foundation stones of the argument for (well-trained) psychotherapists working alongside GPs to the present day.

"Many patients said they valued the ease and informality of being seen on the doctor's premises..for some patients it would have been very difficult to overcome their fears if they had to go to a psychiatric clinic..several indicated their appreciation of the psychiatrist and GP talking over how best to help them...it became increasingly clear to the psychiatrist that what were referred to as minor psychological problems in general practice were far from that and that the term is really a misnomer... and are sometimes major problems for the doctor in terms of how to help the patient...over half the illnesses were associated with an internal, developmental life-crisis, or an environmental 'crisis' such as a sudden death or serious illness"...(Brook 1967:129)

This short passage makes a compelling case for the importance of brief psychotherapy being practiced in primary care: its accessibility, lack of stigma, the particular value of its collaborative nature, the large number of patients who are not suitable for onward referral or are resistant to it, and of particular relevance at the present time, that GP patients often have complex mental health problems. In contrast to this, our present hyper-rational approach to mental health envisages an orderly progression of complexity from primary care (simple) through to secondary and tertiary care (more complex). However, in the 'stepped care' model which describes complexity on a scale of 1-5, many patients in primary care seem to be in Step 6! These are patients who continue to trouble their general practitioners and often need long-term help and have already had all the appropriate specialist treatment, or refused it.

It is also clear from Alexis's report that the experiment was of mutual benefit. The psychiatrist, says Alexis, had 'now experienced at first hand what he had only understood intellectually before'-something of the frustration and limitations of being in the doctor's surgery (Brook 1967:130). This emphasis on mutual change occurring between two professional disciplines is central to Alexis' approach. His strong encouragement to younger colleagues to take up GP work arose partly out of his belief in its value to them as well as to the primary care team to which they were attached.

Early Influences

In the 1960s there was a great deal of interest in exploring new ways of getting a psychiatrist's expertise (and also other professionals, particularly social workers) out to support front-line professionals whose work had a bearing on mental health, and to whom people readily turned with their troubles. Much of this work originated from the Cassel Hospital. In 1961 Tom Main had read a paper to the Royal Society of Health entitled 'New Developments in the Psychiatrist's Role' (Main 1961). For Alexis, it seems to have been the experience of taking a case discussion seminar for GPs at the Cassel (what we would now call a Balint group) that led him to undertake his project. In its third year of work the group elected to study 100 so-called 'ordinary' GP cases plucked at random from the participating doctors' morning surgeries (Brook 1966). As a result of listening to these apparently 'non-psychiatric' cases, Alexis decided to visit the doctors' surgeries and see the patients himself.

Of course, the presiding figure behind all these experiments in psychiatrist-GP collaboration at that time was Michael Balint who had begun his research-cum-training seminars with GPs in 1949, and had published his groundbreaking account of that work, *The Doctor, His Patient and the Illness* in 1957. In this he had written, 'I have mentioned that in Utopia the specialist will not be a superior mentor, but the general practitioner's expert assistant... and he (the GP) will have to shoulder the privilege of undivided responsibility for people's health and well-being, and partly also for their future happiness'(Balint 1957:289). Whereas Michael and Enid Balint, in their groups with GPs, were interested primarily in fostering a change in the individual doctors to help them respond more fully to their patients, Alexis' work can be understood as initiating a similar developmental change but in relation to the practice itself. 'The aim of our project was to study how a worker with psychotherapeutic skills could help general practice to develop its resources as well as exploit its special advantages in the field of mental health' (Brook and Temperley 1967:92). There is a similarity in the way the Balints described the role of a psychoanalyst whilst leading a group of GPs and the approach adopted by Alexis and his colleagues when visiting a practice: not teaching but listening, tuning in to the doctors' concerns, having an exploratory attitude and only introducing ideas that seem consonant with the doctors' own understanding of their role.

Tavistock Community Unit

Following his appointment to the Tavistock Clinic in 1971, Alexis continued to develop his interest in primary care. The Community Unit of the Adult Department at the Tavistock launched a project to study the impact of experienced mental health professionals (well advanced in their training as psychotherapists) visiting a general practice on a regular weekly basis. Four practices volunteered to participate in the scheme initially, others were recruited later. This project laid the foundations for therapists (and counsellors) seeing patients in GP practices. It inspired a new generation of psychotherapists to take an interest in this work and had a lasting impact on the

participating practices, which continues in some until the present day. The key ingredients of the project were careful discussion in setting things up; discussion between the collaborating workers about each patient before any management decision is taken; ultimate responsibility remaining with the general practitioner; and a weekly workshop focussing especially on interdisciplinary aspects of the work (held at the Tavistock) to which two members of the practice team were invited. The Tavistock 'clinic workers' were left free to decide how to respond to the various requests for help they received in the practices. Different patterns of collaboration emerged; sometimes the 'clinic worker' saw the patient themselves for a period of brief therapy; at other times conducting an assessment followed by discussion with the referring clinician (patients were seen for between 30 and 60 minutes); or directing their attention to the practice 'team meeting' and offering consultation to the doctors on their difficult cases or on roles and relationships within the team. It was felt to be important for those working in a surgery to be experienced enough to tolerate what cannot be achieved for patients and therefore to help the surgery staff tolerate this as well. A number of publications appeared describing the different aspects of the project's work (Graham and Sher 1976; Smith et al 1982; Dawes 1985). The overall account of this important study was published in 1976 in the Journal of the Royal College of General Practitioners as 'The Contribution of a Psychotherapist to General Practice' (Brook and Temperley, 1976).

Essence of the Tavistock approach

In their description of the project, Brook and Temperley state clearly, 'our aim was to reduce the amount of splitting and dissociation that so often occurs in patient care when different professionals may be played off against one another. This splitting can be a reproduction of the patient's need to keep various aspects of themselves in separate compartments; it can also result from the staff's reluctance to bear looking at the patient's situation in toto' (Brook and Temperley, 1976:87). Alexis always emphasised how easily the tensions within the doctor-patient relationship can lead to premature referral and result in frustration for both patient and doctor. Perhaps it would be useful at this stage to remind ourselves of the range and pressure of clinical work in general practice, aptly compared by Jan Wiener to a souk, a chaotic Arab bazaar, 'where everything is potentially available, like a practice, where GPs have to maintain a gate-keeping function with often limited resources. GPs have to cope with whoever walks through the door and must decide what is treatable and what must be borne or managed' (Wiener and Sher, 1998:11). In such work, the complex tensions that surround decisions about 'referral' or the 'need for treatment' are critical. Such decisions can arise from a number of sources – only one of which is the patient's clinical need. Decisions to refer may also arise from pressures within the doctor-patient relationship as well as other sources. Alexis made this point with characteristic clarity in a letter to the BMJ entitled 'Be honest about referrals'. He gives four reasons for referral to a psychiatrist (or any other professional for that matter): to provide or arrange specialist treatment; to assess and clarify a situation and provide expert advice so that the GP can then continue treating the patient; the GP wanting to share the burden and responsibility of looking after a patient for whom little can be done but who insists on more and more investigations; and lastly, when the GP wants to be relieved of the patient for a while. He states that the 'latter two can be considered to be primarily in the interests of the doctor'(Brook 1994:340). These reasons of course apply equally to referrals to counsellors or therapists working in the practice itself. The essence of the Tavistock approach is to look as far as possible at the whole picture: the needs and presentation of the patient, the pressures on the doctor and any tensions that there might be in the doctor-patient relationship. Without such an understanding, fragmentation soon follows, and cycles of unfounded hope, frequent frustration and disappointment ensue. The extent of this phenomenon is not easily recognised, particularly where the research instruments employed to study outcomes are themselves too narrowly focussed to reveal the individual narrative and contextual links behind the 'treatments' studied.

Brief historical sketch

The first reports of counsellors attached to GP practices began to appear in the 1960s and 1970s (Sibbald et al, 1996). Many were trained in marriage guidance and worked without payment. Often they were recruited by doctors who had been in Balint groups and whose practices had an existing commitment to psychological thinking. There followed a slow but steady growth in the number of counsellor appointments until a massive expansion occurred from the 1990s onwards. By 1992: 31% of practices had counsellors; by 2001 the figure was 51% and by 2007, it had reached 88% of GP practices having access to practice-based counselling. By this time the workforce was estimated to be approximately 3500 therapists in total (Barnes et al, 2008). Many factors led to this rapid expansion. Undoubtedly the introduction of fundholding was an important factor in the1990s. Many GP practices, already disillusioned with local mental health and psychiatric services, decided to employ their own counsellors and save money from their secondary care budgets. As the complexity of primary care has increased, GPs have felt the need for more accessible help in responding to the emotional problems of their patients. At the same time, a large number of counselling trainings came into existence and newly qualified counsellors were attracted to working in primary care. A professional organisation, now called Counsellors

and Psychotherapists in Primary Care (CPPC) was established in 2000.

The expansion of primary care counselling occurred during a time of rapid change in the organisational and employment environment of the NHS. Service development had to take account of the need for evidence-based practice, increased equity of provision, greater accountability and a much more active clinical governance agenda (Mellor-Clarke, 2004). Employment control has largely shifted away from GPs to service managers in primary care trusts or large mental health trusts (usually to their psychology departments). Although these changes have led to some benefits, in practice they have also led to a disruption of the previously close working relationship between counsellor and GP, and to a narrowing of understanding of the counsellor's role. Counsellors now often work in multiple surgeries with an accompanying loss of feeling for the particularities of an individual GP surgery; communication is often by computer rather than in person; the clinical contract is often circumscribed (without any supporting evidence of benefit) to a 'six session' model, rather than a model which seeks to understand and exploit the natural rhythms of consultation that patients exhibit towards GP surgeries; GPs no longer have freedom of referral and sometimes have to make their referrals to an independently contracted 'separate' team which then decides on an appropriate route for the patient – sometimes even referring the patient on to a counsellor or psychological therapist working in a different practice! In such a system, no value is placed on the GP's experience and knowledge of the patient, and counselling is thought of as a stand-alone service with the need to maximise its efficient use. If this path continues to be followed, the future may hold many failed appointments, a demoralised workforce and a much less effective service for patients. Most important, however, is the loss of understanding of the wider role of a therapist's work as a member of the practice team: availability for discussion, participation in team meetings, and undertaking a collaborative role in relation to the mental health work of *all* members of the primary care team. Where such collaboration flourishes, the doctors and nurses grow in the use of their own psychological skills and the counsellors take on a deeper understanding of the therapeutic opportunities gained by working in a medical setting.

Where are we now?

A further important development is occurring at the present time. In 2005 The Depression Report (Layard, 2005) made a compelling case for an increased investment in psychological therapy services. As mentioned earlier, unfortunately it also failed to recognise the central role that primary care plays in the containment and management of common mental illness. The IAPT programme (CSIP, 2007) which has followed the report is spending £173 million over three years towards increasing access to psychological therapies. The money is allocated for treatments according to evidence assessed through the restrictive criteria accepted by NICE and is therefore predominantly based on Cognitive Behavioural Therapy (CBT). New services are commissioned according to the design of the 'stepped care' model. Thus, a template largely derived from theory is being transposed onto existing services with little thought about how it fits with primary care (which remains by far the major provider of mental health consultations), or other services. Although the programme was intended to supplement existing services, in fact many new and relatively inexperienced CBT-based therapists are being deployed in primary care *at the expense of* those who have already gained experience and have had a psychodynamic training, often at considerable depth. It seems that insufficient thought has been given to how new services are best grafted on to existing ones. Underlying this, there is an unrecognised disjunction between the concepts that lie behind IAPT and those that are needed to understand the work of GP surgeries. The IAPT programme is based on a rationalist 'treatment-based' medical model approach. Such a way of thinking seeks to isolate 'disorders' called 'anxiety' and 'depression' from the daily flow of people with life problems that come in and out of a doctor's surgery, and then to treat them according to evidence-based guidelines. A large proportion of primary care work consists of containing and listening to emotional distress (expressed through the body as well as the mind and frequently co-existing with multiple other problems) in the context of what has been learned already through the doctor-patient relationship. One of the key skills that GPs slowly acquire is the judgement of when treatment is necessary (in whatever form) and when it is not. Along with the 'stepped care' approach, perhaps a 'stepped concepts' approach is also needed. It may be appropriate to apply strictly evidence-based criteria (albeit broader than the existing NICE process allows) in the assessment of specialised treatments (steps 4-5) but a much more pluralist approach is needed when assessing the value of work undertaken in the more complex arena of primary care. One of the skills of general practice is in matching treatment (and therapist) to patient. What of patients' choice?

