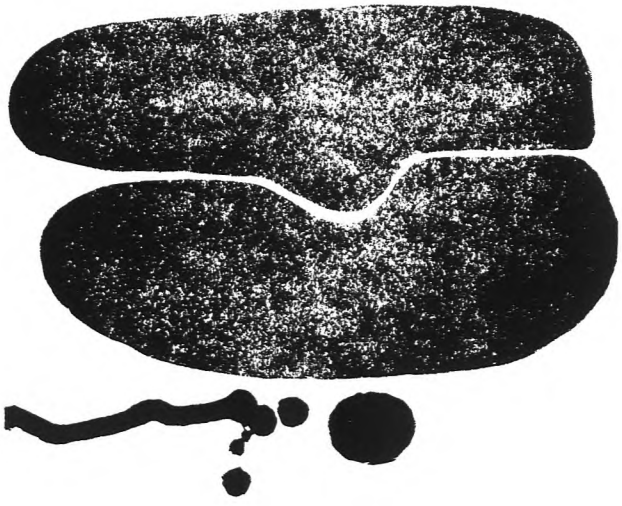
Journal
of the
Balint Society

2012



Vol. 40

JOURNAL OF THE BALINT SOCIETY

Vol. 40, 2012

Editor:
Tom McAnea

Some of the attendees at the Whalley Abbey weekend.

The Balint Society:

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

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

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

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

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

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

The Balint Society (UK)
Diary of Balint Society events
2012-13

Balint Group Leaders Workshop Tavistock Centre, 8.00 pm — **Wednesday 30 October 2012**

2012 Belfast Balint Weekend — **16-18 November 2012**

The Balint Society Annual Dinner will be held in New RCGP Building, Euston — **Friday 8 February, 2013**

Whalley Balint Weekend — **8-10 March 2013**

Balint Memorial Lecture. Dr Andrew Elder at Medical Society of London — **Thursday 25 April 2013**

Longhirst weekend — **June 2013 date TBA**

Oxford Weekend — **September 2013 date TBA**

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

The Balint Society Website news

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

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

You can also:

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

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

Ceri Dornan

The Balint Society
(Founded 1969)
Council 2011/2013

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Editorial

It is with great pleasure that I introduce the journal for 2013, the 40th volume, and my first as Editor. On reviewing the contributions and contents for this year I am encouraged by the variety and quality of material suggesting Balint work is very much alive and thriving across the world.

In particular, the personal papers include a fascinating contribution from Kris Wheeler in the United States about his experience of Balint work and its parallels with the creative process. For the first time in the history of the journal, we publish a Villanelle by another colleague from the US, Ann Sinclair. I am impressed and delighted that she has successfully conveyed the sense of a Balint group through this somewhat difficult medium.

The UK Balint community remains as active and enthusiastic as ever with an excellent paper by our new President, Jane Dammers. This describes work she did with other GPs in the North East using Balint groups as a means of improving the relationship between trainers and GP trainees. Also included is an extract from that great work of literature, 'War and Peace', read by Jane Dammers as part of her Longhirst weekend address. I agree with her that it captures wonderfully the crucial importance of the emotional and psychological in the doctor-patient relationship.

We were fortunate to enjoy two excellent lectures over the previous year, both of which are published here. Dr Gearoid Fitzgerald, a psychiatrist in Leeds, described his work running Balint groups with doctors at all grades and levels of experience. It shows the real need amongst doctors to have a forum where they can safely talk about their feelings about patients. Peter Schoenberg, a retired psychiatrist, describes his work with medical students at University College London medical school, running Balint groups for undergraduates. The response from those trainee doctors taking part shows there is a real need at every level in the profession for understanding the effect that patients can have on us as clinicians.

Both David Watt and Ceri Dornan, GPs and experienced Balint group leaders, describe similar work with junior foundation year doctors and psychiatry trainees. These accounts are fascinating and I believe very encouraging for the future of Balint work in the UK.

Of course, Balint work extends beyond medical professionals and is very established amongst our therapist colleagues, amongst others. Both Katherine Knowlton and Jan Wiener discuss the importance of their work and how it affects professionals in their field, on both sides of the Atlantic.

Humour is an essential part of survival in caring for patients I find, both John Salinsky and Jeffrey Sternlieb give amusing accounts of their own experiences with patients and Balint work. At our annual Oxford conference, John described his changing relationship with patients over a 40 year career as a GP in north west London, and how he has found Balint work essential in helping him understand his patients, but also sustaining his resolve through a long and fruitful career. Jeffrey Sternlieb gave a very funny account of the impact of Balint work on a personal level, between him and his wife, at the International conference in Philadelphia in 2011. It would seem that the potential benefits of being part of a Balint group transcends the professional and personal.

As a practising GP in north London, my life is dominated by my patients and the toll that can take on me personally can be significant. I find my involvement with the society and reading others' accounts of their work and experiences, both nourishes me and offers encouragement. Over 50 years on since Michael Balint first published his seminal account of his work in 'The Doctor, his patient, and the illness' it is clear that the need for understanding ourselves and our patients is greater than ever.

Finally, I wish to thank all my colleagues in the society and beyond for their support and encouragement in my first year in post. In particular the former Editor, John Salinsky, who continues to act as advisor, mentor and 'Executive Editor'. However, the Journal would not exist were it not for the contributors, the active Balint community around the world. You are the lifeblood of our organisation and keep it thriving and growing. I hope to hear from many of you over the year with comments, suggestions and submissions for 2013.

Tom McAnea
Editor

Guidance for Contributors

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

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

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 2013

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 2013. 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 2012

The awards will be presented at the 18th International Balint Congress in Heidelberg, Germany in 2013.

The prize-winners will be expected to take part in the Congress in Heidelberg September 7th to 11th, 2013 and 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 reasonable travel expenses (the cheapest available air fare) on the production of appropriate receipts.

The Balint Society Essay Prize 2013

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

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

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

Length of essay is not critical.

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

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

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

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

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

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

The prize-winner will be announced at the Annual General Meeting.

Entries must be received by 1st May 2013 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
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The Trainer, the Trainee and the Balint Group

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Abstract
The paper describes extending the Balint method by using Balint groups to explore the GP Trainer-Trainee relationship. This work has been carried out by a multi-professional group of Balint group leaders working in the North East of England.
We describe our experience of the process of running such groups, the feedback received from group members and the working group's reflections on the challenges of working in this way. Our experience suggests that this is a helpful extension of the model which merits further discussion and development, but we have debated whether this is a valid use of Balint's methods. As we move away from the 'pure' Balint group of GPs talking about patients are we creating a helpful extension of the method, a legitimate child of Balint or a bastardisation of the method?

Introduction
The authors are experienced Balint group leaders working in the Northern Deanery. We are a group of GPs and psychodynamically trained clinical psychologists and psychotherapists who meet regularly and usually work in a GP / psychotherapist pair when leading groups. Between us we have run Balint groups for experienced GPs, Health Visitors, and trainees in General Practice, Clinical Psychology and Psychiatry. A benefit from working in Balint groups, in spite of initial feelings of unease when first encountering a new model of learning, has been documented for doctors in training in psychiatry (1), family medicine (2) and clinical psychology (3). We have also led experiential introductory workshops for GP trainers, introducing them to the Balint method anticipating they may take something from this approach to use in their practices, particularly with trainees. In all these groups the focus has been on the clinician-patient relationship but at times presenters have brought 'cases' to do with relationships with colleagues and the institutional setting. Our experience has been that when careful attention is paid to the boundaries, such discussions can be productive and helpful and we have felt it has been legitimate to explore such cases in a Balint group on an occasional basis.

In 2009 we were asked by the Northern Deanery to run a two day workshop at the annual GP Educators' conference, with a brief to 'provide an experience of Balint work relevant to GP trainers'. We wondered if we could use a Balint approach to examine not only the doctor-patient relationship but also the GP trainer-trainee relationship. Could we 'borrow' the Balint method to help trainers reflect on their relationships with their trainees and thus get hold of the whole experience of engagement with a trainee in a Practice as opposed to thinking more narrowly about whether competencies, aims and objectives have been achieved?

GP trainees are normally in a practice for six to twelve months and have a close 1:1 relationship with their trainer, which can at times be challenging, uncomfortable, perplexing and difficult, just like relationships with patients. We wondered if trainee-trainer relationships could be legitimate Balint group cases and if a Balint approach could provide helpful insights into what goes on. Some trainers meet in a 'trainer group' every few months and may have an opportunity to talk about a trainee. However these groups tend to be large and may be rather protective of the trainer so that representation of the trainee in the discussion may get lost. We approached this experiment with some hesitation and trepidation and also with the excitement of venturing into the unknown.

The 2009 Two day Workshops
The first workshop was run in Oct 2009 and repeated with a different group of trainers in Nov 2009. We limited the group size to 10. We led each two day workshop with a GP and psychologist/psychotherapist pair. Alongside the Balint groups we decided to present some theoretical material over the two days introducing some core psychodynamic concepts including

unconscious communication, defences, attachment and containment. This material was presented by a third staff member who also observed the Balint groups and discussed how these concepts might help to illuminate some of the issues brought to the group discussion.

On the first day of the workshop delegates were asked to bring Doctor-Patient cases to the group and were introduced to working in a Balint group in the normal way. On the second day delegates were invited to bring either a Doctor-Patient or a Trainer-Trainee/GP-GP case.

Vignette of trainer – trainee case 2009 workshop

A trainer brought a case of an international medical graduate who had recently arrived in England. The trainer had found it uncomfortable to ask the trainee direct questions regarding their health which he worried was affecting their clinical practice and so the practice had managed this by devising a 'strategy' as to who would ask what, and a division of tasks in relation to the trainee. The discussion brought up the issues of race, culture and ethnicity which were felt as taboo at the practice. What followed was an exploration of the trainer's feelings of shame and guilt about knowing so little about their trainees' lives, cultures and backgrounds, and sadness about the loss of the personal/mentorship relationships they had experienced with their own trainers. When thinking about this case we can see how much it parallels common themes in discussing patient cases brought to Balint groups – issues of not really knowing much about a patient despite having seen them on numerous occasions and feeling awkward about asking or exploring certain things.

Reflections of the staff group

We felt that the groups mostly worked well with interesting and appropriate discussion of the patient and trainee cases which were brought. The trainers appeared to get hold of the basic Balint method quite quickly, bringing patients as cases on the first day and were then willing to bring trainer-trainee cases on the second day. There was no shortage of trainer-trainee cases to discuss and we seemed to have been able to explore them within a Balint group. Two days was a reasonable length of time to attempt this work. We had some anxieties about the theoretical input which we had tried to deliver with a light touch but which in reality was quite dense. How much of this could delegates cope with and how useful was it? Also we felt that having an observer may have inhibited the group and that their giving feedback may at times have been helpful but at other times closed the group down in an unhelpful way. We had strong feelings and reservations concerning confidentiality when working on trainer-trainee relationships as the trainees are easily identified in a small geographical area and also move from one practice to another. However if trainee issues are going to be discussed at all among trainers it is probably impossible to conceal their identity in any group discussion.

The 2010 One day Workshops

In 2010 we were again asked to contribute to the GP Educators Conference with the same brief but this time with only one day available for each of two workshops, one in October and one in November. Using the delegate feedback and our reflections we made some changes. We sent out some pre-conference reading, a paper on "medical defences against involvement with patients" by Tom Main presented at the Michael Balint Memorial Lecture 24th Jan 1978 (4) and and 'A short introduction to Balint groups' by John Salinsky (5).

We decided not to have any theoretical presentation of concepts or an observer, and agreed only to highlight relevant concepts as they appeared in the material presented if it seemed helpful. Delegates were invited to bring Doctor-Patient relationship cases to the morning session and trainer-trainee relationship cases to the afternoon session.

As before, we worked in pairs to lead the workshop. The Balint groups in the first workshop felt pressed for time as there was considerable initial discussion on Tom Main's paper. One GP-patient case was discussed in the morning and two trainer-trainee cases in the afternoon.

The second time we ran the workshop in November the leaders decided to use the time entirely in setting up and running the Balint groups without any initial theoretical discussion on Tom Main's paper. This second group quickly settled into productive work, the first case presented was about the Doctor-Patient relationship and following a discussion about confidentiality, boundaries and containment the group moved on to two trainer-trainee cases.

Vignettes of trainer-trainee cases 2010 workshops

In the October workshop a trainer brought a 'case' of an anxious trainee who found it very difficult to receive feedback, it sent them into a panic. The trainer was wondering how she might help. The group mostly seemed to want to pathologise the trainee and refer to occupational health or the training scheme rather than find out more about the trainee and her underlying anxieties. The trainer rejected this formulation and continued with her desire to help the trainee herself. This was quite a difficult group, the majority of trainers seeming to want to follow procedures rather than listen to the trainer and be curious about the trainee. Again we might see parallels in an ordinary Balint group where the group might become rather prescriptive and suggest referrals or treatments to the presenting doctor as a defence against the anxieties of the case. This was quite a difficult group – it seems that the group was reflecting something of Tom

Main's paper which they had spent some time discussing, re-enacting defences against engaging with the trainee and the difficult feelings encountered.