At the same time as *psychological* therapy services seem to be moving towards this more separate and restricted way of functioning, GPs are increasingly being driven by a strongly *disease-centred* performance-related contract, QOF (Quality and Outcome Framework). Under QOF there is no incentive for integrated thinking or genuine whole-patient care. For instance, payment for the treatment of depression is made on producing evidence of the completion of a questionnaire. Thus the current contractual

underpinning of GPs and psychotherapists in primary care, sadly, is tending to an aggravation of the separation between body and mind again; a split which is so often central to illness, and which thoughtful work in GP practices can often help to bring about some healing.

Re-visiting Brief Psychotherapy in Primary Care

With the pendulum, at present, having swung so far towards a medical model of mental health and away from an understanding of the role played by human relationships, perhaps a return of interest in psychoanalytically informed therapy is due. When Alexis Brook founded the Tavistock Community Unit, the psychotherapists in his team were experienced professionals who were also undertaking a substantial training in psychoanalytic psychotherapy. Their work in the practices was strongly supported by the regular forum for discussion held at the Tavistock. As described earlier, there has been a considerable increase in the variety and number of psychological therapists now working in primary care, and many of these therapists feel isolated and unsupported in their work. For all these reasons, perhaps it is a good time to reconsider the theoretical underpinning and techniques employed in brief psychotherapy *when it is practiced in primary care*. There is now good evidence for the effectiveness of short-term psychodynamic therapy. In a meta-analysis of 26 studies it was shown to be as effective as other therapies at completion, and showed slight superiority at later follow-up (Anderson and Lambert, 1995). A further exhaustive meta-analysis has been published as part of the Cochrane Database (Abbass, 2006). Where better to practice short-term therapy than in GP practices? Although often characterised as brief psychotherapy, such therapy might be better thought of as '*brief-in-long*', given the long-term timescale in which GP practices and their patients relate to each other.

Timescale

The 'six-session' model has been extensively criticised and may have been driven primarily by considerations of funding and equity, as well as possibly having been an expression of anxiety about being swamped by unmanageable numbers of referrals. Professionals now experienced in primary care tend to emphasise the need for counsellors to be able to respond flexibly to different patients and adapt their clinical framework to reflect the patterns and rhythm of consultation in general practice – patients coming at a time of need within a long-term timescale (Murphy, 2004; Wiener and Sher, 1998). This has been described as a revolving door model 'in which a contract is made with the patient that includes both a period of brief therapy and the possibility of a future return for more sessions if necessary. The focus then falls more onto the specific phases of therapy as they occur and working with an ending is not central for long periods of time' (Lee, 2004:7). The essence of this work lies in a flexible and creative response to the primary care setting, which needs to be seen as an opportunity rather than a restraint. One practice has described a system of allocating patients according to a 'menu' of different options, following initial assessment. The menu varies through one or two exploratory sessions; weekly fifty minute sessions for ten weeks; fortnightly fifty minute sessions for twenty weeks; thirty to fifty minute sessions every four to six weeks over a longer period; and 'don't know and 'emergency' slots (Pietroni & Vaspe, 2000). Although this may seem rather schematic, it does represent a move towards tailoring the provision of counselling to the differing needs of patients. In many other practices the length of therapy has been left to the judgement of the counsellor, with no limit imposed. Without any limit, the *average* number of sessions for which patients are seen is reported to be eight. It is interesting that this is also thought to be the minimum number of sessions required for therapeutic change. In one such practice, no waiting list developed (96% of referrals seen within three weeks); and a few patients have been seen for a year or more (Sharifi, 2004). Lengthy waiting lists are more closely related to low-threshold referral patterns of doctors, rather than to the availability of counselling. In practices where there is frequent discussion between the doctors and counsellors, a balance seems to emerge between supply and demand.

A Primary Care Model

There are of course many different models of brief, focal, and time-limited psychodynamic psychotherapy. However, no approach has been specifically and systematically studied in relation to therapy undertaken in a GP surgery. *In Psychotherapeutic Techniques in Medicine*, Michael and Enid Balint wrote that 'the importance of the setting in which the doctor (or therapist) works is such that it largely *determines the techniques used and the results obtained*' (Balint & Balint, 1961:6). Almost all models of brief psychotherapy have been developed as stand-alone methods without any surrounding structure of continuing clinical care, as is the case in a GP's surgery. This has led to techniques in which early emphasis is placed on separation and ending in the therapy. Whilst separation, loss and mourning are always of central importance in psychotherapy, there may be good reasons in primary care (where there are other professional relationships continuing and where there is a possibility of return) to focus on other aspects of the therapy relationship. It may be more useful in primary care for the accent to become one of 'in quickly, out quickly' an approach in which *intensity of contact* is the key rather than length of time and working through. In focal therapy (Malan, 1963) an interpretive focus is selected which is both symptomatic of the patient's

presenting problem and can be seen to have an early, often oedipal, background which is accessible in the transference with the therapist. A similarly selective focus may sometimes be appropriate with patients in primary care - bearing in mind the intense triangular dynamic that is often present in the referral and the likelihood of this being symptomatic of the patient's early difficulties as well as related to current problems in the patient's life. Given the containing effect of the therapy being 'in-house' it is possible that areas of deep conflict can be approached more safely than in free-standing short-term therapy. Also, in the same light, if the therapy is able to examine some of the emotional difficulties that have led to referral it is possible that a shift in the patient-doctor relationship may follow, and this in itself, could be of long-term benefit to the patient. Such intensity of focus is most often avoided by patient, therapist, and doctor, alike. A recent editorial by a practice counsellor draws attention to this: 'we are not working solely within a dyadic therapeutic relationship in which transference interpretations can be understood in terms of the therapeutic pair, but within a complex web of relationships which at best is a threesome (GP, patient and therapist) and at most a group' (Murphy, 2004:305). Another experienced primary care therapist, a Jungian analyst, writes 'the setting provides the containment necessary for therapy with very disturbed patients partly through availability of medication, ease of referral on to other services and also, importantly, through case discussion' (Bravesmith, 2004:44).

Further research is needed to define more closely the characteristics of the patients for whom in-house therapy is suitable, rather than onward referral. They are likely to include those who have enmeshed relationships within the practice, and where either the patient, or the doctor, or both, are reluctant to accept referral. And those for whom collaborative work is particularly valuable, or necessary.

Intensification of Transference

It is generally agreed that transference is found within all relationships and is a ubiquitous aspect of relating to others and to institutions. But the extent to which these relationships become intensified by being a patient and attending a doctor's surgery remains largely unstudied, particularly in relation to the effect this might have on the practice of psychotherapy *in* a surgery. Although many consultations with a GP are for apparently minor matters, there is often an associated fear of serious illness, disturbance (and mortality) not far away. As anxiety levels rise, the historical patterns of dependency on parental figures emerge more strongly and are often transferred (with all their ambivalent complexity) to the professionals connected with the patient's care. This quasi-parental component of transference is further intensified by the doctor's (or nurse's) handling of the body and their role in physical examination and physical illness. After all, the origins of transference lie in the maternal care of the infant's body-mind. Any such intensification of the patient's transference can have the effect of amplifying the significance and therefore the impact of any therapeutic work done within a primary care team. Of course this applies just as much (maybe more) to the opportunistic listening of doctors and nurses in the course of their clinical work, as it does to the more structured listening of primary care counselling.

The practice as a secure base?

GP practices often become familiar and trusted places. Attachments grow in the course of medical care. The doctors, nurses, and counsellors who work in GP practices often contain knowledge of the significant events and patterns of illness that have shaped the lives of their patients. In a sense this knowledge comes to reside in the practice itself, which then begins to take on some of the characteristics of a secure base to its patients. This notion of the practice as 'a secure base – a place to which both patients and professionals become attached in characteristic ways' (Elder and Holmes, 2002:2) - is noticeably missing in present day thinking about mental health. Such a concept might be helpful in understanding the role that practices play in maintaining the health and wellbeing of their patients. A sensitive recognition by the practice of a particular patient's pattern of insecurity, for instance, may well lead to a more secure attachment relationship to that doctor and the practice: 'although built up through individual contacts over time, the attachment spreads out to be held by the practice itself, even by the physical space and presence of the building. After a time, all the staff who work in the practice inherit the mantle of what we might think of as a collective transference relationship' (Elder, 2009:59).

All members of a primary care team benefit from developing their understanding of the *particular nature* of a GP practice as a setting for psychotherapeutic work. A GP practice has been aptly described by Launer as 'a community of listeners' (Elder and Holmes, 2002:126). Whatever advances there are in specialist services, much will always depend on the sensitivity and skill exhibited in the many thousands of daily contacts that patients make with their local doctors and nurses. A recent report 'Psychological Therapies in Psychiatry and Primary Care' makes the point clearly, a 'significant and lasting improvement in mental health in the population will depend on...enhancing the psychological awareness and therapeutic skills of the existing healthcare workforce, in addition to providing dedicated psychological therapy services'(RCPsych, 2008:7). Further, the quality and effectiveness of all clinical work in a practice is enhanced by teamwork and a culture of communication between professionals working together. Contact with patients in primary care frequently involves

high levels of distress and disturbance. Often an experienced mental health professional is needed to facilitate the necessary teamwork and discussion from which support and professional development may follow.

And so, with this thought, as is so often the case with this work, we return full circle to the example set over forty years ago by Alexis Brook.

Conclusion

Only a small proportion of the clinical work undertaken by GPs can be attributed to a defined condition with an appropriate evidence-based treatment. Much is taken up with a supportive and therapeutic use of the relationships that patients form with members of their local practice team through the course of responding to all the varied reasons that bring people in and out of a doctor's surgery. There are many patients who continue to consult (and trouble) their doctors but who are either too ill, or unsuitable, or simply won't accept psychological treatment; or perhaps they are too traumatised, and have already been up and down the 'five steps' of 'appropriate' specialist treatment. For many there is also a strong attachment to the practice, a surrogate home, and they will not make (or do not trust) the journey of outward referral. But in all these categories, there are a significant number who can be substantially helped, albeit in a small way, to continue their lives in their own way by suitable therapeutic help being close-at-hand within the local surgery. Some may also benefit from a collaborative (parental) couple (GP and counsellor) to get them through a crisis. Primarily, and this is something that Alexis Brook always stressed, the therapeutic help is about Listening, Not About Treatment. Listening to people and learning to listen to the setting. The listening is part and parcel of good medical care.

Maybe it is time for a new Community Unit to be established which will begin to undertake a renewed, systematic and serious study of Brief-in-Long Psychotherapy in Primary Care, based firmly on a psychoanalytic understanding of the GP setting. This would be a fitting tribute to the pioneering work of Alexis Brook.

Summary table

Characteristics of primary care as a setting for psychotherapeutic work

Timescale
- Consultation at times of need within a long-term relationship
- Opportunistic listening

The practice as a container
- A secure base
- History and patterns of attachment to the practice
- Life stories held in practices

Intensification of transference
- Anxiety in relation to life and death
- Parental projections
- Physical care and origins of transference in infancy
- Significant actual relationships to doctors and nurses

Framework of highly charged (triangular) relationships giving rise to referrals

Implications for technique
- Less emphasis needed on endings
- In more quickly, out more quickly
- Intensity, depth of contact, not time
- Not 'brief' but 'brief-in-long'.
- Attention to tensions leading to referral
- Demanding place to work, highly trained
- Need for specific training for primary care

Therapeutic Focus
- current problems in patient's life
- current tensions leading to referral resulting from doctor-patient relationship
- both of these viewed in the light of what is revealed about early relationships and experienced in the transference relationship during therapy, however brief.

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Some reflections on health and illness including the background of the history of medicine

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I relate to Aharon Antonovsky (1987) who formulated the expression:EASE - DIS EASE – DISEASE, which means that there is a continuum between health and illness, in both directions. Further, I relate to R. Felix-Lorenz (2008) who stated that there is almost no human being who is absolutely healthy or absolutely ill. Most people are in a "mixed" situation, partly ill and partly healthy. When the ill parts are heavier than the healthy ones, one feels ill; when the healthy parts are more dominant, one feels healthy. Perhaps, before dying, a person may be completely ill. There have been many attempts to define the concept of health. The World Health Organization (W.H.O.) published a very extensive declaration on this subject. Certainly, "no illness", does not always mean health. Health is something dynamic that has to be watched, cultivated and developed. Health enables movement, activity, adjustment, coping, creativity, development and self-realization. Also, a general feeling of wellbeing.

Antonovsky asked the naïve question about the sources of health, (Salutogenesis) and found that one of these sources is the "Sense of Coherence", which is made up of three components:

1. The perception and understanding of the whole picture of a given situation: "Comprehensibility".
2. The understanding that things can be controlled and actively changed: "Manageability".
3. The conviction that things have a meaning, an emotional and spiritual value and an explanation: "Meaningfulness".

On the other hand there is Illness. According to Fried and Agassi (1983), there exist two traditions in the history of medicine concerning illness. The tradition of the "externalists" that emphasizes external factors as causing illness; and the opposite tradition of the "generalists" that emphasizes the "generality" of illness. The slogans of this second tradition were in ancient times (Hippocrates): "do not raise a scalpel" and "nature cures". The first school defines illness as the result of an injury that was caused by external factors such as a wound, a physical or psychic injury, infection by bacteria or viruses, poisoning, a deficiency of a substance (e.g. of a vitamin) or a genetic or congenital defect (which is seen also as external). The disease is a result of this penetration or of this deficiency or of this inherited or acquired defect. If one wants to cure it, one has to get rid of, to destroy or at least to weaken, isolate, this pathogenic external factor, or to restore the needed substance.

The second tradition sees illness as an attempt of the living (bio-psycho) organism to fight against the injury and to reach a new equilibrium. Perhaps the same equilibrium that had existed before the illness, and perhaps a new equilibrium that enables one to live with the defect that was caused, which means in a situation of chronic illness or invalidity. This fight is the essence of the illness. The possibility, that after an illness, an organization on a higher level will develop, also exists.

Do these models exist also in psychiatry and in a profession that does not exist in many countries, namely psychosomatic medicine? Fried and Agassi deal in depth with this subject. They emphasize the theory of the neurologist (and psychiatrist) Hughlings Jackson. Jackson pointed to "different levels of organization" in the entire brain-psyche apparatus. When a higher level does not function, for one reason or another, a lower level is liberated and becomes active, until a new equilibrium is established. (And so forth, concerning lower levels). Jackson was influenced by the philosopher and sociologist, Herbert Spencer, and was one of the few "generalists" among the British neurologists of his time. As I have already mentioned, health has been, for the generalists, since ancient times, a harmonious state of a well-functioning organism. Illness is the attempt of the organism to regain this harmony. Life with a "defect" (not with a disease) is the aspiration of the organism to be content with functioning on a lower level, and in this way to function again in a kind of lower equilibrium.

Illness is thus a situation in which no equilibrium exists but the fight for the establishment of a new equilibrium continues. There exists thus a quasi- and temporary-equilibrium. As long as the organism continues to fight and this fight does not endanger the patient and his or her life, one should not interfere in the situation and should give the organism an opportunity to continue with the fight. Jackson went one step further and spoke about "levels of organization" as given elements, or aspects, within the system during different situations. He saw life as a hierarchy of levels of organization. These levels are not a kind of mysterious entity but real characteristics of complex systems, which are no less real than the parts which compose this system.

At the present time, in the epoch of cybernetics, one may say that levels are "things", that will resist and not disappear, but which – in the opposite of Jackson's opinion – do not have to be ordered in a hierarchy. But we often call them "high" and "low". If then a "high" level is not functioning well, is damaged, weakened or even out of order, the inhibition of the "lower" level

does not function and consequently this level becomes "free". When an organism is content with a new lower (defective) equilibrium, an earlier congenital phenomenon may appear; in other words, a phylogenetic or ontogenetic older level may become active again (this is Jackson's opinion, which is not always accepted at the present time). An example: The Babinsky reflex, which exists normally until a child is 3 years old, and then disappears, but appears again when the "higher" pyramidal system is damaged and does not inhibit this reflex any more (One can speak about "regression").The "tumult" which exists during an illness, prevails as well in the damaged higher level, as in the lower activated level, and also between the levels.(By the way, this is a position which stands in contradiction to that of Freud. Freud claimed that a primary "disturbance" on a lower level (in the unconscious, in the region of the instinctual drives), causes a secondary disturbance on a higher level of organization: the conscious, the region of rational and irrational thinking, in the conscious emotions etc.)

Fried and Agassi also discussed the phenomenological and existentialistic approach to psychiatry and medicine in general. They lead us to the following conclusion: In phenomenology, an objective truth does not exist. Everything is based on feeling and sensing, on the subjective perception and on the subjective truth of the individual. According to this view, "objective illnesses" cannot exist, only "subjective situations".

Every human being who suffers and whose suffering is manifested by symptoms is in a situation of a special-personal illness. There is no scale and not any external factor that can define, if a certain situation belongs to a category of illness (to pathology, or psychopathology), or not. In order to help the suffering patient, the physician must mobilize all his/her empathy, to come as near as possible to the understanding of the patient's feeling and sense of suffering. There is no need for global definitions, or for diagnosis and classification. It is not necessary to put the suffering of the patient into scientific patterns. One should try, together with the patient, to reach a new understanding (more realistic and with better adjustment) of the situation that caused the forming of symptoms, to enforce the person and to strengthen his/her healthy powers.

Most existentialists do not go so far and still try to define what is pathology and psychopathology. They do not deny the "given situation", which means the biological-physiological base of the symptoms. A person with "bad faith" (being dishonest, cheating and having a "false self") is "psychopathological". Here they introduce an ethical scale in order to evaluate "pathology". In reality and in life there exist only ill organisms (living beings: human beings, animals, plants). Illness by itself is a perception, a generalization and an abstraction that grew out of experience and empirical research, and therefore could be described. We need these concepts, certainly in practical medicine and in research. But an illness is not necessarily a diagnosis. One may just label a certain situation. But often it is possible to find out what are the characteristics which may appear during a certain illness, among different people suffering from it. These are the etiological factors, the pathogenesis, symptoms and course, the prognosis etc.

When this information is gathered, one can speak about a "nosological entity", which is practically the same as a diagnosis. In psychiatry we usually do not have "complete nosological entities" that include: etiology, pathogenesis, course and clinical manifestation, prognosis, possible complications. Therefore one talks in psychiatry about "disturbances" and not about "diseases". In spite of that, in another context, we may certainly speak about "mentally ill" people. Kraepelin described the psychiatric syndromes on the base of clinical psychiatric examinations and longitudinal clinical observations. He relied on phenomena, signs and manifestations. The general aspiration is, however, to reach an etiologic classification. In this context I would like to discuss briefly the contemporary classifications of diseases (and "disturbances"). Both, the DSM (of the US,) as the ICD aspirate neutrality. This means that they are not based on etiologies which are founded on a certain theory. They include precise descriptions of phenomena (personal sensations, complains, symptoms) which were collected in broad surveys, were statistically analyzed and tested in "field experiments". In this way clear criteria for different diseases were created. Also, phenomena which may often appear (later) in the course of a disease were mentioned. Besides that, the DSM recommended the diagnosis on five axes, so that a broader and more complete picture may appear. It is interesting, that it was impossible to find a compromise for the sixth axis, which should have included psychoanalytically oriented "defense mechanisms"; or behavior-cognitive oriented "coping styles". As far as we know, a sixth axis concerning the person of the patient is at the present time in discussion

In practical medicine, usually only the first two axes are related to seriously Besides that, many medical students consider the DSM and the ICD as textbooks. Therefore they scarcely think about possible etiologies and about psychopathological theories. One examines the subjective complaints and the objective findings of the patient, tries to classify then as exactly as possible into a specific category (diagnosis) and finds the appropriate pharmacological treatment or technology. In this way we finally come to a diagnosis, that has always some variations in every individual case. As we shall see below, this diagnosis should not be too narrow, but broad and comprehensive.

The French psychiatrist Henry Eye tried, following the a.m. phenomenological and

existentialistic streams, and the well known developments in psychoanalysis, to bring psychoanalysis back into the main stream of medicine, by emphasizing the "generalist" aspects of psychiatry. A human being may become ill, because of an external factor (or a number of external factors). Perhaps, the external factor succeeded in penetrating and attacking and, because this human being (organism) was weak at that time of his/her life, and his/her defense mechanisms were not efficient. The disturbance that was caused by this factor, is not only direct and "local'. It causes a process in which many extended mechanisms, on different "levels", enter a state of "restlessness". The illness is thus a broad systemic event. In Eye's terminology: "a psychological event". (We would say: a bio-psycho-social event).

Eye also explained the genesis of a neurosis in another way, comparable to psychoanalysis: a child experiences a traumatic situation and copes with it, as far as he/she is able to. There remains always a scar, that Michael Balint called a "Basic Fault ". When this human being grows, he/she gets another opportunity to cope with this old trauma, this time having more possibilities. Some people succeed; those who fail will develop a neurosis. The unconscious conflict, which Freud saw as the reason for the neurosis is, according to Eye, a symptom of the process of the fight to gain a new equilibrium. Classical psychosomatic medicine, which is based on psychoanalysis, saw in an unconscious conflict, which became relevant, and therefore "pressing", the reason for a psychosomatic disease. (Thus: an "external" factor). This conflict finds its expression in inner organs, mainly via the autonomic nervous system. At the present time one would say that certain traumatic or stressful life-events and experiences are expressed in a very individual way in somatic symptoms. This is a more "general" explanation.

As we know, a system is more than the sum of the parts (or the sub-systems) of which it is composed. But, every part influences the system and vice versa, the system influences every one of its parts. Henry Eye also emphasized in this connection the ethical aspect. Every part is responsible for the whole system, the system is responsible for every part. Due to one or more external factors, extended systems enter a state of instability (restlessness) and they look for a new, relatively stable, perhaps temporary, equilibrium. Therefore the ill person should be treated in an integrative and holistic, sometimes multi-professional way. One should try to remove the external factor or to repair it; but at the same time also the bio-psychic organism should be supported and assisted in finding a new equilibrium, which will make further living and development possible.

Eye, as he was introduced by Fried and Agassi, gives mainly clinical examples from neurology, psychiatry and psychoanalysis. E.g. for him, epilepsy is not only a neurological ("external") disease, but could be also a state of psychic illness ("general").In epilepsy a "lesion" in the brain develops (a scar). This can, happen as result, among other things, of a viral or bacterial infection. The first stage of this pathological development belongs (also) to the bacteriologist or to the virologist, or to an internist (who specialized in infectious diseases). When epileptic attacks appear, the disease belongs to the neurologist, who can establish the diagnosis by further investigations and treats the disease with medication. As result of the epilepsy (the brain scar, the convulsions, etc.), the side-effects of the medication, and the anxiety about further attacks, a "Homo Epilepticus" develops: a person who is ill.

Such a person often needs, in addition to the chemical treatment of the convulsions, rehabilitation and strengthening of the healthy parts, tertiary prevention of further attacks and/or complications. This is the task of additional professions and specialties and also of the family physician or the care of the elderly physician, who can integrate All the different aspects.

Modern imaging procedures such as MRI, and the use of contrast substances, allowed us to demonstrate the pathological processes in the brain. We read recently about the progress on research of Parkinson's disease (Arieli 2009). The brain-damage is not restricted to the known extra-pyramidal centres of dopamine activity, as other centres also participate in the pathological process, as centres of affect and cognition. Therefore exact stereotactic, operations on the focus of the disease often help only in the improvement of motor-functioning, and not in the affective and/or cognitive aspects of the disease. So, in this respect also, there are more "generalist" developments.