In the November workshop a female GP found herself becoming very irritated with a female trainee around issues of maternity leave. The group worked well with this case to help the Trainer understand the source of her irritation as stemming from her feelings of how different things had been for her when she was training and how she had struggled with the dominant medical culture at the time, having to return to work without much in the way of support and despite having an infant to consider. This case demonstrates a parental type of envy which doctors may also experience towards some patients.

Feedback and reflection from delegates

Overall feedback from delegates was very positive with all but one delegate over the 4 conferences rating the experience as good, very good or excellent. Mean scores for the 2009 workshops were 4.73/6 and for the 2010 workshops 5.36/6 (with a score of one being poor and a score of six being excellent). Most delegates were new to Balint work and found it a useful model...

'...This was a very valuable opportunity to experience Balint group work. The patient discussions were excellent...'

'...very relevant to GP, with very thought provoking cases, and just the right amount of theoretical knowledge given. The whole 2 days stimulated my interest in Balint work and psychodynamics in general, that I would like to take further in the future. I have felt it has changed my approach in the consultation already'

'...really enjoyable to try out a Balint group. Found the process useful and could imagine using it in future.'

Feedback on the theoretical psychodynamic aspects of the 2009 workshops was mixed with some with prior experience finding it very useful

'...I have done Balint before but without the psychoanalytical theory. Having this in took me to a further level. I found it useful for a specific patient I am treating.'

'...It was well put together combining sessions of theoretical aspects of contemporary psychoanalysis with Balint group work. It certainly gave me a valuable insight into Balint group work and the theory behind it.'

Others finding it more difficult...

'...group led work was excellent, the delivery of the theory was the weaker part although how to deliver such a difficult topic I am not sure.'

'...some of the theory was a little dry and the timing of the theory session at the end of the first day should probably be reviewed as I think we were all a little tired to take in the new language.'

Comments regarding the use of the model in looking at the GP trainer-trainee relationship were all positive...

'Interestingly it proved perfectly possible to use the principles to explore trainer / registrar interaction and inter-colleague relationships.'

'I enjoyed the group work and the opportunity to interact with peers regarding patients and GPR problems...'

'I found the day thoroughly interesting and enjoyable. The content of the day was agreed at the beginning of the day and the facilitation was excellent. Discussing problem GPRs was particularly helpful and I now understand the purpose, process and value of Balint group work.'

'...This was brilliant. The facilitators quickly put as at ease and encouraged us to contribute in a constructive and safe way. I was anxious about moving on to the trainer/registrar scenario but found it very useful and again extremely well-facilitated. I'm very much hoping to attend the Balint weekend.'

Final Reflections

In the past we have worked with GP trainers for as little as half a day to introduce them to the basic Balint method of case discussion of the doctor-patient relationship. We have demonstrated that we have been able to extend this work to discuss GP trainer-trainee relationships. Participants have been willing to bring and discuss trainer-trainee cases and there are noticeably, and not surprisingly, many parallels with doctor-patient cases. There are also differences. Trainers have complex relationships with their trainees, having a variety of roles – their employer in the NHS, their assessor, their colleague in the practice sharing workload and clinical responsibility, their advocate within the practice (needing at times to defend against other colleagues), as well as mentor, appraiser, long-term educational supervisor and often have a wish to be a friend as well! There is plenty of potential for powerful feelings to be stirred up in all these roles, feelings which may reverberate around the practice, the trainers' group and the whole training scheme.

We have felt more comfortable doing two day workshops but have been able to accommodate this work within one day. We are aware this work can be tricky and have valued having two

facilitators – a GP psychologist/psychotherapy pair for each group. To work together bringing different and shared experiences of our different disciplines to leading the groups has been invaluable. We are aware that the work seems to require special attention to boundary issues and that the facilitators need to take quite an active role at times. We wonder whether, given that all that is new to the group, that the work is easier when facilitators are already an established pair with experience of running a Balint group together. We would welcome the opportunity to do this work long term and examine the outcomes with a stable group of trainers meeting regularly.

We are a strong staff group and meet regularly to support one another and develop ideas about Balint work in our region. Throughout this piece of work we have been able to discuss openly what has occurred and make changes as we go along. We have moved a long way from initially bringing quite a lot of theoretical material to more or less abandoning it. In future we might simply send out Salinsky's brief introductory notes to Balint groups as we do before our Balint weekends. Those who resolutely hold fast to the Balint method will probably say 'we could have told you so' - it has been an interesting journey for us as a multi-disciplinary team to come to this conclusion.

This work has been challenging and we welcome debate on the issues that may need to be considered when working in this way. Is this a valid use of the Balint approach? Is this work a legitimate child of Balint or a bastardization of the method?

Acknowledgement

The authors would like to thank Dr Margaret Rangecroft for her contribution to the development and delivery of the workshops.

References

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4) Tom Main 'Some medical defences against involvement with patients' Michael Balint memorial lecture 24 Jan 1978, published in 'What are you feeling doctor?' p151-168 by John Salinsky and Paul Sackin. Radcliffe Medical Press 2000.
5) John Salinsky 'A short introduction to Balint groups', The Balint Society Journal 2011.

Balint Groups for Therapists:
Fostering Creativity and Improving Internal Supervision

By Katherine Knowlton, Ph.D., University of Washington,
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This paper originally followed a demonstration Balint group at the conference for the Division on Psychoanalysis of the American Psychological Association. The participants/audience of mental health providers had not had any previous experience of Balint group work. The emphasis on creativity meshed with the conference theme of "Psychoanalysis and Creativity."

This paper spells out what I see as the effects of Balint group participation and why these effects support a therapist's creativity. One basis of these thoughts is my having led Balint groups for physicians since 1995. I have also led mixed medical and mental health groups and had several groups just for therapists with members who had a range of experience and various theoretical orientations.

It was Enid Balint (Balint and Norell, 1973) who realized that physicians, without becoming therapists, needed to learn to tolerate being "used" for emotional purposes, a la Winnicott. Balint groups provide a setting to practice the basics of this capacity by imaginatively 'taking on' a colleague's case, tolerating not knowing, and allowing multiple possibilities without resolution. Conversely, when one is the presenter, one has the chance to use others to good purpose.

Enid Balint also identified something she called a "flash" of genuine understanding between the physician and the patient. She said this signaled therapeutic effectiveness, even in a visit of under ten minutes.

Her insights arose in the medical context, but they help explain Balint groups' unique appropriateness for therapists. Balint groups offer a setting, protected from any immediate need to act, to practice affect-laden imaginings and speculations, to develop greater understanding of and compassion for others.

These skills grow not simply through practice, but through the repeated, intentional lowering of defenses in a relatively safe environment. Intentionally lowering one's defenses is usually relegated to the therapist's own analysis and sometimes considered in the supervisory relationship. In Balint groups everyone participates, thereby diluting the intensity of one-on-one dynamics. The group structure makes them unique in their capacity to create safety, and to support participants' valuing diversity of opinions and otherness, an attitude that goes hand in hand with the lowering of defenses. While I do not believe there is any substitute for supervision, I do think Balint groups are uniquely qualified to broaden and deepen acceptance of affect.

Patrick Casement (1985) has written about the process of supervision in a way that emphasizes its potential similarities with Balint group processes. He describes establishing a "play space" in supervision and learning to do "trial identifications" with the client to assess the clarity of interventions. But making a play space, where one needn't have one's ordinary defenses, can be hard. Just think about an early or scary supervisor.

Because the task in a Balint group is to speculate imaginatively, members quickly realize they can say things that might otherwise sound accusing or unwelcome. In one meeting a member offered the idea very tentatively that the client could be angry with the therapist. She was pleased to learn later that the presenter had heard this with interest and without being upset. Speakers own their thoughts and share them in a spirit of identifying with each other rather than talking about the presenter. "If I had done that, I would be mad at myself" is a relatively benign self-revelation, and likely to allow a presenter to be aware of similar feelings. Of course, whether discussing the client or the therapist, when speakers offer what they imagine, they reveal themselves as well as uncovering real possibilities connected to what they have heard of the case, so defenses come down all around.

In Casement's examples of supervision he imagines aloud to supervisees how their remarks may have sounded to clients. Similar content is offered in Balint groups, when members imagine what the client may be experiencing in various contexts e.g. "If I were this client, I'd always be waiting for the other shoe to drop."

Thomas Ogden (2006) identified his own experience in a Balint group as a necessary, second phase of psychoanalytic learning, a phase in which learned procedures are "overcome... in order to be free to create psychoanalysis anew with each patient". He valued the Balint group's creation of a "dream space" for its ability to rise above the "numbing automaticity" of standard procedures. Like Casement's play space, Ogden's dream space exists beyond the need to act, beyond the need for everyday certainty, beyond the quotidian realm of defenses.

With regard to teaching clinical psychoanalysis, a central goal of analytic teaching is the enhancement of the analyst's capacity to dream those aspects of his experience in the clinical situation that he has not previously been able to dream. (p.1069)

The lowering of defenses required for a dream space is sometimes easy to see in a Balint group: the presenter may begin with obvious constrictions, what is colloquially referred to as 'being defensive'. For example, one presenter began, "I'm so sick of what I've come to see as

manipulative exaggerations, that I just want to shake him." By the end of the group the presenter's toughness, as if he were refusing to be touched, had softened. He became more able to dream meaningfully into his patient's experience, and his need to make something happen lessened. You can often see such a relaxation in several group members, not only the presenter.

But there are other, subtler signs of a group's success, since defenses operate constantly, and have subtle influences on one's moment-to-moment awareness and internal freedom.

For example, presenters may forget details at first. By the end of the session the presenter will have become aware of omitted material. Perhaps hearing people talk about the patient's imagined social supports reminded her of the patient's hint about arguing with relatives. Such remembering is common and may happen with a feeling of relaxation or relief. The recalled material may be neither weighty nor fraught with emotion, though it is usually useful.

Another familiar short-term effect is that the presenter can feel more compassion for herself. A presenter's lack of compassion for herself usually involves an oversimplified or harshly applied notion of what it means to fulfill her role. Watching colleagues own up to things one had been disavowing and seeing them do so without losing respect for one another, provides excellent food for thought and growth.

For instance one group began with, "This is really an easy case. I don't know whether it's even worth presenting," and ended, "Wow. I said it wasn't complex, but I was wrong. It was no mystery diagnostically, so I told myself it should be easy. No wonder I've been having trouble!" Once the presenter relaxed her defenses and looked at the whole picture, her relief was palpable.

Of course, part of that 'whole picture' may be the practitioner's countertransference. This has come up in therapists' groups, and so far has been relatively easy to acknowledge. For example a group member rather than the presenter might say something like, "I seem to be stuck. All I can think about is the spouse we haven't met and how this person's actions have hurt him." The group would go on to play with this and to voice other possibilities, associated to and beyond the 'stuck' member's statement. In the end, without explicit analysis, the countertransferential observation is of interest but now rests among other possibilities. It can be lightly held and considered by all.

Less frequently, the presenter may speak candidly about countertransference. For example, one presenter might admit, "This reminds me so much of my brother, I just don't know what to do. I keep thinking about him instead of my client!" Then the members' work is to try to speak empathically about that experience. One member might say, "If I were this therapist I'd be wanting to refer the client to somebody else. Get rid of him! Tell him I can't handle it!" Another could offer, "I'd feel guilty all the time, like it's my fault I can't do my job, but underneath it all I'd be mad at the client for stirring all this stuff up." In this way the presenter gets a detailed, sympathetic but unsparing picture of some of the potential aspects of a countertransference reaction. Even when the members' speculations are not veridical in their fine points, experiencing such attention may encourage the therapist's own reflectiveness.

If the group's work does not produce a new understanding for the presenter, that person may still be aware of some expansion of possibilities, a return of curiosity, as if to say, "I now have subjective room to be observant. Before I could only feel frustrated or confused or prepared for the worst."

People who lead Balint groups are familiar with these effects: increased awareness or remembering, increased acceptance of experience, including tolerance for affect and tolerance for complexity, decreased need to judge self and others, and decreased need for control, including less need to know the answer.

These short-term effects achieved by the repeated intentional lowering of defenses develop their flexibility. The defenses don't necessarily change. You may still get overwhelmed and have thinking that is limited in a way characteristic for you. But if the way you use your defenses develops, you can recover more quickly. You have a more nimble mind.

Here's an example of what I'm calling flexible defenses: after feeling inept in a session the therapist responds fearfully to the client's calling to cancel the next appointment. The therapist feels "sure" the client is going to quit therapy. But he's been in a Balint group, so he can pause and think, "Well, maybe, or maybe not." The phone call continues and rather than trying to say the perfect thing to keep the client in therapy, he is able to be curious about what may be going on.

This example of flexible defenses involved little insight or complex integration. Certainly the therapist did not work through his own desire to reject the client or explore his sense of himself as worthy of rejection. There may be that and more for him to understand in this incident (Salinsky & Sackin, 2000). But the sense of multiple possibilities, and the sense that it is okay not to be able to think of everything created options that his defenses were on the way to impeding.

Carlsson (2002) investigated the defenses characteristic of individuals with high or low creativity and found that flexibility in the use of defenses was strongly correlated to creativity. Her definition of flexibility is not identical to mine, but is wholly compatible with it. She suggested that creative people with flexible defenses "move relatively freely along the primary-secondary process continuum." (p.347) It is such freedom of movement I am claiming as

the longer term effect of Balint group participation. In conclusions relevant to Casement's "play space" or Ogden's "dream space" Carlsson connected flexibility of defenses with "openness to childlike functioning or adaptive regression." (p. 347)

Other work by Domino et al (2002) suggested that "the high-creative in contrast to the low-creative person....uses not only [the] more mature defenses, but [the] more immature and neurotic defenses as well." (p. 22) In other words, leaving the therapist role responsibly, letting your hair down and trying to describe the subjective truth of lurking immaturities as one may in a Balint group, should be good for your creativity.

For therapists I believe the work of a Balint group may have as profound an influence on the development of one's professional self as analysis has on the whole person. If the case presented is the material, the group's work can be thought of as free association. At times the entire process may provide a kind of slow-motion tour of the lightning fast preconscious activity that occurs in the therapeutic hour. When it works the Balint process enhances its members' capacity to consider aspects of experience previously unavailable. The group itself can demonstrate conflict without judgment, clarity without oversimplification and cohesion despite a multiplicity of viewpoints. Repeated exposure to such a group may help us internalize and create for ourselves a more complex, nuanced sense of what it means to be a therapist. Repeated exposure in such a group may help us use that understanding more creatively.

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Welcome to the 17th International Balint Congress

Philadelphia, Pennsylvania, USA

Jeffrey L. Sternlieb, Ph.D. – President, American Balint Society

Jeffrey L. Sternlieb, Ph.D.
Donald Nease, M.D.
Conference Co-Chairs

There is a phrase in the United States – very likely, it is universal – that Talk is Cheap! I would like to add to that idea one more idea, and that is Advice is Cheap. It seems like everyone everywhere needs or wants advice. It's what we do when we don't know what to do. And I think Balint work is really about finding out what it is we are really responding to when we give advice.

Advice giving is easy – and Balint work is more challenging. We see the easy part every day in our news commentaries, blogs and even our papers. In the USA, we have Dear Abby. Perhaps you have your own Dear Abby's?

I imagined that early group leaders probably had many questions, and they probably wouldn't be asking Michael Balint directly, but they might ask Enid, his wife and colleague in this work. I wondered what it would be like if Enid was a Balint Group advice columnist at the Tavistock Daily Times - a precursor to our list serve for instance.

Imagine my surprise when I innocently saw the following letter on my wife Andi's laptop - it started:

Dear Enid,

I can't think of anyone else to write to - you are my last hope!

I believe that my husband is having an affair - with your silly groups! Balint has become his mistress! It's all I hear about - Balint this and Balint that. I can hear it in his voice when he's talking on the phone with one of his Balint colleagues. There's a lilt, an excitement - even when it's serious, it seems more important than anything else. I never have to ask who he's talking to! I know it's Balint business. I have become jealous and envious - he claims to have deeper relationships with his Balint colleagues - he says they talk about more meaningful things than we do with our friends or even at times with each other. He defends himself by claiming Balint work has made him a better person - more sympathetic, empathetic, a better listener - it makes me want to throw up!

Her letter continues:

It would be different if it was just sex, but it's worse - it's all about intimacy, he says. I'd rather be a golf widow than a Balint widow! At least with golf, there's nothing that has any meaning. It's just a waste of time.

Now, he not only goes to leader trainings locally, but he goes all over the country. Just when I got used to that, he started going to Europe - Oxford, but just for a weekend. When I complained to him, he dragged me to Romania and then he went to Copenhagen without me. Romania was a great trip, but I'm being converted from a Balint widow to a Balint wife. I feel like I'm losing control of my life.

I don't want to get lost in the group - isn't there something you can suggest? I thought about starting a support group for Balint widows, but I didn't want to hear any more about boundaries and transference, or be part of another parallel process.

Enid, you really are my last hope. What can I do?

Signed,
A Balint Widow in PA.

And to my surprise, there was the following brief response from Enid:

Dear Balint Widow in PA,

First of all, stop your complaining! Your husband has clearly found something he is passionate about. I applaud your accompanying him to Europe. I hope he communicated his appreciation.

Ultimately, I think you are the one who will need to solve your own problem, but I do have one suggestion. I happen to know that he is helping to plan the next International Balint Congress in Philadelphia - not far from where you live - and I believe it will be a great event. They have planned lots of activities for all with great speakers, great opportunities for discussions, some free time to enjoy the city and each other, and yes even Balint groups. I wonder if you might speculate what it would feel like to help him out with the planning and organizing of such a big project. The rest I'll leave up to you.

Signed,
Enid

Well, I would like to, on behalf of the American Balint Society and my co-chair Don Nease, welcome all of you who have traveled short and long distances to be here together to listen, learn, participate, make new friends and re-acquaint with friends of old.

Balint Villanelle

We've time today to take a slower pace
And talk about the patients whom we see.
Does anyone among us have a case?

Our office hours are short. Our patients race
From head to broken heart, ache to anxiety.
Who has the time to take a slower pace?

Their pain a metaphor for what they face
In daily life, their struggles to be free.
Does anyone among us have a case?

Our own unknowns arise within the space
Between us, joining with the patient's plea.
How can we understand at faster pace?

Dropping judgments, labels, to embrace
Simplicity of self that sets us free.
Does anyone among us have a case?

We try to move into their lives with grace
And pull away, now changed by where we've been.
We'll use this time to go at slower pace.
Does anyone among us have a case?

Ann Sinclair

Conditions that support creative process:
Contemporary dance meets the Balint Group Method

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Creativity is said to have a life of its own yet, in my experience, it needs support. I find that creativity thrives in conditions that simultaneously contain and expand the process. Balint Groups (for consulting about relationship issues that arise in doctor-patient relationships in physical or mental health settings) provide excellent conditions for creative engagement. This brief paper explores lessons I learned about supporting creativity in dance as a student, and over the course of 20 years of professional work performing and teaching; and links these ideas from the arts to the Balint Group Method. I continue to use these ideas to access creative process in the dance studio, the consulting room, as a teacher of clinical psychology and as a leader of Balint Groups. While experiences with dance remain my gold-standard, I find the basic format of the Balint Group to be compatible with the best of my experience in the studio. This writing draws especially on my experience of working with renowned contemporary dancer Deborah Hay, and also references work with Eva Karzag, Janet Adler, and the artist peer-review process called *The Field*.

1. **The first provision is to use specific practices to focus attention, *practices* that are meaningfully relevant to the work you are developing and are open-ended, without the possibility of fulfillment or perfection, then observe what emerges.**

There is a paradox here: the expansiveness of creative process thrives within containment – containment of timeframe and focus of attention. At the same time, it is important that the focus be open-ended, allowing for unpredictable results. Clinical psychotherapy hours, particularly psychoanalytically oriented psychotherapy, provide just this – the setting, frame and theory provide containment within which we engage in the open-ended endeavor of psychotherapy. (The open-ended endeavor I am referring to is the specific aspect of clinical practice that is about getting to know the internal life of a patient and allowing oneself, as psychotherapist, to experience one's own internal life so both patient and therapist can dream together and develop understanding that furthers growth.)

Balint Groups also provide a focused and open-ended practice by asking group members to speak about what arises in their imagination with three basic questions: What is it like to be this patient? What is it like to be this doctor working with this patient? And, what might be going on in their relationship? These are not arbitrary questions; they are the stuff of subjectivity, the heart of clinical psychotherapy. At the same time they invite participants to discover the dreams of their imagination. Meaningful engagement with this process asks participants to surrender to what emerges, not to perform well mastered scales.

My creative work in dance was helped tremendously when I was introduced to the "practice of attention" by Deborah Hay. A practice of attention can take many forms, much like meditation practices. Contained within a specified timeframe, it identifies the focus of attention, which triggers a reflective potential in which one can observe experience. (Examples of practices will be given later in this paper.) Like the Balint Group questions, Hay's practices of attention are in the form of a task (usually a question) that is impossible to either achieve or answer conclusively. We can't "know" the answers to the Balint questions, but we can engage with them. Hay's practices open one to glimpses of experience that are not yet known and formulated. Unlike typical dance training, which is about physical mastery, Hay takes greater pleasure in how the dancer's imagination and attention can alter perception of both mover and viewer. This is much like the Balint Group experience, where presenter and participants can enter into unfamiliar experience as they engage with the questions. Like engaging with Hay's practices of attention, I find participation with Balint Group questions to be an experience of opening my mind to unexpected associations, where I am not seeking a "correct" response. "La réponse est le malheur de la question" (the answer destroys – or, is the death of – the question) is relevant here. Balint Groups can offer a deeply satisfying and rich creative experience with members oriented to the basic questions in this manner.

2. **Approach with an attitude of experimentation.**

Although this idea is implied in the first provision, it is important to give it specific attention. Providing space for a discovery process is the spirit of the Balint Group method. Generally speaking, after the presenter shares clinical material, he or she steps back and allows the group to work with the material. In this way, much like a researcher awaiting results from an experiment, the presenter discovers what the group comes up with. Additionally, the limited interaction between presenter and group members allows the group to proceed without a corrective or qualifying presence. This gives group members a wide space to see where their imagination goes, both individually and as a

group. We aren't in a position to direct this experiment. We are more like separate elements interacting in unpredictable ways.

The results of the Balint Group experiment are multileveled; some are apparent at the time of the meeting and others unfold over time. A Balint Group is a culture of spacious play, where the presenter isn't required to respond, but simply listens, and group members don't need to follow a linear progression, and instead can simply offer additional points of view like articulating facets on a not-yet-known gem of experience. This allows both conscious and unconscious processes to unfold within the presenter and within the group.

An attitude of experimentation is the *sine qua non* in creative work. Experimentation with associations and ideas, as in a Balint Group, stirs anxiety as we share our ideas in the public setting of the group. This is exactly the challenge dancers face when, rather than performing carefully rehearsed choreography, they perform creative process itself. Hay has cultivated powerful tools to foster this capacity in a performer. She brings explicit attention to the experiment that is being played out in the laboratory of one's body. The results of the experiment are the *received feedback* from the body while engaging a specific question. An example from Deborah is: "What if every cell in my body has the potential to perceive beauty and to surrender beauty, simultaneously, each and every moment?" Both in the Balint Group setting and with Deborah Hay's work, the questions are posed with the recognition that there is no single, correct response. This basic feature sets in train a *process* rather than a conclusion. It furthers the activity of creative intelligence rather than seeks to find answers. The presenter leaves the Balint Group meeting enlivened with new ideas stirred up, not with an answer pinned down.

3. Time is your ally - proceed with a spacious sense of time.

A spacious sense of time supports the tasks of imaginative association in the work of a Balint Group. Eva Karzag, another teacher and performer of dance, offers the words, "time is my ally", to remind her students that although we work within a time-frame that will define a series of endings, and even an ultimate ending; within the time frame, no rushing. Experience happens in time; and it takes time to reflect upon it, represent it and engage with it. Rushing, and the atmosphere of rushing, interferes with the creative life of a group and puts one in the position of trying to catch up to something outside of oneself which takes one away from direct experience and contact with creative process. Balint Groups provide a setting where doctors and psychotherapists slow down and give time to a particular experience with a particular patient. The group's capacity to proceed with maximal creativity is supported by the basic ground rule of taking turns, not interrupting the person who is speaking. This gives that speaker the time to allow thoughts to take shape without undue concern about being interrupted.

4. Focus on Description rather than interpretation.

The Field is a method of peer review used by artists to enhance their working process. Composers, choreographers, performers, visual artists and writers meet as a group to offer reflective and descriptive feedback about works in progress while refraining from being directive or suggestive. The fact that viewers articulate their experience and speak in a manner that does not attempt to guide the creative process of artist, gives the artist information to integrate in his or her own way. This is quite similar to the way a Balint Group works. The specific questions of the Balint Group move participants toward description rather than interpretation and the basic ground rules explicitly encourage them to avoid giving advice. The Field and Balint Groups' leaders support the group to offer feedback in a manner that doesn't intrude on the space for the artist or doctor to find his or her own way to integrate and take what is useful while feeling free to let go of what doesn't help.

A perhaps unexpected benefit for engaging with a focus on description rather than explanation, interpretation or advice is that through this effort, one is also likely to become more aware of how one perceives. Descriptive language from participants assists the presenter by offering possibly unrealized images, narratives and ideas about his or her case, and it simultaneously develops the speaker's awareness of perceptual tendencies and qualities of his or her intuition. In this way participants in both The Field and Balint Groups often discover that it is as profound to be a participant, a giver of feedback, as it is to show work or present a case, and receive feedback. The ethic of focusing on description rather than interpretation cultivates an internal culture of observation and loosens attachment to personal identifications and impulses toward action. This deepens and expands empathy.