Several papers, published in recent years, reported that the effects of anti-psychotic medications on schizophrenia could be demonstrated by MRI (imaging of the brain); this finding is, of course, related more to the "external" model. In this connection, the following information could be interesting. A"typical psychiatric" disease, schizophrenia, is also a general systemic disease, and not merely a process that take place in the area of neuro-psychiatry.(Munitz 2009). It is known at the present time that schizophrenic patients have a shorter life expectancy (60-65 years, with a difference between males and females). These patients suffer much more frequently from metabolic diseases, as high cholesterol and other lipid values in the blood; high blood pressure, etc. This is certainly not only the result of long-term use of anti -psychotic medications (and their side effects), but also of the schizophrenia itself. These metabolic disorders appear later in life, generally long after the beginning of schizophrenia. The bio-psycho-social model of Georg Engel is actually a hierarchy of open systems which are in connection one with one other. It starts at the lowest, intra-cellular level

and ends with (high) systems of ecology or of the organization of medical services in the area. In the middle, one finds the person and his/her relationships with others and with the environment. Engel's model is a further step on the base of the models of Jackson and Eye. Here we deal not only with "levels of organization" (systems) in the brain, but in the whole living being. Engel also pointed to the fact that doctors can concentrate at one time only on one system, e.g. a case of a suddenly appearing myocardial infarction. At the time-point T1: how can we get an ambulance that will take the patient to the hospital? At point T2: has the patient high levels of certain enzymes in his/her blood? At T3: how can we diminish the patient's anxiety? And so forth.

Concerning this bio-psycho-social attitude, which propagates integrated and holistic therapies, some thoughts about rehabilitation, tertiary prevention and salutogenesis arise. It is well-known what rehabilitation means; I have explained what is meant by salutogenesis; but it is important to reflect briefly about "tertiary prevention" a term that was introduced by Gerald Caplan. In tertiary prevention, one wants to prevent recurrent attacks or exacerbations of a chronic disease; one wants to prevent any complications (the term "complication" is relative and depends on the age of the patient). One would like the patient, in spite of his/her chronic disease, to continue to function actively, although in another equilibrium. It is possible to reach such a position by reinforcing the healthy parts of the patient and by coming to terms with a (somewhat) lower equilibrium.

The philosophical –phenomenological (or pseudo-philosophical-populist) way of dealing with the treatment of a symptom and with different ways of "health promotion", using methods originating in the areas of: ecology nutrition, physical exercises, body expressions, relaxation, learning of healthy life styles and behavior, beliefs and religion, world view, philosophy ideology, etc, take the "promotion of health" out of western, official and academic medicine. Such approaches often deny the fact that diseases really exist and that death cannot be denied. Diseases and ill people must be treated in an integrative and multi-professional way.

I do not know much about alternative medicine, but I usually respect it, as long as it does not endanger the life of the patient. I usually like to work in parallel (and complementarity) with folk or religious healers (e.g. Bedouin Dervishes) Some of the alternative methods are based on old (e.g. Chinese and or Bhuddist?) traditions; but some are based on the ideas of certain gurus and some were even invented by charlatans. I would like to keep my reflections in this paper within the frame of official (academic, western) medicine. Therefore we should not give up diagnoses, classifications, standard guidelines for treatment, etc. But diagnosis should be broadened and completed; one should pay attention to the particularity and individualistic uniqueness of the ill person. But the use of agreed upon diagnoses and of an agreed terminology makes communication between doctors possible. Discussing the value of diagnosis, we shall hint here only very shortly at to other aspects of health and disease. In legal medicine and forensic psychiatry, the criminal responsibility of a person must be defined and diagnosed, thus distinguishing between the sane and insane. In Psychiatry we have a big problem with the category of "Personality Disorders", which do not fit into the concept of illness or disease, and were basically defined as behavior patterns that do not conform to a certain society and culture. But it is important to extend diagnosis and to make it more inclusive and containing. For example, the individual personal and cultural background should get more attention.

The phenomena of Salutogenesis as they were developed by Ursula Brucks (1988) and her colleagues in the book "Handbuch der Salutogenese"; and further in the investigation of "Salutogenesis-promoting " surgeries (offices, clinics), that was carried out by I.O.Bahrs and P.F. Mathiessen (2007), point to the importance of including in the extended diagnosis, the biography of the patient and the quality of the relationship between the doctor and the patient, which is often discussed in Balint groups. On the other hand, the "externalist"-mechanistic and reductionist approach, which is accepted in most of the medical professions, almost does not pays almost no attention to the more "generalist" and systemic aspects of the human being. This approach wants to rely only on "evidence based medicine". This approach is based on the assumption that all the collected data and evidence should be regarded as absolutely scientific and objective and therefore undisputable "truth". They are perceived in an exaggerated way as "absolutely objective".

Not enough emphasis is put on other kinds of scientific psycho-social evidences e.g., data which show that the relationship between doctor and patient, and getting details of the biography and the social-cultural background of the patient are important elements of good medical treatment. These are data that were found by scientific methods of epidemiology, social and behavioral sciences and are not only based on belief and philosophy.Everybody is somewhere on the spectrum Health – Illness. Most diseases are treated during their course, from one or another point on the spectrum: "externalist" – "generalist". The approach advocated in this paper certainly should have consequences in the field of medical education and training. But this could be a theme of another additional paper.

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Note: The German titles were translated into English. B.M.
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An anthropological look at gifting in the doctor-patient relationship

by Zoe Kenyon

Some years ago, I found, almost by chance, on a library shelf, a copy of *The Gift*. In this small masterpiece Mauss clarified the process and underlying implications of gifting previously described by Malinowski in his ethnographic observations of The Kula. As a practicing GP in a densely populated multi-ethnic population I was intrigued. Exploring the complexities of gratitude, obligation, power, credit and honour within the context of healing relationships in different societies across the world has been both enlightening and fascinating. The literature is based predominantly in the anthropologist's camp as references to medical awareness of obligation and gratitude (let alone power, credit and honour) are scant in bio-medical texts and seemingly absent in current target-driven practice. Is this because it is so obvious, platitudinous, so much a part of every-day work that it does not warrant further thought? I think not. Mauss, when describing Potlach (practiced by native Americans) and the exchange activities of Trobriand Islanders, reveals implications for contemporary society He reflects that by understanding others we are helped to understand ourselves; conversely many medical educators would agree that only by understanding ourselves can we begin to understand our patients. His work has undoubtedly generated many questions.

Pertinent to current debate is his point that the replacement of traditional exchanges by economic trading results in moral and social loss. Exchange of goods is a transaction involving warmth, friendship and loyalty, whereas commercial trading is a mechanical economic and historically recent replacement. A gift that does nothing to enhance solidarity is a contradiction. Although gifts may appear voluntary, disinterested and spontaneous they are in reality both obligatory and interested. The trinity of "give, receive, repay" can be seen as a perpetual interchange ranging over time and between the sexes, generations, individuals, clans, even nations. A formalised linear version is less appropriate than a circular model, the latter offering multiple points of entry into the exchange cycle. Thus the recognition of the anthropological significance of a patient's present could avoid much soul searching by the doctor who fears he is being bribed. "What does this patient want of me?" The answer may be nothing more than a continuation of the professionalism which initiated the cycle in the first place.

In a system where health care is "free", that is where the mode of payment is distanced from the recipient, there may be a greater need to reciprocate with material goods. This is apparent in Japanese and Zulu medicine, neither of which operates in the same way as the British NHS.

The Japanese are a health conscious nation with culturally patterned illness couched in biomedical terms. Ohnuki-Tierney writes of the personal choice made by the patient in establishing a relationship with the physician. What is not clear is whether or not this choice influences the locus of power. Although these days the doctor is regarded with some esteem, prior to the Meiji emperors in 1868, he was a craftsman rather than a scholar. *I wa jinjutsu* is translated as "medicine practices mercy" so no fees are due. However a donation is acceptable and all medication carries a charge. Hence bewilderment, surprise and even disappointment if, in this country, no prescription is issued. Consequently, quite inappropriate, even extravagant gifts may be offered. R.P. Dore writing about city life in Japan says "only a hair-line separates a token of gratitude from a bribe" and families will offer gifts prior to surgery hoping to ensure a successful outcome.

The acquisition or purchase of material goods and their personal ownership is a relatively modern concept and is related to the development of a currency: Money then has intrinsic worth. However the purchase of goodwill from the spirit world is ancient and universally understood in our notions of honour and magic. Out of these ideas grows the concept of alms, a combination of the moral view that gifts redress the inequalities of this world while at the same time incorporating an act of personal sacrifice. This immediately raises the issue of altruism.

Is there any such thing as a disinterested gift? Even the apparent altruism of Christian love is entwined in the anticipation of a glorious afterlife. Mary Douglas in her foreword to the 1990 translation (by W.D.Halls) of The Gift underlines the view that even the idea of a pure gift is a contradiction. Davis argues that altruists are not free to make purist decisions because there are so many external and internal factors influencing the act. Most of these operate at a subliminal level and the criteria governing decisions and actions are the same for market choices as for altruistic decisions. In my opinion the difference is a question of degree and it is the internalisation of the act that approaches true altruism.

The cost to a blood donor (explored by Titmus and debated by Davis) is not only time and discomfort but also a specific volume of blood. An important component of this exchange lies in the complexity of giving part of one's own body, especially to an unknown recipient. The image of self, deeply seated anxieties about weakness, strength, potency, and unspecified fears of immediate or potential physical harm inevitably bias a discussion on altruism. Is this an

area which, if discussed more openly, might encourage organ donation?

Another often cited example of pure altruism (in itself a tautology) is the gift of suckling, but any mother who has deliberately chosen to breast-feed will proclaim her personal gains without hesitation. The notion of altruistic purity in the practice of medicine is obscured by the overt approval of peers and positive feedback from the patient (which doctors call job satisfaction). The personal gift is prone to distortion by individual maximisation, a desire for status, prestige, self-justification and power. In medicine this gift is rarely recognised as a powerful primordial and pan-global characteristic of mankind. In the doctor-patient relationship it is often abstract, and the ideas of Mauss illuminate the dynamics of this relationship. The roles of giver, receiver and reciprocator are interchangeable and the gift can be expressed in many ways. Often there is no intrinsic worth in the gift itself but it may have a mystical value: a token as in the emotional content of a "worthless" ring, coveted because of attached legends or by having historical family or clan meaning far beyond any "market" value. The need for ceremonial cannot be ignored and major life events are marked with gifts. For our profession retirement is especially prone to the giving of commemorative items. In this respect doctors have much in common with J.R.R.Tolkien's hobbits. In Hobbitan was a Mathom House where ceremonial gifts (often unwelcome and useless) were stored awaiting re-cycling. This great storyteller had remarkable but widely unrecognised anthropological skills (e.g. ethnography, demography, kinship studies, myth and ritual).

The complexity of the exchange ritual described in *Argonauts of the Western Pacific* provided a focus for peaceful behaviour, a means of preserving political peace and, according to Sahlins, an alternative to warfare. It also provided a vehicle for everyday exchange and barter (and no doubt contributed to a growing and healthy gene pool). On the other hand, the North American Indian tribes gathered for shows of wealth (Potlach) to the detriment of their communities, echoed in modern materialism associated with manipulation, extravagance, ostentation and power. At a personal level, gifting offers many opportunities for expressing and developing relationships. Currency as money is unambiguous, it is what it is; but a gift is a complex soup. The content remains the same but the emphasis changes according to the cook's mood and the diner's palate. When the cook complies with market convention, and has no other motive than to follow the recipe and make a modest financial gain, the diner's basic need to assuage hunger is met. In this simple transaction the principle of individual maximisation is met. Extended to other settings, as for example in the home or the doctor's surgery, other considerations, the need to nurture and be nurtured, love and control come into play. This analogy can be extended into the soup- kitchens of the world where charity, guilt and elusive altruism hover over the phrase 'give, receive, respond'.

The market view is clear, with well-defined rules into which contractors must fit their exchanges. Each party is responsible for their own interests, be it the quality of the soup or the confidence placed by the patient in the ability of the physician. If the soup is not good the cook will lose customers just as the doctor will loose status if his ability is in doubt. Considering the complexity of the doctor- patient relationship it is little wonder that the introduction of a market economy continues to be an emotive and contentious subject and the dysfunctional administrative reality of UK medicine is the result. Our patients need confidence in their doctors, and when this is well founded then so is the basis for gratitude. Reciprocal trust and honesty follow. I wonder if our profession is loosing sight of the importance of continuity of care and the value of "The Gift".