5. Value group process as a part of creative work.

A group setting allows multiple perceptions and ideas to emerge, and although the uncertainties that accompany such diversity engender anxiety, when the group is well contained, as is the case with a well-structured Balint group, this potential for new ideas thrives. Surrendering to the unpredictable process of a group's unfolding, particularly when the members are engaging with sincere compassionate integrity, locates the participant in the flow of an unfolding larger than the self. This is the nature of creative process itself. Creative process has its own life, its own intelligence. We need to bow to this life and allow ourselves to be informed and shaped by the process if we want to experience creativity.

Balint Groups work precisely in this

manner. As noted earlier, in a typical Balint group the presenter steps back to allow the group to take on the case. As group members begin to speak, they associate to one another's ideas as well as to the material given by the presenter – sometimes expanding on images offered, sometimes distinguishing a different idea relative to what has been shared. Sometimes complex collective conjectures may become articulated; other times the tension between different points of view becomes apparent. All participants engage in their individual ways, expanding their range of, and confidence with, empathic imagination. What occurs is immeasurable, and exponentially larger than the sum of the parts. Both presenters and group participants leave Balint Group with greater sensitivity to the nuances of emotional life which leads to change; often at times subtle, but profoundly valuable changes in how we participate in relationships.

6. The role of witness is significant to creative unfolding.

After leading a demonstration Balint Group at a conference in Seattle, one of the workshop participants wondered if this model could work in a leaderless situation with a group of peers. The subsequent discussion arrived at consensus about the significance of the leadership role. Participants said the presence of leaders provided a level of freedom that would not be possible without the presence of that function. What exactly is that function? Certainly the time-keeping and gate-keeping elements are significant, but I'd also like to draw attention to the role observation has in the vitality of creative process.

As my artistic work matured, I became vividly aware of how crucial the role of witness is to the emergence of creativity. What had been supported through training in a modernist value system – technical proficiency and replication of familiar forms –no longer gave me artistic satisfaction. To plunge deeper into my work required me to shift the nature of how I experienced my work to be received (both internally and interpersonally) from audience as admirers to audience as witness. I needed receptivity and mindful reflection on direct experience, not reassurance and accolades. Psychotherapists understand that this kind of interpersonal engagement also engenders intrapsychic change (and is the essence of how an infant is helped to grow his or her mind), but at the time I came upon this crossroads, I had not yet begun my studies in clinical psychology. I first learned of this through a dyadic exercise called Authentic Movement, and immediately knew I had stumbled upon a practice that could offer a life-time of support to creative practice.

This form was originated by movement therapist, Mary Starks Whitehouse, who had studied with pioneers of modern dance including Martha Graham. It was further developed and named Authentic Movement by Janet Adler. Based upon a dyad of mover and witness, it investigates embodied presence through movement and stillness: the inner life of the mover in the midst of what emerges and the inner life of the witness in the presence of what emerges. The mover closes his or her eyes and brings attention to his or her internal life. Following these inner impulses he or she enters into an embodied experience with mindful awareness of being with his or her inner life. The witness has a more complex role. He or she observes the mover and simultaneously observes his or her internal experience – a task that is direct exploration into the territory psychotherapists call "use of self." Psychotherapists know that although interpretations can be useful at times, a significant part of our work involves bearing witness to the experience of our patients. The creative receptivity of the witness offers containment which supports self-reflection in the patient and opens space for considering alternative possibilities. In Authentic Movement, one discovers that the quality of witnessing impacts not only what emerges from the mover, but also sets in train a process of internalizing the witnessing function and thereby developing the mover's personal observing ego. The witnessing function is potentially offered by all participants in a Balint Group and this is supported by modeling by the group's leaders.

7. Enjoy expression as a reflection of something beyond yourself.

This final point supports faith for engaging in a process, whether artistic or clinical, when it is confusing or frightening. There are common misconceptions about the role of self-expression in the arts as well as in personal development. In actuality, the artist is burdened when under pressure to express him or herself. The same pressure arises in our psychotherapy practices when our patients are anxious about the content of their dreams. Both dreamers and artists are better off when they can open their minds and become interested in what emerges from their dreams and from their exploration of various media (such as paint, movement, music), because our creative potential is diminished when we are concerned about being defined by what arises within the frame of sleep or work in the studio. When a dancer avoids particular shapes or rhythms of movement, she has less available to work with. It is helpful when peer consultants in a Balint Group, engaging their imaginative attention with the basic Balint Group questions, embrace and articulate the imaginative conjectures that arise rather than worry about what they may mean about oneself.

Returning to Deborah Hay, relieving one's creative process from the pressures of self-expression is explicit in her work. Her practices begin with the words seventy two trillion cells invite being seen in the practice of... and this would be followed with a question – usually, as mentioned earlier, a 'what if?' question. For

example, seventy two trillion cells invite being seen in the practice of What if I am the impermanence I see? Or, what if alignment is everywhere? Or, what if I admit dying into my living? She orients attention to the impossible task of imagining the intelligence of seventy two trillion cells. Her idea is that when she dances, it's not an expression of Deborah Hay. It's what arises when 72 seventy two trillion cells, each with their individual intelligence, are felt to be in relation to one another and engaged in the practice she defined. The past 30 years of cultivating this approach to performance has led to a distinctive aesthetic statement, making Deborah Hay's work internationally renowned and leading her to receive numerous prestigious rewards.

In conclusion, I'd like to share a thought I took from Christopher Bollas' book, Cracking Up, (1995) from a chapter entitled "What is this thing called self?" After discussion about various contents that possibly comprise a self, he writes: "the self is not the sum of the parts, it is creative intelligence"(p.166). Psychotherapy is help for those times when creative intelligence isn't working, and the use of self in our work as psychotherapists involves engaging our creative intelligence. I find the Balint Group Method an excellent way to cultivate the creative intelligence of therapists. I believe participation in a Balint Group, both as presenter and group member, expands and deepens the resource of "self" for the work of a psychotherapist by engaging in a method that offers containment and focus in the open-ended manner that supports creative process.

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War and Peace by Leo Tolstoy

Book Eight Chapter XVI

On receiving news of Natasha's illness, the countess, though not quite well yet and still weak, went to Moscow with Petya and the rest of the household, and the whole family moved from Marya Dmitrievna's house to their own and settled down in town.

Natasha's illness was so serious that, fortunately for her and for her parents, the consideration of all that had caused the illness, her conduct and the breaking off of her engagement, receded into the background. She was so ill that it was impossible for them to consider in how far she was to blame for what had happened. She could not eat or sleep, grew visibly thinner, coughed, and, as the doctors made them feel, was in danger. They could not think of anything but how to help her. Doctors came to see her singly and in consultation, talked much in French, German, and Latin, blamed one another, and prescribed a great variety of medicines for all the diseases known to them, but the simple idea never occurred to any of them that they could not know the disease Natasha was suffering from, as no disease suffered by a live man can be known, for every living person has his own peculiarities and always has his own peculiar, personal, novel, complicated disease, unknown to medicine- not a disease of the lungs, liver, skin, heart, nerves, and so on mentioned in medical books, but a disease consisting of one of the innumerable combinations of the maladies of those organs. This simple thought could not occur to the doctors (as it cannot occur to a wizard that he is unable to work his charms) because the business of their lives was to cure, and they received money for it and had spent the best years of their lives on that business. But, above all, that thought was kept out of their minds by the fact that they saw they were really useful, as in fact they were to the whole Rostov family. Their usefulness did not depend on making the patient swallow substances for the most part harmful (the harm was scarcely perceptible, as they were given in small doses), but they were useful, necessary, and indispensable because they satisfied a mental need of the invalid and of those who loved her- and that is why there are, and always will be, pseudo-healers, wise women, homeopaths, and allopaths. They satisfied that eternal human need for hope of relief, for sympathy, and that something should be done, which is felt by those who are suffering. They satisfied the need seen in its most elementary form in a child, when it wants to have a place rubbed that has been hurt. A child knocks itself and runs at once to the arms of its mother or nurse to have the aching spot rubbed or kissed, and it feels better when this is done. The child cannot believe that the strongest and wisest of its people have no remedy for its pain, and the hope of relief and the expression of its mother's sympathy while she rubs the bump comforts it. The doctors were of use to Natasha because they kissed and rubbed her bump, assuring her that it would soon pass if only the coachman went to the chemist's in the Arbat and got a powder and some pills in a pretty box of a ruble and seventy kopeks, and if she took those powders in boiled water at intervals of precisely two hours, neither more nor less.

What would Sonya and the count and countess have done, how would they have looked, if nothing had been done, if there had not been those pills to give by the clock, the warm drinks, the chicken cutlets, and all the other details of life ordered by the doctors, the carrying out of which supplied an occupation and consolation to the family circle? How would the count have borne his dearly loved daughter's illness had he not known that it was costing him a thousand rubles, and that he would not grudge thousands more to benefit her, or had he not known that if her illness continued he would not grudge yet other thousands and would take her abroad for consultations there, and had he not been able to explain the details of how Metivier and Feller had not understood the symptoms, but Frise had, and Mudrov had diagnosed them even better? What would the countess have done had she not been able sometimes to scold the invalid for not strictly obeying the doctor's orders?

"You'll never get well like that," she would say, forgetting her grief in her vexation, "if you won't obey the doctor and take your medicine at the right time! You mustn't trifle with it, you know, or it may turn to pneumonia," she would go on, deriving much comfort from the utterance of that foreign word, incomprehensible to others as well as to herself.

What would Sonya have done without the glad consciousness that she had not undressed during the first three nights, in order to be ready to carry out all the doctor's injunctions with precision, and that she still kept awake at night so as not to miss the proper time when the slightly harmful pills in the little gilt box had to be administered? Even to Natasha herself it was pleasant to see that so many sacrifices were being made for her sake, and to know that she had to take medicine at certain hours, though she declared that no medicine would cure her and that it was all nonsense. And it was even pleasant to be able to show, by disregarding the orders, that she did not believe in medical treatment and did not value her life.

The doctor came every day, felt her pulse, looked at her tongue, and regardless of her grief-stricken face joked with her. But when he had gone into another room, to which the countess hurriedly followed him, he assumed a grave air and thoughtfully shaking his head said that though there was danger, he had hopes of the effect of this last medicine and one must wait and

see, that the malady was chiefly mental, but... And the countess, trying to conceal the action from herself and from him, slipped a gold coin into his hand and always returned to the patient with a more tranquil mind.

The symptoms of Natasha's illness were that she ate little, slept little, coughed, and was always low-spirited. The doctors said that she could not get on without medical treatment, so they kept her in the stifling atmosphere of the town, and the Rostovs did not move to the country that summer of 1812.

In spite of the many pills she swallowed and the drops and powders out of the little bottles and boxes of which Madame Schoss who was fond of such things made a large collection, and in spite of being deprived of the country life to which she was accustomed, youth prevailed. Natasha's grief began to be overlaid by the impressions of daily life, it ceased to press so painfully on her heart, it gradually faded into the past, and she began to recover physically.

Students and their Patients:
Evaluating the UCL Medical Student Balint Groups

INTRODUCTION

Thank you for inviting me to give this lecture in memory of Michael Balint who had such a strong involvement with University College Hospital and its students over many years.

Medical students beginning their clinical studies go through an enormous psychological transition from being passive recipients of academic knowledge to engaging in active encounters with patients and illness and the clinical world of the hospital. For the first time they see people with life threatening illnesses, disability, disfigurement, and encounter death and dying. In our medical school, as in others, in their 1st clinical year, they now have special teaching on communication skills and ethical issues, and also have to follow up a cancer patient over many months in this 1st clinical year.

53 years ago, in order to help students to gain a deeper understanding of the doctor patient relationship, Heinz Wolff, Dorothea Ball and Roger Tredgold began a scheme for carefully selected outpatients to be seen by the students for one year of supervised once weekly psychodynamic psychotherapy (Ball and Wolff, 1963). This scheme has remained extremely popular with our students who found it helped them to learn to listen to their patients and to speak about difficult topics such as death and dying, to appreciate the value of continuity of care, and to recognise the significance of the patterns of dependency repeated by patients in therapy. Many have taken these skills into general practice and psychiatry. This scheme has always been limited in its size by the limitations of space, of finding enough suitable patients to be seen and of finding enough supervisors to offer expert supervision, so that in practise only 10-18 clinical students could join it each year, which is about 10% of the annual intake (Shoenberg, 1992).

Around the time that this Student Psychotherapy Scheme began Michael Balint started two long term discussion groups, which he referred to as seminars for medical students to talk about their experiences with patients (Balint, Ball and Hare 1969). The first was a group for students in the 1st six months of their clinical years and the second was a senior group for students lasting until their final year. In his paper about this experience which lasted for seven years, Balint made a plea for developing patient-centred medical teaching as opposed to illness-centred teaching. It is clear from the cases presented that his students got to know their patients very well and were able to discuss their experiences with them at a very deep psychological level in this group. For reasons that are not clear this work with students did not continue.

For a few years after 1998 we received support from the Winnicott and Melanie Klein Trusts and the Academic department of Psychiatry for 3 psychoanalysts- Abe Brafman, Fakhri Davids and Ronnie Doctor- to run 3 short term discussion groups for students attached to the psychiatry firms in their 2nd clinical year. These groups ran for four sessions and they allowed students to reflect on the impact of seeing mentally ill patients.

However in 2004 when we were faced with an increase in the medical school's annual intake of clinical students from 180 to 360, Heather Suckling and I decided to offer the 1st year clinical students an alternative to our Student Psychotherapy Scheme by reintroducing Balint groups in a modified form (Shoenberg and Suckling, 2004): the students were invited to participate in a weekly Balint discussion group which was to last only three months. Heather and I found this experience with our 1st group very rewarding, even though it could not go as deeply as Michael Balint's original groups did. This development has eventually allowed many more 1st clinical year students to benefit from a psychotherapeutic teaching approach than was previously possible. With the Vice Dean Margaret Lloyd's help, this has now been included in the curriculum as a Student Select Component: because of being a Student Selected Component it generated enough university funds to pay for two group leaders for each of ten groups, one a Balint leader from general practice and one a medical psychotherapist from our department. At the end of three months the students are expected to write a reflective essay on their experience with a patient and how this has been influenced by discussion in the Balint group. Nowadays up to 100 students participate a year in these ten Balint groups running either in the spring or the summer terms. So, up to 30% of the annual clinical intake gets one or other special psychotherapeutic teaching.

The experience of running a student Balint group has proved inspiring and moving, as the students are so enthusiastic, sensitive and imaginative. Sadly their encounters with their patients, apart from with their cancer patient, are extremely brief, mirroring both the new shorter stays of their patients on the wards, and their own rapid changes from one medical speciality to another. Often they only see a patient in groups of 2 or 3 students, so that individual patient encounters are less common nowadays. Today I want to discuss some of the ways we have evaluated these student Balint Groups at UCL, firstly by describing some of our experiences of these groups and then by speaking about a randomised control trial of the effectiveness of our two psychotherapeutic teaching methods that Jessica Yakeley and I recently conducted on 28 students .This trial was done with help of the statistician Richard Morris and 3 independent

raters David Sturgeon, Sarah Majid and Dick Joyce (Yakeley, Shoenberg, Morris, Sturgeon and Majid, 2011).

BALINT LEADERS' EXPERIENCES

The Balint groups provide the students with an opportunity to explore a number of themes. Heather Suckling and I found in the first Balint group we did in 2004 that initially the students discussed several cases briefly in the early sessions and more time was spent on general issues, but as the students became more confident they began to discuss individual cases in greater depth. Often in the initial groups students speak about their anxiety that they have no real role and of their concern that they are exploiting the patients in order to learn to become doctors. Later they begin to explore their communications with patients in a more positive way and begin to appreciate their value to their patients.

I would like to describe some of our experiences with the student group that Sotiris Zalidis and I ran this spring:

In our first group this year, a student Theo, told us about an 80 year old woman brought in after collapsing in the street. The registrar asked him to clerk the patient but when he went up to her she angrily told him that she did not want to talk to him. He told the Registrar who insisted he returned to take a history, saying that if he was a junior doctor he would have no choice. He felt it wasn't fair to make this woman speak to him, but decided to do as he was told. On returning he was surprised that she now accepted to see him; as he went through the history he noticed that she couldn't remember what had happened to her and was unaware of what was going on; he thought she might be confused. The group considered Theo's conflict for Theo about doing what the Registrar wanted rather than following his conscience. Someone said that being rejected by a patient can make you lose your confidence. Melindi said that if she were rejected by a patient, she definitely would not have returned.

Jonathon thought Theo's experience was similar to the experiment where people were made to give electric shocks to somebody and it was found that they too easily followed the dictates of authority rather than the dictates of their conscience. Theo felt that he was only a student and that he had nothing to offer the patient; the others were worried that they were not actually contributing to their care.

In another of the early groups, Jonathon told us about trying to take blood without succeeding. When he offered to try again, the patient said "get me someone who knows what they are doing". The registrar told him off, saying that the blood sample was needed urgently, which made him feel guilty. He said that he had never failed to get blood before. It also worried him that he had caused the patient unnecessary pain.

Hanna remembered being helped by a registrar to learn to cannulate a patient. The others agreed that it was better when somebody was there to hold your hand. Others commented that it was all right for a doctor to go on trying but not for them. I said it seemed the discussion was about their fear of hurting the patient versus their fear of being humiliated by the registrar.

As the groups went on the discussions focused on the problems of communication: Margaret told us about an elderly man who had approached her in tears during a tutorial, saying "do you know that I am dying?" She didn't know how to respond. The junior doctor told him to go back to his bed, but the man now said that someone had tried to strangle him in the night. After the man had left, the doctor said he thought this man was paranoid. Margaret spoke of the contrast between her initial concern when she had heard the man saying that he was going to die and her subsequent feelings when she realised that he was confused. Jonathon suggested that as he had been admitted with respiratory distress, his difficulties in breathing might have felt to him as if someone was trying to strangle him. They all felt that the doctor had behaved too dismissively when this man was so clearly frightened. Arthur said as students they were different from the doctors who became desensitised when they saw this sort of thing so often, whereas they were still surprised and shocked by such events.

In another group Melindi spoke about an elderly Bangladeshi man who was calling for help for his pain. The first time she saw him she felt influenced by the nurses who told her not to get involved because this man complained too much. However the next day she learned on the ward round that this man had had a colonoscopy and that his bowel had been perforated. Now she felt badly about her initial dismissive reaction towards this man and returned to talk to him. The man spoke Bengali, which she couldn't speak but she realised that he might understand Urdu which is her language; but his voice was very indistinct so it was hard for her to work out what he said and she often had to repeat phrases. He told her that he wanted to be helped back into bed. She called a nurse who said she would have to get a hoist for him. She waited with the man, keeping a conversation going and eventually she returned to the nurses' station where she found the nurses talking. They said they would come but they still didn't come to help him for some time. She felt upset about the whole experience, particularly when she learned that this man had developed necrosis of his bowel and the surgical team where worried about his condition. The man said he thought they were all liars.

I wondered why they thought the nurses had taken against this man. Arthur said he thought the language barrier was an issue and then Jonathon said that if the man had been white and middle-class then he might have got some attention. Hana described a patient whose children were a lawyer and a doctor where the nurses behaved differently. In fact Melindi noticed that the nurse behaved in a better way

towards the man when she had thought that Melindi was a relative; then she changed back to her old manner when she realised that Melindi was a medical student. The group were shocked. Tahir talked about a report about the mistreatment of elderly patients in hospital and wondered if this man's age had contributed to his neglect by the nurses. He hadn't wanted to eat any of the food he was given; Melindi had offered to go to a nearby Indian restaurant to get food for him but he had refused. Sotiris wondered if in fact she had become this man's advocate. He thought this man might have been very angry about what had been done to him by the surgeons. Tahir said that people from his part of the world took such events in a different way from Westerners.

In another group a shy and usually silent student, Arthur, presented a middle-aged man with chronic obstructive airways disease, who had welcomed him, saying that he was glad to help students to learn something. He talked of his life before he had become ill: he was a keen sportsman and seemed to be coping with his illness with a positive attitude. Arthur, a keen footballer, who was wearing an Arsenal supporters' shirt in our group, had clearly identified with him. Then, as he talked about his family, he burst into tears speaking of his son who had died at a young age. Arthur didn't know how to handle this situation: he had been told that if a patient became very emotional, the student should not do anything to make the situation worse .He asked the group what they would have done, as he had felt reluctant to ask more questions for fear of spoiling the man's positive attitude. Some students felt that he shouldn't make the man more upset by probing into the story of the death: one said he couldn't imagine what it would be like to experience the death of a child. Two other students said that it might have been worth asking this man if he wanted to talk about his son. They spoke of the pressure they were under to produce a good medical history as opposed to feeling they could spend time listening to the emotions of their patients.

In a review made of 3 separate groups she conducted, Heather Suckling recorded a total of 63 cases as having been discussed and identified 17 themes, of which the following 10 were commonest:

1. The students' role.
2. Confidentiality.
3. Consent.
4. The very ill patient.
5. Death and dying.
6. Revulsion towards patients.
7. History taking.
8. Professional boundaries.
9. The student-patient relationship.
10. The doctors' behaviour.

The students in their feedback reported that

1. Participation in the group increased their confidence.
2. It improved their communication skills.
3. It encouraged whole patient medicine
4. It encouraged reflection
5. It provided support
6. It increased their enjoyment of their work (Suckling, 2005).

THE RANDOMISED CONTROL TRIAL

This randomized controlled trial Jessica Yakeley and I conducted, aimed to evaluate the effectiveness of the Student Psychotherapy Scheme (SPS) and participation in a Balint group in teaching students about doctor patient communication and the doctor patient relationship. These students had originally attended our annual introductory lecture about the two schemes and had then been interviewed to assess their suitability to see psychotherapy patients. Thirty students were originally allocated to the study and were then randomly allocated to 3 groups each containing 10 students in: a Student Psychotherapy Group (SPS), a Balint group starting at the beginning of the trial and a Balint group starting at 3 months (so acting as a partial control) – they were then rated on a questionnaire, testing their knowledge of emotional and psychodynamic aspects of the doctor-patient relationship administered at the beginning, at three months and at one year.

We decided not to have a pure control group, as many of the students volunteering for the research had opted to do the SPS or a Balint group for their SSC. Both Balint groups were run by the same two group leaders, to avoid any variation in the style of the group leaders which might have interfered with comparisons between groups 2 and 3.

The following questions were asked and the students' responses were rated according to a guide.

1. What effect can the relationship between a doctor/student and patient have on the patient's overall care?
2. How may a doctor's/student's feelings be affected by a patient?
3. How may a doctor/student use those feelings in relation to the patient?
4. How do you cope with your anxiety and uncertainty in your work with patients?
5. Do you feel that the relationship between the doctor/student and the patient should be an equal one? If not, why?
6. Why is it important to understand the nature of the patient's attachment to the doctor/student?
7. How do you recognise emotion in a patient when it is not verbalised?
8. Please comment on your experience in this project.

These are examples of our guide for marking the responses: An 'ideal' answer was to include reference to all of the following ideas for each question.

1. What effect can the relationship between a doctor/student and patient have on the patient's overall care?

A good relationship can promote trust between the doctor/student and patient which will

(a) Allow the patient to confide and so give a fuller history,
(b) Help patient to comply with treatment,
(c) May help the patient to recover from their illness,

If the relationship is a poor one, it can have a very negative effect on patient care.

4. How do you cope with your anxiety and uncertainty in your work with patients?

(a) Acknowledge that I can sometimes feel anxious or uncertain
(b) By trying to reflect on why I am anxious or uncertain
(c) By discussing these feelings with a senior colleague.

5. Do you feel that the relationship between the doctor/student and the patient should be an equal one? If not, why?

(a) Although a doctor should respect the ideas and views of the patient, the relationship between doctor and patient cannot be an equal relationship.
(b) A doctor/student cannot impose his own difficulties on the patient.
(c) A doctor/student can expect that many patients will develop a dependence on their doctor/student.
(d) The reverse may also happen in that a student/doctor may come to depend upon the patient.

Results:

Shortly after the research started, two students dropped out of Group 1, one due to illness, and the other as she decided she could not commit to participating in the SPS after all leaving 8 students in Group 1, 10 in Group 2 and 10 in Group 3. At time 1) 25 of 28 students returned completed questionnaires, at time 2) this had dropped to 14 of 28, but by time 3) i.e. at one year, we achieved a return rate of 22 of 28.

We took the mean score of the three raters for each student, and from this calculated the mean score (and standard deviation) for each group at each measurement time.

Table 1

Group	Time 1	Time 2 (3 months)	Time 3 (1 year)
SPS	6.7 (3.0) (n=8)	7.7 (1.4) (n=4)	8.0 (3.1) (n=8)
Balint Group 1	6.8 (1.2) (n=8)	7.6 (1.7) (n=5)	8.3 (1.8) (n=7)
Balint Group 2	6.0 (2.2) (n=9)	5.4 (1.7) (n=5)	7.4 (0.8) (n=7)

Standard deviation is in brackets.
n = the number of students who filled in the questionnaire.

At 3 months the mean difference in scores between the SPS and Balint Group 1 was negligible (adjusted difference in means 0.1, 95%CI -2.5 to 2.6, p=0.96). However the difference in scores between the SPS group and the partial control Balint group 2 approached statistical significance at the 5% level (adjusted difference in means -2.2, 95%CI -4.8 to 0.4, p=0.083). Similarly, the difference in scores between Balint group 1 and the partial control Balint group 2 was approaching significance (adjusted difference in means -2.2, 95%CI -4.6 to 0.3, p=0.076). However, this was based *on only 14 students* at this time.

At time 3, i.e. one year, there was no significant difference between any of the three groups, however *the mean difference in scores (n=21) between the start of the project and one year was highly significant* (mean difference =1.5, 95%CI 0.6 to 2.4, p=0.0023).**

The main findings were:

1. A significant improvement in the scores compared to baseline scores in all three groups at one year, after the students had all participated in one of the two teaching methods.
2. The finding at three months that the scores of the two groups who had participated in the SPS and Balint groups showed a trend that did not quite reach significance, towards higher scores compared to the control group who had not participated in either intervention at that stage. These results supported our initial hypothesis in suggesting that the interventions were effective in increasing students' knowledge of the doctor-patient relationship as compared to students who did not receive such teaching experiences.