I wish to acknowledge the work of Caroline Palmer as manifest in her keynote address to the Balint Society in September 2008. It is a remarkable, honest description of the gift cycle, with more nuances along the way than could ever be packed into an ethnographer's notebook. It embodies all that is important in the art and practice of our profession and illustrates with profound insight and sensitivity much of what I have been trying to express in this essay. Here we are, back in the cycle!

Sitting in – or sitting out?
A discussion about group-leading

Anne Tyndale and John Salinsky

You may have noticed that we now have two slightly different models of conducting a Balint group. In the 'traditional model', when the presenter has finished speaking, a general discussion follows straight away, with the presenter taking a full part.

In the newer variation, after the case presentation, the leader asks the group if anyone has any questions of a purely factual or clarifying nature to put to the presenter. Questions such as 'how does this patient make you feel?' are excluded at this stage. The leader then invites the presenter to move their chair back a few symbolic inches and remain silent for the first part of the discussion. After about 20 minutes, they are then invited to rejoin the group fully, for the rest of the session. This is called 'sitting out' or sometimes 'pushback' (referring to the movement of the chair).

The point of sitting out, according to those who favour it, is that it blocks the over-eager interrogation of the presenter, which is often a problem for the leader at the beginning of the discussion. Once the factual questions have been dealt with, the presenter is free to listen and reflect on what she hears without having to answer questions. The group, meanwhile, are thrown back on their own resources and have to work on the case themselves, by examining their own thoughts and feelings about the story they have heard.

Some group leaders are very enthusiastic about sitting out. Others think that it detracts from the flow of the traditional group process with its free association and the phenomenon of 'parallel process' in which the presenter and the group mirror the interaction between patient and doctor.

Where and when did sitting out begin.?

It began in Germany, but we are nor sure exactly when. According to Heide Otten of the German Balint Society it was often used on an occasional basis when it seemed to be appropriate. Perhaps if the questioning of the presenter was getting too prolonged and too intrusive. Balint doctors from other countries experienced it at International Congresses and it became popular in Scandinavia and Britain, Australia and the USA. Sitting out has been used as a matter of course in the very successful American Balint Society Intensive Leader Training courses for a number of years. It seems to be used much less in France and Belgium. The present position in the UK is that some groups and their leaders use sitting out while others stick to the traditional model.

The London Group Leaders Workshop Discussion

On 11 February 2010, the London Group leaders' Workshop devoted one of its meetings to a discussion of the relative merits of the two models.

Those present were Doris Blass, Tessa Dresser, Andrew Elder, John Salinsky, Oliver Samuel, Lenka Speight, Heather Suckling Anne Tyndale and David Watt.

What follows is a summary of the main points made for and against the sitting out model:

Points against sitting out

- It makes the discussion less alive because the identification with the patients and the projections which the presenter may be carrying are put aside.
- There is awkwardness when the presenter comes back in and they sometimes feel a pressure to 'report back' on the discussion they have heard.
- The presenter may feel identified with a repulsive or rejected patient and therefore discarded from the group.

Points in favour of sitting out

- It makes the task easier for the leaders who no longer have the burden of trying to get the discussion into the group rather than continuing as a question and answer session with the presenter.
- Sitting out is sometimes useful if the group gets stuck.
- An example was given of a group which was nagging the presenter to say why she found the patient repulsive; she didn't know and when she withdrew, the freer discussion brought up ideas.

There was a feeling that Sitting Out had been adopted in most countries and might soon become worldwide practice. But that didn't mean that we all have to do it!

This led to a consideration of The Aims of a Balint Group which were thought to include:

- To facilitate free association as effectively as possible.
- To help all the members to think about the patient in relation to themselves as well as the presenter so that all can benefit.
- To facilitate 'the limited though considerable change in personality' which was the Balints' ideal result. This seemed to imply a move towards withdrawing ones own projections from the patients and being able to deal with the patients' projections onto the doctor.

This would lead to a capacity to relate to a wider range of patients.

- To help the doctor and the patient to be seen as human.

Other issues about the format

There should be at most a low table in the middle of the group and not a high table.

Should group members be allowed to eat biscuits?

Should note-taking be discouraged or permitted? (It sounded as if the doctor in one group who regularly took notes was allowed to get on with it without much comment).

There was a general consensus that there should be no rules. This meant no rules about whether the presenter should stay in or withdraw for a while; and no rules about asking factual questions at the start.

Sitting in – or sitting out?

A view from our president, Andrew Elder

The 'sitting out' or 'pushback' method of leading groups seems to be becoming accepted as a new Balint orthodoxy. At a recent international Balint conference an enthusiastic delegate, relatively new to Balint, included the 'sitting out' technique as one of the characteristic ingredients that define a Balint group. This is not so. As far as the UK tradition is concerned it is a relatively recent import, and apart from its occasional use by some of the present generation of leaders, I cannot think of a single earlier experienced Balint leader who used this technique. It seems that 'sitting out' was introduced in German Balint groups quite a few years ago, although some German authors have written questioning it as a technique.

Why has it caught on so quickly? What effect does it have on the group process? What advantages and disadvantages does it have as a technique? Such questions have arisen at a number of meetings in the last year or so. The editor invited those present at the Leaders' Workshop discussion about this subject (February 2010) to send him their views. Personally I have often found the technique rather artificial and formulaic so I was pleased to have a chance to think more about it.

The main advantage seems to be that it gives the leader a structure to follow and helps the leader in his task of protecting the presenting doctor from too much questioning or other forms of intrusion. Presenting doctors also often report that they like this method. However a more interactive exposure to the group process might be more rewarding even if less comfortable. Although it is sometimes said that group members feel freer to make their observations if the doctor is sitting out, the opposite point of view also gets expressed. Some group members say they find it inhibiting to talk about the doctor's work, 'in her absence', without the reality check of her reactions.

At a practical level, there is often difficulty about 'when' to bring back the presenting doctor (no doubt this is a matter of experience) and sometimes difficulty re-integrating the presenting doctor when she returns to the discussion. There is often a logjam caused by the presenting doctor wanting to give feedback to all the various comments that have been made. It may be of importance to note that the custom in Germany is to have longer case discussions; often one case will be discussed for an hour and a half in a German group. This would then allow for a much longer period of discussion with the presenting doctor back as part of the group after the initial 'pushback' and may combine the benefits of both approaches. Perhaps those leaders who like using the sitting-out model should consider lengthening the time allocated for each case?

To my mind, the principal disadvantage arising from this technique is being unable to observe the interaction between presenting doctor and the group. After all, it is central to the theory of a Balint group that the presenting doctor brings (and often unconsciously represents) the patient to the group. Indeed, this is often so to a truly surprising extent. Of course it does mean that the leader needs to be prepared to intervene in the early stages of the group and not allow too much questioning of the doctor who has brought the case. Too much questioning in the group is a defensive reaction and the particular pattern (and extent of) defensiveness in the group may be useful for the leader to observe, as it will be different in every case. Sometimes the leader will need to say 'let's give Dr X a break now, what do the other group members feel might be going on here...? Or, conversely, 'it doesn't seem that anyone wants to find out much about this patient...' It's not true that presenters are always bombarded by questions. Sometimes the group doesn't want to go anywhere near the case.

Similarly, when the doctor sits out, the spontaneity of suddenly recalling forgotten aspects of the case (as would also happen in the consulting room) is lost. With the doctor present in the group there is much to learn from the living interaction between the group members and the presenting doctor. There are skills to be acquired by the group members in how observations are made to the presenting doctor during the course of the group discussion. Talking to doctors in a defensive state and talking to patients in a defensive state are not so dissimilar!

Of course Balint groups have many different aims. If the aim of the group is to introduce GP registrars (or medical students) to thinking more about their own feelings and reactions to cases while at the same time broadening their understanding of the lives of their patients, then the sitting-out technique may well be useful. But if the function of a Balint group is seen more as an instrument through which rather detailed observations can be made about the professional impact of the doctor-patient relationship, then it becomes important to avoid muddying the waters as much as possible.

My impression from the workshop discussion is that it is very valuable to discuss attitudes to leadership in more detail than we usually do. What is the aim of a group? What role do we think the leader has? What relationship might there be between the role and interventions of a leader and group process? And how can we study this in order to learn more about it?

So, in conclusion, my own feeling is that the 'traditional' way of leading groups - i.e. not to use 'sitting out' – has many advantages and that we should not lose the experience of working this way, despite it presenting more of a challenge to the leader(s). And that 'sitting out' may be

particularly useful in 'training' groups and for less experienced leaders, but leaders using the technique should perhaps allow longer for each case discussion.

And some final thoughts from our secretary...

Does complete exclusion of the presenter really lead to clear thinking and listening? The presenter may remember something very important and be desperate to bring the case discussion back to this patient and this doctor. Without formal exclusion by the leader, the presenter can still stay detached and then choose himself when it is right to come back in. Perhaps by being forced out, the presenter does not 'learn' to listen in the way that we learn to listen to patients.

Is there a problem with time pressure in a 45-minute discussion? Many case discussions in Germany go on for 90 minutes.

Both methods have their virtues and it would be a pity if both did not survive.

David Watt

Balint for all or all kinds of Balint?

Ceri Dornan

(Keynote address at the Oxford Weekend, Lincoln College, 2009)

I am grateful for the opportunity to give the opening address to the 2009 Oxford Balint Weekend in this new venue. Our theme for the weekend is 'Balint for all' which rightly reflects the widening participation in Balint work across health disciplines. When I describe Balint work to people who don't work in healthcare, a number comment that the method could be used with benefit in their work setting. It is an appropriate theme for a year which included the International Balint Congress in Romania, where people from across the world discussed their approaches and experience of Balint work and shared in Balint Group work. As ever, the language skills of those who do not speak English as a first language were humbling. This was certainly Balint for all nations. The popularity of Balint work in an emerging country such as Romania and the description of its survival through the troubles in the Balkan states indicate to me what a powerful meaning Balint has for people.

When reading about important issues in service redesign, I came across a paper written by a town planner (Hester 1993), which used the term 'sacred places' to describe those places which have a meaning to people which may not be obvious to outside observers. For example, an insignificant looking street corner may be a popular meeting place. 'Balint' has a meaning to many people which evokes a sense of a 'sacred place'. However it would be rare now to find a truly traditional group which meets weekly over a period of years. A number of papers presented in Romania described how Balint work has been adapted to fit the needs of participants from particular disciplines or at particular stages of training. So I would like to extend our theme of 'Balint for all' to include 'all kinds of Balint'. I would like to present some thoughts and questions which I hope can lead us into a discussion about the challenges of taking Balint work into the twenty-first century and whether people see developments as threat or opportunity. I expect that for some people this is not a new discussion, for which I apologise, but this is a valuable exercise for me, as we consider how to embark on our Balint development in the North West of England and engage successfully with existing groups which may have some differences in style and approach.

Last year, Caroline Palmer talked about the tension we face in General Practice between meeting targets and continuing to practice person-centred care. I learned at the International Congress that we are not alone in the UK in facing this tension, but it felt as if there was a collective determination to find ways round the obstacles to ensure that the professionals of today maintain the values felt to be the heart of healthcare. Balint work was felt to be one way of achieving this. A common experience now is that GP groups meet less frequently than weekly as in the past. Many GP groups, mine included, meet on a monthly basis. This sometimes feels more like a containment approach which might be offered to someone who cannot tolerate more intensive therapy. Established GPs, certainly, do not seem to have the energy to engage in the traditional model. I wonder if our daytime contract and perhaps a simmering resentment against the 'system' which drives our busy days, makes us more protective of 'our' time. Does this mean that the less frequent contact is really 'low intensity' Balint as in the Improving Access to Psychological Therapies programme (CSIP 2007)? In our group, the members have yet to reach a stage where they can be challenging to each other, which can limit the depth of thinking and discussion. The dynamic is lost between sessions and leadership can be hard work. Would introducing more active components to the group, such as role-play, or as in some countries, psychodrama, accelerate group cohesion?

A number of the papers presented at the Balint Congress (IBF 2009) concerned work with medical students and doctors in training. There are people here this evening whose work on these areas has been published (e.g. Pinder et al 2006), who will be far more knowledgeable about this area than I am and I hope will offer some comments later. The debate continues about when, if and how Balint concepts can be introduced and whether groups should be compulsory, as they now are for UK psychiatry trainees, or voluntary, as our Royal College of GPs prefers. Some of the challenges encountered in trying to engage trainees and students in classical Balint work and compromises reached are illustrated by the following examples.