There were important limitations to our study:

1. There was no control group at 1 year so we do not know if the improvements seen might not have been accounted for by other factors such as the students' encounters with physician-patient interactions.
2. The numbers of students participating in the study were very small because we could not have a large sample for the Student Psychotherapy Scheme.
3. The questionnaire tested their knowledge at an intellectual level, and we do not know how much this acquired knowledge translated into actual improved communication skills.
4. Our ideal answers to the questionnaire may have assumed a greater potential in the students for learning about the doctor patient relationship than was possible with such a short exposure to these psychodynamic teaching approaches, which may explain why the changes in the three groups were relatively small.
5. The inter-rater reliability was not perfect, with the observers having different overall mean scores, and a less than ideal correlation between the scores.*

CONCLUSION

The results of our study suggest that both our psychotherapeutic methods of teaching help medical students to learn about the doctor patient relationship and as such are useful additions to the undergraduate curriculum. Whereas running a Student Psychotherapy Scheme requires considerable resources, as well as complex

clinical governance and ethical issues, and can only be available to a small number of students, Balint group teaching, which also requires experienced group leaders, can accommodate many more students due to its shorter duration and its group approach. This also has the advantage that as a Student Selected Component it can be included in the curriculum and as such generates university funds which pay for an adequate number of Balint leaders. Student Balint groups have been used in several countries, including Germany (Sollner, Maurer, Mark-Sternberger and Wesiack 1992), Italy (Castiglioni and Bellini, 1982), Switzerland (Luban-Plozza , 1989 and 1985), South Africa (Levenstein 1980), Poland (Jugowar and Skommer 2003), Finland (Torppa, Makkonen, Martenson and Pitkala 2008) and the United States (Brazeau, Boyd, Rovi and Tesar 1998). Michael Balint wanted all the 1st year clinical students to have the experience of participating in an initial 6 month group. I suspect that if such teaching became obligatory rather than an option some of the aliveness and imaginative quality of the groups would go, but I do think that there could be an enormous value in offering some students the chance to be in a group for 6 months.

We see in these groups how students begin to see themselves as future doctors with a responsibility for another person: in this process changing from feeling mere observers, of little use to their patients, to realising that their listening and caring skills are at a premium; this is often in settings where they turn out to be the only person with enough time to consider the emotional aspects of the patient's illness. So we believe that the Balint group experience helps them to appreciate the significance of emotions in medical illness and with that to appreciate their true value as students for their patients.

Arthur the rather shy and silent student who was reluctant to explore the death of a patient's son with him when this came up in his clerking wrote in his reflective essay:

"When the majority of the group seemed not necessarily to agree with what I had done I felt defensive feeling that if they had been in front of him they would have acted similarly, but then I saw my patient with respiratory disease two days later. He joked with me 'I'm invisible, I've been discharged'; I realised there was a strong bond between us and thought of the comment by one of the Balint leaders that as a young man I might have connected with him as he might have seen me as having similarities to the son he had lost. This allowed me to interact with him on a more meaningful and personal level. I realised he was interested in my education and my love of football. Now I think about my hesitation to speak about his loss when he got so upset. I can see that by simply asking whether a patient wishes to talk more about an issue means you give yourself the possibility of learning more about the patient on a more personal level while giving the patient the power to make the decision about where the consultation is going.

** Recorded scores at all three time points were pooled, giving 62 data points for which comparisons could be made between the three observers. The mean scores for all students at all time points were 6.8, 5.6 and 8.7 respectively, and the within-student standard deviation was 2.4. The correlations between scores of pairs of observers ranged from 0.49 to 0.65.

* If the observers had been blind, any biases should not have affected differences seen between groups at 3 months. Since only one observer commented that they were not blind when making assessments, the analysis was repeated with that observer's results omitted. Results were essentially unchanged, with magnitudes of differences among groups being very similar to those reported. Indeed, the lack of reliability would have tended to mask true effects of the intervention, so we believe the poorer performance for the control group at 3 months is likely to be real.

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A developmental view on FYI, FY2, Core Trainee, SpR and Consultant Balint Groups

Dr Gearóid Fitzgerald

I work as a Consultant Psychiatrist in Psychotherapy in a Psychotherapy department in Leeds. I trained as a psychoanalyst at the Institute of Psychoanalysis in London. I wanted to describe the Balint Groups that we do as I think they are a very important way of introducing young doctors to a way of thinking about themselves, and themselves at work. My thinking was influenced by a conference I went to in Budapest in 1996 where I saw a Balint Group that could be done where a presenter presented their case for 10 minutes then withdrew from the group for the rest of the discussion and then came back in at the end. That is the model we use in Leeds.

Before doctors come to a group, they are invited to a business meeting where we go through a Learning Contact where we read what a Balint Group is, the statement of the Balint Society and a Learning Contract that tells about time and expectations of presenting a case, confidentiality and the basic structures that allow a Balint Group to have a space to be helpful.

I also wanted to take some time to review Michael and Enid Balint's core concepts because I think they are phenomenally useful and they have become so well known that people think they know what they are. I think they are like most psychoanalytic concepts as it does depend on the subtlety of their use in the present day context to allow them to be really helpful. I think they are both verifiable in these groups that I am going to describe and underpin the doctor-patient relationship. I think the language of the doctor-patient relationship has changed in how it is presented to you. It seems to me the language of the relationship has become more cognitive. For example, the Foundation Year doctors seem to speak about communication skills and I think the doctor-patient relationship is hidden in that view of the doctor-patient relationship; it stands behind it in a way.

I do not want to generalise my observations but a number of words are used by doctors at particular times of training in which are embedded a whole range of fantasies that I think are a hidden version of the apostolic function, valency and hence the doctor-patient relationship. Communication skill is one, being professional is another we hear a lot from the Core Trainees which seems to involve two ideas. The first is of being able to be personally unmoved by anything you are presented with. The second is that one should be able to manage to get the patient to do what the doctor feels they ought to do and if one does not then one is failing and that any personal feelings are seen as a professional failure.

I think when one listens to these groups over time, one does begin to get a sense of an apostolic function that is both developmental and personal. I think that Balint's description is terribly helpful because he says, "It is a fallacy of common sense where a doctor has a set view which is unconscious, unstated and unformulated as to how a patient should be and how a doctor should be."

I think Enid Balint brought this on again by linking it with the counter transference in that these unconscious, unformulated, unstated orientation points become manifest through the feelings evoked in the doctor. If one listens carefully to the feelings that are presented in the dilemma, one might get a sense of what is going on in the doctor-patient relationship, hidden out of view. I think this is very clearly picked up in the emotional tone of the consultation which can be communicated in a group.

I feel it is easy nowadays to shut things down and use formulation as a desiccated way of knowing the patient in a very pseudo-scientific way but my understanding of a Balint Group is the aim is to open up a field of speculation where the person might be surprised in their next encounter with the patient or with a patient who reminds them of the presenting patient. I have noticed that sometimes we do formulate in our groups, particularly in the Consultant Group and in the SpR Group and I wonder about that tension between keeping a very strict view of the doctor-patient relationship and sometimes, is it helpful to that aim to help them formulate the patient?

In an aside in his first book, "The Doctor, his Patient and the Illness" Michael Balint comments that some patients seem to be determined to have a bad doctor-patient relationship. Now in psychiatry where I work, the majority of patients seen by doctors of any grade usually seem to have personality disorder alongside a possible mental illness. I think this is a particular type of doctor-patient relationship that can be quite brutalising for any doctor but particularly for doctors who are training and who are therefore a bit more open to what might be impacted upon them and communicated to them in this way.

It is interesting that the counter transference with psychotic patients with psychiatrists is completely different to that with personality disordered patients. It is here that there are certain key words (a shared code) that doctors use in the group. They all share this and a knowing nod can run around the group. It is almost like a process of listening to a different language for a while until one gets to translate these subtle codes that they use to distinguish the patients in quite a subtle way, and implicitly their feelings about the patients,

We run a group for Foundation Year doctors that meets weekly. We provide tea, coffee

and biscuits and I led the first group with an SpR. The SpR now leads it on his own. In this group, they have been very interesting because they have been the most open and thoughtful – even those not interested in psychiatry. They have taken to it in a way where they found it a relief where they can talk about how they actually feel rather than always having to do something pseudo-scientific about communication and managing in a cognitive way.

Case 1

Towards the end of the 4-month placement, an Arab doctor decided to present for the group. He is usually late for the group but he was on time because he wanted to present a case that troubled him. Some of the others knew the patient as he had admitted her and she had been admitted to a ward where one of the others covered. He had been very concerned for the patient when he saw her. What followed was a complicated story of a 30-year-old patient on her way to a city further north who had returned from abroad. She had presented as very depressed and suicidal and had got off a train in Leeds and presented to the Emergency Services. It was a very complicated story to follow although to the doctor, it seemed to make perfect sense. She had been on one continent (America) for a number of months and then she had been in Australia and then she had been somewhere else. Then she had returned to this country because her father was ill but she had taken an overdose on her way to going to see her father, whom she said was dying, in Edinburgh. She seemed convincingly suicidal to the doctor. As she had no home, she was admitted. He was very concerned for her and checked up on her on a number of occasions and completely believed her. He felt they had a good doctor-patient relationship and he felt he had got a good history. On the ward over 10 days, he found out that none of her story was true and that she had made it all up. He felt more and more embarrassed that he had believed her and she discharged herself when they were going to – as he put it – confront her with the truth. Two days later, he had taken a call from a hospital further north where she had presented again with the same pattern.

He spoke of his dilemma – as he put it – because at the end, I ask them to identify a doctor-patient dilemma. I wonder if this is something that other people might not do. He said he felt that he was coming to the end of his placement in psychiatry and he felt that all he had learnt was useless because he had been completely taken in. He felt he had got a handle on psychiatry. He sat back. One of the other doctors spoke quite quickly and the group were quite animated. They talked about how – and the doctor had mentioned this in passing – the doctor felt he was clever but he felt that he had been fooled and this was the theme they had picked up: the thrill of the chase, the taking of the history, how some of it is about getting it right and almost getting one over on the patient and stopping the patient fooling you. I commented that it felt that the doctor seemed to me out-manoeuvred in the doctor-patient relationship and wounded in his pride by this.

They all agreed and then they went on generally to say that with personality disordered patients they felt that quite a lot. They talked a lot about how when you assume in the doctor-patient relationship they are telling you the truth but they are not, you could end up disbelieving everybody and becoming quite cynical. On the other hand, there was this sense that if you believe people then you would get very hurt and made a fool of. The predominant feeling was this sense of intellectual thrill and satisfaction – shared by three men in the group more than the women - of the sort of predatory nature and dominating nature of being the doctor. The doctor returned and he agreed with the thrill of the chase and he picked up the wound to his intellectual pride and how he felt that he knows nothing. Then there was a pause. I remarked that I found the story quite complicated and he had seemed to see it as quite normal. There was a long pause and he said well actually to him it was because her story made sense to him in terms of his family and how they have all gone all over the world to study and how they move between continents quite easily. He felt that in some way he had empathised with her and then she had used this in a way that had blinded him. Then they began to discuss about communication skills and how a feeling came across that their fantasy of communication skills was finding the right words and body posture to get the patient to do what they want. We finished there.

Case 2

The next group is a Core Trainee Group. It is a group of 12 CT1s and it meets weekly for 9 months. It is set up in the same way and I lead it with no co-leader on this occasion. One quiet female doctor wanted to talk about a case. She felt very badly because she really disliked this patient and did not want to have anything to do with him. She felt guilty because the patient zoomed in on her all the time. The patient was a 25 or 26-year-old male at an Acute Day Service who was self-harming and depressed and he asked for regular medication reviews with her every day or every two days. These were pointless, longwinded and he never did as she suggested. They talked and talked with him and he would agree but then never did what had been agreed. In this story, her communication skills were emphasised and her wish to be professional: how she talked to him and gave him all the information and the date in a very technical way but somehow she thought he was not going to do anything and she thought that he knew. She retired after some questions and there was a long, involved discussion about communication skills and being professional.

Gradually, it dawned on me and I said to them that it seemed that it was not professional to have negative feelings about a patient. They

agreed and felt that something could be done or should be done to make him comply. Then I said it seemed to me that it might be something about feeling helpless and blaming yourself for not being able to get the patient to do what you felt they should do. There was a discussion and then out of the blue, one of the doctors said they wondered why this patient targeted this doctor when they knew there were two other more senior doctors in this service as well. There were various polite comments about maybe this doctor was more helpful and more available and more thoughtful. I said that he was a young man and maybe there was something else going on as the doctor was a woman of a similar age. There was a silence for a bit and someone leapt in and said something sexual which actually shut down the conversation and it became quite desultory.