A survey of USA family medicine resident doctors about Balint group work they experienced showed that they understood the purpose of the group but wanted to have more focussed topics, to discuss solutions to specific problems and include time to talk about issues such as dealing with professional demands. By taking these concerns on board, the leaders found that although the group task was diverted initially, there was a spontaneous return to the original purpose. Cases remained the vehicle by which discussion took place.

A paper from Sweden described how Balint experience was successfully established for trainees in Obstetrics and Gynaecology, by first offering some themed seminars in topics with a potentially strong emotional content, such

as perinatal death, abortion and cancer, then leading on to spontaneous case presentations in later sessions. To some extent, this approach was needed to satisfy the department that the activity had an educational value. By the nature of the speciality, cases presented were usually one off contacts which had made an impact on the doctor, sometimes because of organisational issues but included events which had an emotional impact. Evaluation of the groups suggested that they improved the professional self esteem of the doctors, who were at the lower end of the department 'hierarchy' and increased their self knowledge. Papers from Sweden and Finland reported groups with medical students in their clinical years. They illustrate the mixture of pressures students face, including acquisition of knowledge and skills, development of professional identity and understanding their role as a student in the medical system. Leaders needed to be sensitive to these needs over their own desire to have the students work on emotional aspects of the student patient relationship. This conflict was reflected in the names given to the groups, described as Reflection and Balint-type groups, or student-Balint...

So there is some confusion around. We really want to preserve the Balint meaning and are apologetic when our groups do not quite match up to the original definition. On the other hand, the context of our work now is very different from the time when Balint developed his methods (Balint 1963), though the need to maintain the importance of the practitioner – patient is just as vital if not more so. Is it acceptable to make modifications and still call what is done Balint work? What is the minimum content to allow the title to be used? The description of a group as Balint-like can evoke strong reactions in Balinteers. Perhaps we should be pleased that people have some interest and want to emulate Balint.

The research method known as discourse analysis considers the words people use as a way of understanding their inner world and what has meaning for them. Gee (2005) describes seven building tasks to analyse texts. Two of these are defined as follows:

Politics (the distribution of social goods)
(In our context, social goods would be Balint groups, which in theory could be available to all working in healthcare.)

What perspective on social goods is this piece of language communicating (i.e. what is being communicated as to what is taken to be "normal", "right", "good", "correct", "proper", "appropriate", "valuable", "the way things are", "the way things ought to be", "high status or low status", "like me or not like me" and so forth?

Sign systems and knowledge
(In our context an example would be Balint versus Balint- like)

How does this piece of language privilege or disprivilege specific sign systems (e.g. Spanish vs. English, technical language vs. everyday language, words vs. images, words vs. equations) or different ways of knowing and believing or claims to knowledge and belief?

Our challenge in succeeding in offering 'Balint for all' is whether we can share our Social Goods and agree on a mutually acceptable Sign System. What seems to be in place is a degree of suspicion about whether people are doing 'real' Balint and some embarrassment or hesitation about the use of the term Balint Group. I wondered what Michael Balint would make of our present day situation. He would probably feel that we have made remarkably little progress in managing medically unexplained symptoms. He would certainly see the need to keep reminding us of the importance of using ourselves in our work, against a tide of increasing technology and pharmacology. On the other hand, my image of him is of someone who would see our situation as a stimulus to adapt and survive, much as he did in his own life and in the move away from his original intention with the GP research groups once he saw the richness in ordinary GP consultations. So perhaps we need Balint leaders who feel secure enough in their ability to preserve the heart of Balint work, whilst being sensitive where needed to the pressures which might temporarily divert group members. This means recognising the difference between a group having important 'here and now' needs and one avoiding engagement in difficult material.

Whilst on the train, wondering how to draw this talk to a close, I allowed my mind to float around the topic, as all good Balinteers should. Being indoctrinated by the plethora of NICE guidelines (e.g. NICE 2004a,b) which arrive in my pigeonhole and with the initials IAPT (Improving Access to Psychological Therapies) stamped on my retina, I couldn't help but picture a stepped model of Balint work, with entry points according to experience. After all, stepped care models are intended to improve access and use resources efficiently. We could start a movement called IABT, or Improving Access to Balint Training. As it takes quite a while to train Balint leaders, we could have Low Intensity Leaders, such as University Lecturers and Course Organisers for students and professionals in training, then High Intensity Leaders and those in training for young professionals, and fully accredited Balint Leaders for established professionals with more complex needs. Low intensity Balint could be CBD, or cased based discussion, with PPR, or patient-practitioner relationship as the focus for more intensive work requiring longer-term attendance to succeed in the self-discovery which Balint held to be so important. Maybe we could attract some Department of Health funding, on the grounds of prevention of costly professional burnout.

Until then, perhaps you would like to

share some thoughts with me about achieving Balint for all today.

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Farewell to Prince's Gate 1969-2010

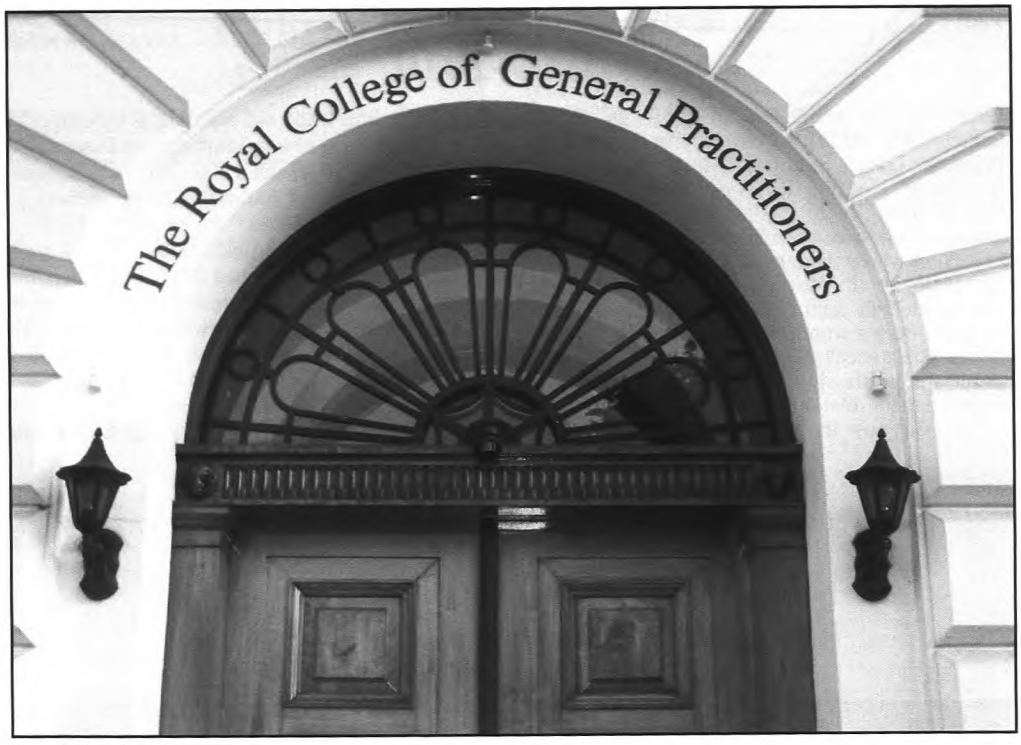
Ever since its foundation in 1969, the Balint Society has held its evening meetings in 14 Prince's Gate, South Kensington, and the headquarters of the Royal College of General Practitioners. There has always been a close association between our Society and the College, several of whose distinguished officers have been Balint Society members. The College's graceful mid nineteenth century building in the classical style has been a wonderful place to meet, to listen to our guest speakers and to agree and disagree about the endlessly fascinating subject of the doctor-patient relationship.

But now the College feels it must move with the times; the old building is no longer 'fit for purpose'. A new headquarters in Euston Road is being fitted out with a 300 -seat lecture theatre, modern conference rooms, bedrooms, offices and computers. It will meet the needs of the Royal College in the twenty-first century; but will not be ready to open until August 2012. Until then, they will be in temporary premises, not open in the evenings and we shall be without a home. Big Issue, anybody? Meanwhile, to remind you of happy evenings at the Balint Society, here are a few pictures of 14 Prince's Gate.

John Salinsky

Pictures of Prince's Gate

Exterior of 14 Prince's Gate.



The front door.

Details from the fireplace in the John Hunt room.

The last lecture at Prince's Gate: guest speaker Raanon Gillon talking to Paul Julian.

Details from the fireplace in the John Hunt room.

Book Reviews

Teach us to sit still: a sceptic's search for health and healing by Tim Parks.

Harvill Secker 2010, paperback 335 pages, £12.99

There was a time when I thought all 'medically unexplained symptoms' must be psychosomatic. That was before I started having them myself. Is it something to do with growing older? Bits of one's machinery rusting, squeaking, groaning; gears slipping, oil leaking, springs wearing out? Or is the body more like a house, that you have lived in for years and is now starting to crack and subside and make ominous noises in the night? Or could it be, as the psychoanalysts suggest, that bodily illness can be created by a psychological need? I try to tell myself that the mind and the body are one and indivisible, but I'm not totally convinced. So it was with great interest that I read Tim Parks's book *Teach us to sit still*. Tim is a prize-winning writer of novels and non-fiction and this is the story of his struggle with what at first appears to be 'chronic prostatitis'. If Tim were to turn up in my surgery with this long and detailed account of his plumbing, I would be inclined to consider him a bit of a heart-sink. On the other hand, he is a literary man and I might give him a double appointment so we could talk about books.

Tim's troubles started a few days shy of his 50th birthday. He developed nocturnal frequency of micturition together with excruciating abdominal pains which felt like a lump of hot lava in his belly. He became a creature of the night, wandering round the house in the small hours, searching for relief. He tried everything: exercise, no exercise, diet, no coffee. No good. He tried single malt whisky (good, but no cure).

Tim lives in Italy and has a friend called Carlo who is a urologist. Carlo tells him all about the prostate and recommends a TURP. So he goes through the investigation mill: blood and urine tests, scans, urodynamic studies and finally cystoscopy. Everything is negative or as the Italian urologists say, *niente di niente di niente*. So where to go now? A little handbook on urology (for medics) confides that chronic prostatitis sufferers are 'restless, worrisome, dissatisfied individuals' and that seems to fit Tim's case. His parents brought him up to be a purposeful striver, like his clergyman father. A sage in India confirms that there is a tussle going on his mind. Different parts of the self are in conflict. Then he gets hold of a book called *A headache in the pelvis* which recommends treatment of the pelvic floor muscles with relaxation exercises and massage. Including anal massage.

Where will it all end? The second part of the book is mainly about Tim's journey into meditation and Buddhism. He makes himself sit cross-legged with a group of other people and concentrate on his breathing. And then on all the different parts of his body. He listens to an infuriating American guru and comes to respect him. He learns how to free himself from words, thoughts and attachments and just be intensely aware of his body, letting the 'I' slip away.

But did it get rid of the symptoms? He doesn't really say; it seems more likely that he simply ceased to notice them. But Tim remains a storyteller and one of the pleasures of this book is his discussion of other writers and their attempts to describe states of mind. We visit T S Eliot who supplies the title (it comes from *Ash Wednesday*, look it up) D H Lawrence and Samuel Beckett, among many others. There are lots of wonderful quotations. So unlike the BMJ reviewer, Christopher Martyn, I enjoyed the book and didn't find Tim a heartsink. Christopher concluded with some surprise (BMJ 7 August 2010) that 'intelligent, educated and apparently rational people may think about their health and illnesses in ways that hardly begin to overlap with ours.' Lucky man, he has obviously never been bothered by medically unexplained symptoms.

When Nietzsche Wept: a novel of obsession by Irvin Yalom (1993)

Perennial Classics edition,2005, 310 pages. Paperback £14.99 (cheaper from Amazon)

Here is a book in which the author takes some real historical personalities and makes up a story about them. It didn't happen, but perhaps it might have done. And if it's a really good story, who cares? The author is the American psychotherapist Irvin Yalom and his principal real life characters are Josef Breuer and Friedrich Nietzsche. Breuer (1842-1925) is best known as an early collaborator with Freud and Nietzsche (1844-1900) was a philosopher notorious for his extreme views.

In 1882, Breuer had recently broken off his treatment of a young woman (known in his casebook as Anna O) because she had declared she was madly in love with him and started having signs of a phantom pregnancy. Breuer panicked and hastily departed with his wife for a second honeymoon in Venice. Meanwhile Nietzsche was having a flirtation with a brilliant young woman (and future psychoanalyst)called Lou Salomé and suffering from migraine. So much is on the record. What Irvin Yalom now asks us to imagine is that Lou Salomé becomes very concerned about Nietzsche's feelings of despair. She visits Breuer in Vienna and asks him to take on her friend as a patient.

So Nietzsche is persuaded to come for a consultation about his migraine. But Breuer wants to get at the underlying despair. On the advice of his young friend Sigmund Freud, he

suggests to the patient that he might need to reduce his stress levels. But Nietzsche will have none of this; he regards stress as essential for his work. So Breuer comes up with a cunning plan. He will admit the philosopher to a private clinic where they will meet daily for a month for mutual therapy. Breuer will treat Nietzsche's migraine and in return, Nietzsche will attempt a philosopher's treatment of the physician's emotional problems. In the course of these dialogues, Breuer hopes to lure Nietzsche into talking about his own feelings. But before long, Breuer discovers that his own despair is all too real. He is tortured by erotic fantasies about his erstwhile patient, the seductively hysterical Anna O. I am not breaking confidentiality if I tell you that Anna's real name was Berthe Pappenheim and that she eventually became Germany's first social worker. Breuer is hoping for a little comfort and support from his patient, but Nietzsche's psychotherapeutic technique is more brutal. He basically uses cognitive behavioural methods to instil some of his more challenging philosophical ideas. These include: 'Become he who you are'; 'whatever does not kill me, makes me stronger' and 'living safely is dangerous'. Oh yes, and keep away from women; they are incapable of love and only out to trap and enslave you. Breuer finds this quite upsetting.

But then, Nietzsche proves to be surprisingly flexible and starts to use the free association method described by Anna O as 'chimney sweeping'. The two men become friends and Nietzsche even makes some progress with his own emotional education, revealing his overpowering feeling of loneliness. When he leaves the clinic, he will go off to write his major work, *Thus spake Zarathustra*. Breuer will continue to be a successful physician and an apparently happily married man. Twelve years later he and Freud will publish their groundbreaking *Studies in Hysteria* from which Freud will go on to develop psychoanalysis.

When Nietzsche wept is an absorbing cerebral thriller, even if you don't believe a word of it. It led me on to read a bit of Nietzsche and to learn that he also had a great sense of humour, which made me feel a lot better about him. By the way, his name is incredibly difficult to spell. The trick is to get the z exactly in the middle.

John Salinsky

President's report on current developments

by Andrew Elder

An informal discussion was held at my house on a Saturday morning in February to discuss the future development of the Society. Fourteen people came and we spent two hours ranging over various ideas and then had lunch! This was intended to give an opportunity to explore ideas in a more leisurely fashion than is possible at Council meetings. I am very grateful to all those who gave up precious weekend time to come and contribute their ideas. I have summarised the main points that emerged.

Name of the society. It was thought to be a good idea to add a **descriptive subtitle** to the name of the Society. Many of the younger generation no longer know what The Balint Society is. There is no intention to change the name of the Society, or that groups should not continue to be called 'Balint' groups. At University College London Hospital (UCLH) the student groups are known as 'Balint groups', and it was thought that on some other schemes the title 'Balint Groups' could be used more actively. The Royal College of Psychiatrists now require registrars to attend 'Balint' groups.
Eventually, after lengthy discussion, the following subtitle was thought best – **'founded for the study of the doctor-patient relationship.'**

Publicity. We thought it would be a good idea to publicise ourselves more; to remind people that we are around and have a useful contribution to make. A specific suggestion was to make a **DVD** (possibly as part of the Manchester/North West project) demonstrating the Balint approach. Such a DVD might include a discussion of what Balint groups are, why they matter, what they aim to achieve. Perhaps they would include a little bit of history, but the main emphasis would be on why the Balint approach remains relevant at all stages of practice: students, registrars, programme directors, returnees, GPs and maybe a researcher, all saying why Balint is important, and include a flavour of group discussion – and maybe some learning points. It could usefully discuss how the Balint emphasis differs from other similar approaches.

A membership pack (including the DVD) could then be available to distribute to students, registrars as they finish the VTS and GPs attending meetings. It might even be published in the British Journal of General Practice. The same material could be designed in such a way that it could be down-loaded from the website.

Website Development. A professional IT web-designer has been engaged to update and improve our website. We are hoping that the website will be able to guide people hoping to join or start a group to find groups or people to contact in each region.

What does the Society Offer?. There was discussion of what the Society has to offer and the need to be clear about the role of the Society. The important point is the balance between a core of active members and the wider influence of the work. The total number of members is not crucial although there does remain a need to attract new members. There was quite a bit of discussion about the relevance of the evening meetings. If the Society increases its calendar of activities, there is more reason for joining. Daytime events may need to be directed more towards students, registrars and young practitioners.

Partnerships/Collaboration. It was suggested that we extend our influence and visibility by seeking to work in partnership with other organisations, particularly with the RCGP. At the time of writing, the Society is in the process of negotiating to become an organisation affiliated to the RCGP. If this goes ahead (and it's looking good) we will have an agreement with the College over areas of common interest. During the coming year we will learn what this might mean for the Society in practice.

Secretary's Report 2009-2010

Autumn 2009 began with the 16th international Congress in Poiana Braşov in Romania, in September. There were ten British delegates, a similar number to those from the other countries with well established national Balint Societies... All who went enjoyed meeting old and new friends, Balint group work, and research presentations, as well as a chance to see a bit of Romania.

The Oxford Weekend, September 25-27, entitled "Balint for All", tried a new venue, a small postgraduate centre, part of Lincoln College. 33 people attended, forming three groups, including one leadership training group, led by Andrew Elder and Doris Blass. The keynote address was given by Ceri Dornan. The venue was fun, but did not provide adequate room for the plenary meetings so we will not use it again.

The lecture series continued at the Royal College of General Practitioners (RCGP), with four presentations, reasonably well attended, the lowest number being about eight, but 20 being more usual. All the speakers were well received. Unfortunately, none of them appear in the Journal this year, for various reasons, including the need to respect patient confidentiality. The last meeting, on 27 April, was given by Dr Raanon Gillon, who spoke on "Physician Assisted Suicide and the Respect for Autonomy". Sadly, the RCGP is moving this summer into temporary accommodation, prior to a final move into new premises in the Euston Rd, and will have no evening opening. We are therefore having a curtailed lecture series in 2010-2011, hoping that we may again be able to use the RCGP, free of charge, when it is settled.

There was another day meeting in Islington on 18 February 2010, a short and inexpensive taster of Balint work, attended by 19 doctors. This was organized by Dr Andrew Dicker, and will continue as an annual event. The group leaders' workshop met three times at the Tavistock Centre and is thriving, attracting new and prospective group leaders. Dates are published in the Journal, and please contact the secretary if you wish to join the mailing list.

The North West Development Officer, Dr Ceri Dornan, organised a morning event on Saturday 14 November 2009 to raise Balint awareness in the Northwest. Attended by psychiatrists, GPs, medical students, and therapists it was a very successful meeting and led to an expansion of the Whalley Abbey Weekend 14-16 May, when about 30 participants met and worked in three groups, including one for group leaders. As usual, Dr Caroline Jones organised the event marvellously. The Society has a considerable fund to promote Balint work in the North West and Dr Dornan is looking at ways to do this, including possible audiovisual materials about Balint work.

The Northumberland Balint Weekend took place 2-4 July, at Longhirst Hall, near Morpeth, organized by Dr Jane Dammers. It was very well attended with several overseas delegates, and also included a group leadership group.

The Annual Dinner took place again at the increasingly expensive Royal Society of Medicine, on June 30th. 28 people dined and listened to Professor Brian Hurwitz, who spoke after dinner about Narrative Medicine.

As a final word, I feel I have perhaps been in post as honorary secretary long enough, and would hope that someone else might be able to bring new ideas and energy to the post. As you can see from the report, most of the Society's activities are now delegated for organization, as could be the Oxford weekend in the future. This makes the role less onerous, particularly with email, and the Society would have a small budget for secretarial help if needed. Please get in touch with anyone on Council if you are interested!!

David Watt

Report from the International Balint Federation (IBF) 2010

www.balintinternational.com

Membership:
The national Balint Societies from 22 countries are members of the International Balint Federation and it also has contacts in five other countries who have not yet formed their own societies.

All members of the British Balint Society are automatically members and are welcome to attend any of the international meetings. These are advertised on the website (see above) and most of them are conducted in English.

Ascona Prize:
This biennial award for medical students' essays will be awarded at the 17th International Balint Congress in Philadelphia, USA in September 2011. The deadline for submission is 31st December 2010. Further information about the Prize can be found on the IBF website.

Events 2009-2010:

- 16th International Balint Congress in Braşov, Romania from 5th –9th September 2009 was very well attended with participants from 19 countries including 11 British participants. It was followed by a post-congress trip to the World Heritage site in Moldavia to see the amazing painted monasteries.

- 15th WONCA (Europe) Conference Basel, Switzerland (15th-19th September) included Balint groups led by members of the IBF which were very well attended.

- Spring Council Meeting 27th-29th May 2010 was hosted by the German Balint Society in conjunction with the Polish Balint Society in Gorlitz, a city that straddles the German-Polish border. Andrew Elder and David Watt represented the British Balint Society.

Future events:
For further information about all future events, including those listed here, please see the IBF website www.balintinternational.com

- IBF Council meeting 2nd October 2010 Oxford, UK.
  This will take place during the annual Balint weekend. This year it is being held at Corpus Christi College, from 1st-3rd October. Anyone may attend the Council meeting as an observer and the international delegates will participate in all the week-end activities.

- IBF Council meeting Spring 2011:
  The Danish Balint Society has invited the Council to meet in Copenhagen 28th-30th April 2011. Further details will appear on the website shortly.

- 17th International Balint Congress, Philadelphia, USA 8th -11th September 2011:
  Further information will appear on the website shortly.

- 16th WONCA (Europe) Conference, Malaga, Spain 6th-9th October 2010:
  The IBF submitted proposals for two Balint workshops which have been accepted. These will take place on Thursday 7th October.

heathers@doctors.org.uk
General Secretary
Heather Suckling

Report from Orvieto: Balint with the Third World?

by David Watt

Two and a half years ago, after an email exchange, I met with Richard Mollica, co-founder of the Harvard Programme for Refugee Trauma (HPRT) and one of his colleagues Aida Kapetanovic from Sarajevo in Bosnia, in a hotel bar on Gower street. Richard discussed his vision of trying to explore the use of Balint work in post-conflict areas as a means of supporting mental health workers on the ground, in countries such as Bosnia, Rwanda, Cambodia and Uganda. It sounded very interesting to me and I involved our President, Andrew Elder. In a matter of months, we were in Orvieto in Italy, at a small gathering, the Fifth Peter Alderman Masterclass. We were a bit bewildered by what was happening, but had been asked to bring Balint work as a commodity to show the HPRT team and a group of health workers from around the world what it was, and to give them an experience of it. The group members (10-12 persons) presented their own work in their own countries: Uganda, Cambodia, Bosnia, Rwanda and Peru. We gave a powerpoint presentation on Balint work and one on leadership accreditation. More importantly, the Harvard team showed an understanding of Balint work, in that an integral part of the three-day residential class was a daily Balint group, run by Andrew and me. In the group, which functioned remarkably as a Balint group with people from many different disciplines, including the American married couple whose son, Peter Alderman, had died in the World Trade Centre attack, and who had formed their charity in his memory, but chose to reach out across the world, rather than stay at home in the USA. We heard desperate cases of rape, death and trauma, but also several members brought "ordinary" cases where their professional identity was threatened by the behaviour of patients or colleagues, and also where traditional cultural values in different countries altered the doctor-patient relationship. We went away not knowing quite how our work had been received but with a moderate degree of enthusiasm from the organisers and the participants. In the year following, a group for medical students happened at the University of San Carlos in Lima Peru which was reported in the *Journal of the Balint Society*.