Another doctor said it seemed like the other doctor was trapped in a pointless conversation yet if she had to do it then she would feel very angry. Then the women in the group began to get livelier and talked about feeling intimidated by young, male patients about which the young male doctors seem perplexed. The doctor came back in and said for her the sexual thing was what had disturbed her. She realised as we were talking that she felt – as she put it – "slimed by him". She knew it was a pretext and he knew it was a pretext. She hated having to be friendly towards him and felt helpless and forced to talk and be professional when actually she knew this was not really the dialogue that was going on. Some of the doctors picked up on the fact that she had said "hate" and it is a strong feeling and she said that is what she thought she felt. She had called it "angry" initially but then thought not.

Case 3

In the next group, there are 8-9 SpRs who meet weekly. They cover more psychiatric specialities: there is the Forensic SpR, the Child & Adolescent SpR, 4 General and one Old Age. I think it is the only forum where these specialities get together. This Balint Group had been requested by the participants as they had all been in a Balint Group as Core Trainees and they wanted to have a group when they became SpRs. It is a very different group and in some ways, it feels quite stuck as the potential I saw in all of them for being bright and able to free-associate seems to have been suppressed in some way and the group regularly gets consumed by questions about risk.

On this particular day, a quiet Asian female trainee presented a case of a woman presenting to a Specialist Service. This patient had campaigned to be re-referred to the service which had quite strict criteria and had been accepted. The doctor was very disturbed by the woman as she found herself really disliking her and actually actively wanting to be cruel to her. The doctor felt this in herself and felt very disturbed by it. She withdrew.

Initially the group discussion was all about this difficult, horrible patient and formulating the patient essentially in terms of the transference that she was re-enacting. I pointed out that the doctor was disturbed and seemed to be upset by her wish to be cruel to the patient but we all seemed to just see it as some re-enactment of something. There was a general rebuttal of that and a general sense of weariness and questions about whether she should be discharged and talks about risk and the threshold for help and ticking the boxes and the complaints procedures. I said it seemed as if it was really hard to think about the doctor-patient relationship and there was not much point to it. It seemed to me that they were saying that personality disordered patients were like this and they said yes, it was a personality disorder patient.

The doctor came back in and felt upset by this discussion as she had been upset by her wish to be cruel. She felt it was unhelpful when it was said that perhaps it was a scenario that was being re-enacted in the doctor-patient relationship. However, this was not quite it. What she had felt if she had listened to us talking was that she had felt disgusted by the patient. Then there was a very lively discussion about what was meant by disgust when you found a patient disgusting. It touched lightly on various things such as the link with eating and refusing to take food and making a fetish of her body and the way the doctor described this patient exercised to get a flat stomach. The other doctors linked this with the doctor having had a baby and she felt it was something about femininity.

We had to finish there just as the group felt as though it was coming alive.

Case 4

Then there is this material from the Consultants' Balint Group which has been ongoing for 4 years and is a mixture of consultants who work in outpatients, inpatients and Learning Disability. It is co-led by myself and another Consultant Psychiatrist in Psychotherapy colleague.

A female consultant presented a patient she was seeing who had been discharged by the CPN as the patient (a 40-year-old man) could not engage with any work. The patient had made four serious suicide attempts and was talking about hanging himself and had taken overdoses. She never knew from one consultation to the next if he was going to kill himself. Her dilemma was that she was not sure what to do about him but she did not feel she could discharge him. Initially, there was a lot of discussion about risk and the Trust's attitude to risk and formulating the patient with a lot of psychoanalytic terms.

At the end of the discussion, I said I thought the doctor sounded very alone in the doctor-patient relationship, that everybody else could discharge him but her. In the history, she said that there had been a huge number of other professionals involved but they had all discharged him as he did not comply. Then there was a

general – and I thought moving – discussion about being left alone and feeling lonely and how she had to bear this patient. One doctor had said he thought the patient was unbearable and playing with her in a cruel way and that he would be angry. Another doctor said he would 'cover his arse' but would 'not be so bothered'. Gradually, it evolved as to why the doctor was so bothered about him in this way.

The group had been running for a while and so the co-leader said he thought that one of the things that seemed to come out was that the doctor felt in the doctor-patient relationship she was obliged to rescue him. After some discussion, I pointed out that it seemed more about making sure they rescue themselves from being blamed for not managing risks and I could see they were a bit irritated by me as I was sitting in my ivory tower, they seemed to imply.

The doctor came back in and she felt that she felt terribly burdened with him and did not feel as if she had a space outside the group to think about how she felt: trapped and corralled by him and by risk by this man. She felt very alone and unsupported where she worked even though there were a lot of people around who were friendly. She did also know that she does get drawn into rescuing him but the problem was that she also liked him which was difficult for her, that there was something likeable about him.

Conclusion:

While I was thinking about the title, I became aware that in the present context of continual changes in the NHS and a certain double-speak, certain aspects of the doctor-patient relationship appear to have changed and become more difficult. The fact that one can realise that having feelings about a patient is not unprofessional but that it is potential data, is in itself useful and something very new for junior doctors. In the Foundation Year and Core Training Groups, it seems to free them up. The conflict there seems to be with an apostolic function developed in medical school, where a good doctor-patient relationship leads to the patient doing what you want them to do because that is what is best for them. The mechanism for this doctor-patient relationship is communication skills, magically opening the door to a good doctor-patient relationship. The other idea is being professional which means being neutral in terms of feelings and seeing it as a personal failure that a patient has provoked personal feelings in one. In a sense, that means then that they are left identifying with a projection and most feel very guilty and ashamed. Once they begin to realise that there is something that happens that might be useful to think about in terms of the patient and that they are not going to be persecuted and analysed, they seem to take to it quite well.

Having done both SpR and consultant groups in the UK, what struck me is the absence of using literature, books, films or art to metabolise one's experience in psychiatry. I think what I mean is what gets suppressed and killed off is the capacity to free associate or to use one's unconscious and other aspects of one's life to help one metabolise what patients are presenting to you. I think the medicalisation and the protocols and the policies seem to play a large part in suppressing this. I guess the unspoken Balint group-doctor relationship that they brought was that it is to help them intellectually formulate and by knowing that they can manage all the risks and burdens they have to bear, as they are in an invidious position of being left with the risk but being told that for any mistake they will not be blamed for, but actually will.

Underneath, in the Balint groups for consultants and SpRs, there was a sense of disempowerment and paralysis almost as if they were under siege from both patients and Trust policies, and yet none of them felt able to take a stand. It was clear at times it was not possible for them to say anything about their experience to people in charge. They seemed both battered by the changes and the real dismissal of their skills but at the same time felt they had to go along with it. Yet, they keep attending and there are some very lively discussions about disturbing patients. I wonder if maybe part of running a Balint Group is to work through the context back to what is happening because I think maybe one can be invited in these groups to just get caught up in the external. But what comes out more is a sense of shame I think in the service they are obliged to offer as they know it is not enough or it is not what they would do if they had their say. This leads them I think to blind themselves to the real doctor-patient relationship in front of them as it will carry obligations and demands and pleas and these frequently go back to a more policy-protocol driven way of relating. Occasionally, in these groups there is a nugget that comes out that allows one to get back to the doctor-patient relationship through the context. I think this keeping one's eye on the internal is important, particularly when all of the external changes are so rampant and unpredictable at the present time.

In a sense, I have tried to describe - in a very un-generalise-able way - a series of groups across the professional trajectory of psychiatrists and how one can begin to see things but essentially, I have begun to describe the usefulness of Enid Balint's and Michael Balint's core constructs in the present day.

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'Balint work and younger doctors'

– a talk given at the Institute of Psychological Medicine, 5th November 2011.

Dr David Watt

Good afternoon. I am David Watt, a GP in a large general practice in Newham (the Olympic borough). We are 8 partners, in our own purpose-built health centre near the London City Airport, and look after over 15,000 patients. I am also secretary of the Balint Society, something I have been doing for about 15 years. The past president, Andrew Elder, and I approached the IPM last year, and with the IPM's hard work today is the result: a day for our two societies to catch up with each other, hopefully as old friends sharing a common background. My brief for myself is to let you know something about current Balint group activity in the UK, and I will do that by talking about my own activities with groups over the last few years

I am going to talk about three groups that I have been involved with. Three groups for different groups of young doctors: one for Vocational Trainees in General practice, one for FY2 doctors in a local district general hospital, and one for medical students in the same DGH. These are a long way from the first Balint group set up by Michael Balint in the spring of 1954. They do, however, have strong links with his original thinking, how it evolved during his lifetime, and how it was subject to modification after his death, when his wife and co-worker, Enid, influenced the way Balint Group practice developed world wide.

The first Balint group was set up by advertising "introductory courses on psychological problems in general practice" in a medical journal where practising GPs might see it. You might not be surprised to find out that my GP trainer, 23 years ago, Dr Philip Hopkins, was in that original group. From Michael Balint's point of view the purpose of the group was to research the doctor patient relationship (the drug doctor) and also hopefully to find a way to train GPs to be able to better help patients with psychological needs. They were flooding through the doors of the single handed practices in the early years of the NHS, as they still do today into our larger and often less personal group practices. At that time he wrote that the only formal psychotherapeutic training was that of psychoanalysis, and that this was not appropriate to the ordinary practice of medicine. In the surgery there were hundreds of patients, rather than the select few in psychoanalysis. He characterised the psychoanalytic training system as working on the "expensive principle of the more the safer". He wanted to spread psychoanalytic thinking more widely for the benefit of patients. Three years later the groups, which he labelled as "training cum research", led to the publication of the seminal book, "The Doctor, His Patient and The Illness", in 1957. In appendix I of this book, entitled Training, are the seeds of much of the current variations in Balint work around the world. The chapter is primarily meant for prospective group leaders, at that time psychiatrists, and not GPs. For instance, he wrote that he would like to try such a group with registrars or senior housemen in a "not too small DGH". He also wrote that he did not think such group work would be suitable for medical students as they would not have enough life experience. Appendix II is entitled Selection, dealing with who should be in groups. Apparently the initial group or groups were unselected (he accepted all doctors who applied) and had about 60% drop out rate. He wrote that he decided to interview applicants carefully to try to reduce this, and managed to reduce to about 35%. I raise this as one of the complexities of modern Balint groups is that they may be compulsory, let alone carefully selected. One of the aims of classic Balint work is to make possible modest personality change in the doctor to enable him or her to be more sensitive to psychological problems. How can one possibly "make" this happen in a group with compulsory membership- and is there still benefit if less is achieved?

Now back to my groups. I will start with mine and Dr Paul Julian's unsuccessful efforts in 3 years to try to run a Balint Group for students in their first clinical year at Newham University Hospital Trust. Balint modified his opinion of student groups after 1963, when he had begun to run them at University College Hospital. He ran student Balint groups from 1962 and went on until 1969. Balint published about them in 1969 in an American journal "Comprehensive Psychiatry". The Balint Society has published papers in its Journal in 2005 from Dr Sonia Bakshi who seems to have been in the first group, and from Dr Paul Sackin who was in a later group. Much as both these three writers found them useful, they died out until 2004, when they were revived by Dr Heather Suckling, a retired GP and past President of the Balint Society, and Dr Peter Shoenberg, a Consultant psychotherapist at UCH. They were a way then to satisfy student demand for the UCH student psychotherapy scheme, a voluntary scheme 50 years old where students, under supervision, could see a patient in psychotherapy for one year. The UCH student Balint groups have now gone from strength to strength. Many psychiatrists, psychotherapists and GP Balint group leaders, lead 10 groups for 13 sessions in one term in the first clinical year. With a written reflective essay at the end it is now a very popular Selected Study Module (SSM). At Newham it has not worked that way. We were not at the centre of our local medical school, Barts and the London, but in a peripheral teaching

hospital, with some interested medical educators. The students have not proved willing to volunteer an hour of spare time a week to a reflective case discussion group which does not seem to have direct relevance to their studies/exams. However, to give a flavour of what a student Balint group can do here is a case from the second year:

This case was presented by a graduate entry programme student, Adam. He met an elderly lady with early dementia on a hospital ward. Her husband, who is severely demented, was on the neighbouring male ward. She needs an x-ray to be ready to go home. Her husband is ready to leave hospital, and may have already gone to respite care. The nurses had liked these patients a lot and wheeled them round to see each other every day. Adam was asked to take her down to the radiology department, and to be very forceful with the staff there to make sure the x-ray got done! He wheeled her down, chatting all the way. The staff there were nice to them, the x-ray was performed, and they let him watch how everything was done. The next day medical staff tested her memory by asking what she had done the day before, and she remembered the medical student's name. He said this made him feel very good. He now recalled to the group that the x-ray was for a broken bone and whether to take a cast off. He said the patient and her husband constantly worry about each other. The group was interested and said he must have made an impression on her. He felt good as he seemed to have done something positive for a patient's care- he was not just trailing behind the real doctors. The group discussed how confusing modern hospitals must be for patients. This made remembering his name even more affecting. He does not know the outcome as he was never able to go back to that ward.

You may notice that in this student's case other staff are involved, and this is characteristic. Other typical student cases are first encounters with medical/life phenomena such as death, severe illness, mental illness, and, very importantly for them, difficulty in working out what their role as a medical student is. In the second two years our group had to be abandoned partway through, when numbers became too small because of non-attendance. Lessons were for us that one needs institutional backing of high order, suitable time slots and venues that are convenient to possible attendees, and ultimately academic (rather than personal) reward for the student for the time spent.