We continued in correspondence with Dr Mollica and his co founder Jim Lavelle. The Balint Society made some needed amendments to its leadership accreditation procedure with this future work in mind in December 2008.

In 2009 the financial world fell apart and they explained that they were unable to run the Masterclass, but would like us to come to Boston for a few days of discussion. So, in June 2009, Andrew and I went to Harvard, where we met the HPRT and Alderman Foundation again. Their enthusiasm had grown and they also wanted to show us their work at home. Jim and Richard work in a primary care mental health office in a run-down area north of Boston where they have had many years dealing with the large Cambodian refugee community. They have a weekly Balint-type group for all the workers there once a week, which unfortunately we were not able to experience. We did, however, meet with their dedicated team which felt very like our own healthcare teams, here in the UK. We also discussed the future. They were and are keen to establish an evidence base for all their work, including the furthering of Balint work in post-conflict countries. It was decided to take on a research assistant at Harvard to review the literature on empathy, the trauma story/narrative medicine, Balint work, burnout and self-care. The idea is to promote Balint work as an established method to provide self-care to workers to help prevent burn out. We would come together at Orvieto in 2010 to put the work together. During the year, they had a team working in Harvard and Andrew and I were brought in on a series of conference calls. We were to look specifically at the evidence for Balint work, and to present it alongside presentations on the other areas.

Thus we met again March 21-25, 2010 at Locanda Rosati, a small agriturismo hotel outside Orvieto. It is a very comfortable, intimate venue, with a good atmosphere and good food. Attendees were: a Ugandan professor of psychiatry, a health psychologist from Rwanda, a therapist (also a Catholic priest) from Haiti, a dermatologist and a psychiatrist from Bosnia, two student mental health workers from Italy, Steve Alderman of the Alderman foundation (an ex-oncologist), and Franco Paparo, an eminent Italian analyst. On the first morning we presented a summary of what Balint groups are about, and also, from some key findings in research papers we had found, a series of positive conclusions about the effectiveness of Balint work.

- "These results might indicate higher work-related satisfaction and better doctor-patient relationship"[1]
- "Balint attendees were more likely to choose the same specialty(family medicine) if they could choose again (86.1% versus 55%)"[2]
- "Our study demonstrates promising trends in residents' empathy and psychological mindedness"[3]
- (Primary care nurses)... "showed significant increases in awareness and ability cognitions after the Balint group and reduced emotional exhaustion and cognitive weariness."[4]
- "Basic psychological competency and the awareness of self in relation to the patient can be fostered through attendance at a (Balint-Style) case discussion group"[5]
- "Psychological Mindedness Inventory (PMI) increases in year one of Balint"[6]
- "The results indicate an expansion of the

skills for handling emotions"[7]

- "Balint group experiences...found to enhance professional self worth, self-esteem and confidence" (in family medicine residents)[8]

Richard did a presentation on the Trauma story, one of his key feelings being that the telling and organising of the narrative can be important in self-healing for patients. The next day Jim Lavelle presented on Self Care. The HPRT feel there is not sufficient emphasis on plans for self-care in ongoing disaster/trauma work, particularly for the local (rather than imported foreign) care givers. Hence the interest in bringing Balint into their programmes. The fourth presentation, on empathy, was shared by Richard and Franco Paparo, who had also been present two years ago, and is involved with Richard in trauma work following the earthquake last year in L'Aquila. The most exciting material comes from neuroscience where he showed us a new basis for empathy, perhaps at a cell level. There was some fascinating work on bodily stress levels in carers. It was not good for them to "put themselves in the shoes of" their clients. What they needed was to be able to imagine the situation for the client from a secure position outside (other). This perhaps enabled them to give true useful empathy and care for themselves at the same time. Running through the three days were the three Balint groups. The presentations were:

1. Being psychiatrist to your professor's demented wife when he was trying to conceal it.
2. From Haiti, being called in as a therapist, by the sister of a 42 year old man whose mother would not allow him to be told his diagnosis of cancer of the stomach. He died very quickly and the therapist could not contact the family, as a result of the earthquake.
3. An 18-year-old imprisoned at home in an incestuous relationship with his father. She escaped to psychiatry, but then the legal system failed her.
4. A woman married to one of the five men who raped her in the genocide in Rwanda with five children who now, after 16 years, seems to want to reject the husband.
5. A Congolese woman in her early thirties, who had been raped in the civil war, living in a refugee camp in Uganda with two children and mother. She had been abandoned by her husband, who presents to psychiatry wanting to be helped to find a new life overseas.
6. The first patient for a therapist who fell in love with him (and he a bit with her), but a good outcome-to cheer the group up at the end of the third group.

In the last lecture session we presented the mechanisms and qualifications for Balint group leadership, as revised by the Balint Council in December 2008. These stress trying to encourage new Balint work and being flexible. We laid out a possible accreditation by emailed group session summaries with telephone supervision every two months, and possible attendance at a group leaders' workshop (perhaps Orvieto in 2011) or a visit to their group if this seemed feasible. We discussed with all what they thought might be the prospects. Time and energy were of course barriers everywhere but attendees did seem to put value on the Balint process. In Uganda, they might present a concept paper on the basis of caring for carers via government channels. In Bosnia, where they have previous experience of Balint groups there was a determination to reopen old channels towards restarting groups in Tusla and perhaps in Sarajevo. In Rwanda, the psychologist has already been pushing for supervision groups in each professional group in mental health, and he may try to use a Balint approach in these. Haiti is still in a desperate state but perhaps in the next year the Haitian culture might be quite receptive to this kind of talking and sharing work.

I think we all left the Masterclass on Thursday morning inspired by each other's work, determined to think about the future. Richard and Jim have the brief to continue to pull things together. They will be in touch with us by conference call and will try to encourage people start Balint type groups and to train for Balint group leadership.

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Balint Society North West Development: Introductory Seminar

held on 14th November 2009, at King's House Conference Centre, Manchester

Ceri Dornan, NW development lead

In 2008, Balint Society members in the North West of England were successful in obtaining a share of funds to develop Balint work, from The Society for Investigation of Human Values, a local charity which was closing. The initiative was launched on 14th November 2009 by holding an introductory seminar. We were very grateful to Andrew Elder, President, and David Watt, Hon. Secretary, of the Balint Society for coming up from London to attend and facilitate the meeting. There were many others interested in Balint work who were unable to attend, but will be part of the circulation list for future activities.

Thirty-five people attended, from the following backgrounds:

Background	*Number*
Medical students	4
GPs	14
Psychiatrists (some also psychotherapists)	5
Psychotherapists / Analysts	11
Psychologist	1

Ceri Dornan, NW Development Lead, opened the meeting, then Andrew Elder spoke about Balint work and the Balint Society. The meeting then broke into small groups with interest in the following areas:

- Medical students
- GPs in training
- Foundation doctors
- Psychiatrists in training
- Established GPs

The groups had broad and lively discussions about existing Balint activity, proposed activity and the beginnings of some future plans. There was much enthusiasm in the room to take the NW development forwards. It would be hard to summarise what was discussed in a few lines, but some examples are:

- Manchester Medical Students are keen to include Balint work in their curriculum and have support from Dr Adrian Sutton (Psychiatry) and Dr Mark Perry (GP) who are Senior Teaching Fellows in Manchester Medical School.
- There are opportunities to demonstrate Balint to GP Trainers at the Regional trainers' Conference in 2010. Achieving a consistent Balint presence in GP training seems to one of the bigger challenges, with a full curriculum being cited by training organisers and the RCGP.
- The NW Deanery has agreed to support a pilot project to recruit Foundation Year 1 and 2 doctors into a Balint group. Dr Jon van Niekerk, ST6 in Psychiatry is leading this project. He may approach the Balint Society NW funds for some additional resources for this project (this was agreed to verbally).
- Those leading Balint groups for SHOs in Psychiatry tend to work in isolation and were pleased to meet others doing the same as well as Balint enthusiasts from different disciplines.
- There is interest in developing more Balint groups for established GPs in the North West. A number of people wish to become Balint trained leaders, suggesting a need to develop local leaders' training opportunities similar to those in London.
- The idea of Balint 'taster days' to gather interest, came from several groups and would be a feasible next step.

In the general discussion, topics included whether the name 'Balint Group' can act as a deterrent to those who see groups as potentially too psychoanalytic and underestimate their ability to participate. This can be challenged with appropriate information and publicity, which is one of the NW Development aims. Another question was whether groups which included specific topics for discussion alongside traditional Balint case presentations, were still Balint groups. The debate continues...!

The enthusiasm to continue to work together in the North West to promote and develop the Balint theme felt very rewarding for those of us who have been involved in the initiative from its beginnings: Caroline Palmer, Helen Sheldon and Ceri Dornan. We plan to meet in the near future to consider our next steps.

Northumberland Balint Weekend 2010
Longhirst Hall Hotel and Conference Centre

by Manjit Suchdev

It was one of the best weekends in the Northeast so far, with delegates from far and wide including Sweden, Finland, Cornwall, Northern Ireland, Scotland, Yorkshire, Cumbria, London and some even from the Northeast. The diversity was also represented by the practitioners from all areas of medicine and allied professions- including a gynaecologist, an occupational health practitioner, an art therapist and a doctor training to be a GP in the Army. People of all ages from young qualifying and newly qualified to post-retirement (Don Bryant) were represented. Everyone appeared to have had a great time.

There were 35 participants including the organisers. There was one rather large group for the leaders and two normal Balint groups. The meeting started with a brief and poignant talk by Peter Brumby on the current state of general practice, primary care and the new challenges. He talked about the almost continuous round of changes being imposed but also about what remains constant in the doctor-patient relationship as well as about the need to protect a reflective space in day-to-day work.

The groups worked well and smoothly over the weekend including the goldfish bowl.

In my view, the following were the highlights that made the weekend a great success:

1. Planning meetings of the organising group, ably led and always encouraged by Jane Dammers, held at Esti's place with beer and curry thrown in.
2. The right balance of group work and free time: hard work followed by hard play as well.
3. Great support from friends/families in organising free time activities.
4. A lovely evening with specially organised sunshine, a local pub with a microbrewery, perfect mixture of cooked flesh and vegetables on the bar-b-que organised by Dave and Leigh and Jane's David (We were rather heavy with Davids that evening; if you shouted David, everyone looked up – had to give them nicknames).

Recitals of local Geordie songs (including some Scottish and Irish ones) with lovely guitar play by David (Christine's) and others were the perfect antidotes to the hard and emotional work carried out in the groups.

The weekend left me drained and exhilarated in equal measures.

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.

Ascona Prize for Students 2011

founded in 1976 in honour of Michael and Enid Balint.

An International Balint Award for Medical Students
Ascona Model (WHO)

The Foundation for Psychosomatic and Social Medicine invites medical students to apply for the International Balint Award 2011. Prize monies of SFR 5,000 are available for the authors of the best three essays.

Papers must be in English. They should describe a student-patient relationship, an experience, or experiences, from the student's medical studies and include critical reflection on personal meetings with patients. The papers should be between 3,000 and 10,000 words.

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

1. Exposition:
The paper should include a presentation of a truly personal experience of a student-patient relationship. (Manuscripts of former medical theses or diplomas cannot be accepted.)

2. Reflection:
A description of how the student experienced this relationship, either individually or as part of the medical team.

3. Action:
The student's own perception of the demands to which s/he felt exposed and an illustration of how s/he responded.

4. Progression:
A discussion of both ways in which the student's own approach might change in the future, and also possible ways in which future medical training might enhance the state of awareness for individual students.

Submissions of 3,000-10,000 words should be sent by email, as a Word attachment to:
geschaeftsstelle@balintgesellschaft.de and heideotten@gmx.de

They must be received before 31st December 2010

The awards will be presented at the 17th International Balint Congress in Philadelphia, USA in 2011.

The prize-winners will be expected to give a short presentation of their essay (not more than 15 minutes) at the Congress and the full text of the papers will be published in the Proceedings of the Congress and other Balint journals.

The Congress fee will be waived for prize-winners and they will be provided with free accommodation. In addition, each prizewinner may claim up to 350 Euros for travel expenses on the production of appropriate receipts.

The Balint Society Essay Prize 2011

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 2011 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

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