The Vocational Training group I have been involved with is on the Tower Hamlets VTS and I have co-led with psychologist Mary Burd since 1995. I took over from Dr Erica Jones (a former GP and IPM stalwart). She had founded the group on that VTS in the way they were usually set up in the 70s and 80s. That is, a Balint trained and interested GP, who was also a course organiser, decided to lead a Balint group on their own VTS. This was a dramatic change in practice and thinking. Balint groups were founded with a psychoanalyst leading and perhaps having another psychiatrist as a training co leader. Before his death in 1970, Michael Balint still felt that a psychoanalyst was necessary. Over the next few years, when Enid Balint was the leading authority in the field, it became more acceptable and practical for a GP, with sufficient training, to be able to run a group. This is the situation we now have in the UK, where a good number of GPs are Balint group leaders, but almost no psychoanalysts. There is also growing cadre of other psychotherapeutically-trained leaders. Ideally one leads with a co-leader, and we had thought that essential in the student group we tried. In VTS courses financial reasons, and also fast expansion of numbers, mean that many people lead solo, as Mary and I do, though we can supervise each other after each group. The cohort on our VTS has risen recently from 20 to about 40, but they do not always all attend. We are trying to assess over the next few months whether we may need a third leader. The Balint group is compulsory and now takes place once a month throughout the year for 90 minutes at the end of their inset training day. The group consists of all the doctors on the scheme, including one third in general practice placement, but two thirds in hospital jobs. This means that each doctor may be in the group for 3 years, but there is a continuously rolling membership (i.e 'a slow, open group' in the jargon). Cases vary from long ongoing general practice cases, to sometimes long ongoing hospital cases (yes they still occur!), to brief hospital encounters that have left a mark on the doctor. Hospital cases tend to involve the system as well as the doctor-patient relationship, and those from registrars in general practice may be much like cases brought in ongoing groups for GPs in practice, though there is always the realisation that the registrar will leave at the end of a year (unless they take a job at their training practice). A recent case illustrates the work of the group:

This was the 3rd case presented in a session at my group last May by a female GP registrar, born in the UK, but of a family from Pakistan. "I was upset about crying in a consultation," she said. It was an emergency case on a Friday afternoon, and Fatima was duty doctor in the practice. It was also thought to be a particularly appropriate case for her as she had worked at The Haven. The patient was a Bangladeshi woman who had been a prisoner in her husband and in-laws' house in Ipswich for about 6 months, since her arrival from home in Bangladesh. She had suffered sexual, physical and emotional abuse. She was with her sister and an interpreter. Her passport said she was 27 but she looked like an emaciated teenager. The story was very upsetting and Fatima knew that a lot of her own personal feelings affected her exceptional reaction and identification. The patient had texted, perhaps to her sister, who had sent the police to the house. She had thrown herself into the policeman's arms, as Fatima said,

a symbol of the UK as a safe refuge and a very powerful emotional and visual image for the group. Both the professionals were crying in the surgery and the Balint group was very emotional, reflecting the charged atmosphere. Fatima, uncharacteristically, hugged the patient in the corridor as she left, and plans to see her again. Fatima and the interpreter, who is a practice receptionist, wept together afterwards. The group reflected that this did seem worse than many such stories. There was a lot of anger at the perpetrators, and how this could happen. There has been a lot in the news recently about the traditional culture and fear of murder or disappearance of unwanted wives. This patient is safe, but has been through terrible things, which have also affected the treating doctor profoundly.

The last group, which has now been running for 5 years at NUHT, seems very closely related to the idea Michael Balint had, which he mentioned in the appendix to the original book, as I said in my introduction-to organise a Balint group for junior hospital doctors. NUHT is large enough to have some anonymity, but not so large as to lose its old DGH cohesive feel. When the Foundation Years were introduced with FY1 and FY2 doctors, instead of preregistration houseman and senior housemen, Dr Alan Naftalin, the head of medical education, asked me to run a fortnightly Balint group for the FY2s. This would build on the discussion group work they already did for the FY1 doctors, led by Dr Paul Julian and a psychiatrist, Dr Peter Bruggen. I asked Paul to be involved, so he now works on both years. Some of the foundation doctors will progress from the issue based discussion group to the Balint group, but many or most foundation doctors change hospitals at this time. The group is compulsory, but, as has generally now been reported across Europe and the USA , doctors in training will generally only be capable of attending about 60% of teaching sessions overall. This is because of holiday, shift systems and occasionally unavoidable on call duties. Thus from a group of 30 each of us could have 15 doctors each fortnight but is more likely to have 7-9, a good size for a Balint group. Unfortunately it means that the group may not be very consistent, but I think we have found that the camaraderie in this hospital enables very open discussion quite quickly. There also seems to be little rivalry in this cohort of doctors. Many are very keen to reflect on their work-one wrote after their first session last month that "it was great to have a place to talk openly and safely about my work". Others attend less, but even so are exposed to this way of working, talking about their patients as people, themselves as doctors as people, and their inter-relationship. Because these doctors are constantly taking on new responsibilities, switching between a bewildering array of posts including 4 months GP placements, in a fast changing NHS, many organisational and ethical issues are very important to them. The early group sessions, in particular, must allow time for these things, albeit trying to keep to the doctor-patient agenda. For instance, a particularly powerful case in the last academic year involved a young Afghan refugee with hepatitis B, whose immigration status was unclear. But I will actually tell you about a case perhaps more relevant to today's meeting.

Last April one of the female FY2s, Lilian, doing a GP placement, presented a 6yr old girl with vaginal discharge. Lilian has seen her now several times with her parents. There has been a problem since age 1 with many GPs and specialists consulted, including a work up for possible sexual abuse when age 4, and invasive sedated urology investigations. There have never been any positive MSUs or vaginal swabs, except for incidental haemophilus influenza B on one occasion. The parents are now swabbing the vagina frequently, though Lilian does not know where they get the swabs. The father, who does most of the talking, checks the child's pants every morning. She is an only child of an African father and a white mother. In the consultation she is happily playing with a computer game and is happy to be examined on the couch, though the doctor feels very uncomfortable looking at her normal vagina. The parents say they are very worried about the child's future, such as how will she manage in gym at school if her friends see her knickers, and more interestingly, will she be fertile? The family have changed GP in the practice many times, and there has recently been a practice discussion about the family which Lilian attended. The plan is to speak to the community paediatrician and then refer her to him, and to the Child and Family Consultation Service, which in Newham includes all psychiatry and psychology for children. The parents agree to this, but the doctor is not feeling comfortable after the most recent 45 minute consultation. Lilian knows, and the group easily point out, how strange this all feels. It seems impossible to address anything but the presented problem with the parents, and there is fear that they will instantly disengage if challenged. To everyone it feels like the child is being abused in some way. Why are there no more children? Does this activity replace intimacy in the couple's life? Where do these odd medical beliefs come from? The group moves onto another case with a feeling that this is all very bad for the child, and that maybe it reveals something about the parents' relationship and sexuality. We hope that the next specialists may be able to help the child and challenge the family. Lilian hopes to see the little girl again.

This group has been reported on in literature for foundation programme organisers as an innovative way to address the personal and professional development of foundation doctors. There is also work going on in Lancashire where one group has been started as a funded research project to try to report back on the effect on young doctors of such an FY2 group. A similar group has run for many years in one provincial hospital

in southern Sweden. Widespread application has not yet occurred. Perhaps for us it has worked so well as NUHT was "sensitised to Balint". The medical educator is the husband of our society's treasurer, and he had previously, in two successive years, run compulsory hospital inset training afternoons consisting of Balint group work, supported by the Balint Society. It certainly fits easily into the curriculum of the foundation programme, unlike it did for the medical students, and similarly to the way VTS programmes can easily integrate Balint into their training days. So successful is Balint group work with junior doctors in the USA, that it was reported at the IBF congress in Philadelphia this September that 75% of residency programmes for family medicine now use behavioural science education time for Balint work.

I hope you have been interested by these snapshots of one person's Balint group leadership work and the way groups are evolving over time to address different needs from those originally envisaged, but perhaps foreseen, by a psychoanalyst working in London in the 1950s.

D Watt 26/10/11

Mindlessness in Troubled Times

Jan Wiener

As I write this short paper to begin our conference, the Psychotherapy Clinic where I have worked for the past twenty two years has been served with a consultation document, launching a thirty day consultation, a clear sign that our managers have the intention at worst to close us down, or at best to severely fragment and thin down the psychoanalytic psychotherapy service for patients needing longer-term psychotherapy that has existed in the area for the past fifty years. This is a service that has been holding and treating patients with serious mental illness who have needed a period of longer-term therapy in addition to, or as an alternative to, the shorter-term treatments that have become so popular in today's culture. We are told the cuts are because of the needs to save specific amounts of money leading to a triage approach to psychological therapies. These advocate shorter treatments for greater numbers of people, but we know that GPs, psychiatrists and IAPT services, already stretched in managing their patient loads, can often be left scratching their heads about where and to whom to refer those more troubling patients for whom shorter-term treatments have proved inappropriate or insufficient. As I prepare to join my colleagues to fight the threatened break-up of our service, I find myself concerned not only for the future welfare of our patients, the staff who have worked there for many years and the team of fresh, young honorary therapists wishing to build clinical experience when at the beginning of their careers, but also for the effects in these troubled times of well-tried and tested ways of thinking about our work as GPs and therapists in primary and secondary care. My wish here this morning is to highlight the danger of an insidious erosion of our ways of thinking imaginatively about patients as people with individual needs during these troubled times, and to open up discussion about how we can best preserve what I regard as the basic human values of the work that we do.

Psychodynamic psychotherapy is of course not just a method of treatment but it also offers a means of bringing to our work a way of thinking about our patients, emphasising the significance of exchange and relationships, of significant attachments and of the consideration of the subtleties of the effects that mind and body have on each other that our patients present in so many different ways. This way of thinking has its origins in the work of those of our founding fathers and mothers (Freud, Jung, Klein, Winnicott, Anna Freud, Bowlby, Balint, Bion etc.) who have shown us the value of attending to unconscious processes in our professional work and there has been more than a century of developments from their followers to refine the theory and technique underlying this way of thinking and working. Jonathan Shedler (2010) in a recent scholarly paper called *'The Efficacy of Psychodynamic Psychotherapy'* looks carefully at the empirical research in all psychological therapies and finds that the effect sizes for psychodynamic psychotherapy are as large as those reported for other therapies and moreover that those patients who have had psychodynamic therapy show evidence that the effects last and that many patients continue to improve after the therapy has ended. Shedler provides us with seven features involved with the process and technique of psychodynamic psychotherapy that seem to me to serve as helpful pointers to remind us all of what is in danger of becoming lost in these troubled times, irrespective of our core profession:

1. Focus on affect and expression of emotion (role of feeling)
2. Exploration of attempts to avoid distressing thoughts and feelings (defences of doctors and patients)
3. Identification of recurring themes and patterns (thinking outside of the box)
4. Discussion of past experience (developmental focus)
5. Focus on interpersonal relations (how can we work this out together?)
6. Focus on the therapy relationship (what is happening between us now?)
7. Exploration of fantasy life (imaginative thinking)

You will notice that I am not restricting these features to patients alone. I imagine that I am not alone in struggling to understand and manage the many new and different protocols that the government has introduced during the past few years as ways of trying to improve health care for our patients. Personally, managing change has never been my strong point but I suspect that for many of us, the number and speed with which new protocols have been introduced has fostered in us a state of mind that is not always conducive to reflective thought. Such protocols often work against continuity of care, creating pressures towards a kind of tunnel vision, placing patients robotically into pre-determined categories designed to meet macro targets rather than involving ourselves in a process of imaginative thinking so that we can put in place the treatments they wish for that we agree will work best for them. A colleague who runs an Accident and Emergency department in a London hospital was telling me recently of such an incident where the short-hand colour coding of patients arriving in the department as green, blue, black etc. according to the severity of their symptoms, really backfired. A memo was sent to staff with the message 'please stop treating all black patients'!

As Andrew Elder has helpfully remarked, GPs are the *connective tissue* for their patients, not only in terms of thinking in a related fashion

about physical symptoms and psychological symptoms, but also the connective tissue within the health care system, having to make complicated decisions about when patients need referrals and when they can be treated in the practice. New protocols introduced with regularity led Andrew to comment with some irony that the most common diagnosis for a patient today in primary care could be described as 'lost in the system'. Troubling patients are of course most likely to become lost in the system since they do not necessarily conform to the protocols forcing health professionals today to resort to back alleys and backdoors to find appropriate help.

I would like to give you a short vignette from my own practice. In my psychotherapy department, I consult with the staff team of a local IAPT service. Previously, it operated as an efficient and successful counselling service offering a range of mental health treatments on a step model ranging from social skills groups through shorter term behaviour therapies to 24 sessions of psychodynamic psychotherapy and the possibility of a further referral to secondary care for longer-term psychodynamic psychotherapy. I have watched the staff group I work with struggling to manage the changes imposed on them by the new IAPT system without due attention to process and their personal well-being. One member of staff has developed severe asthma; another more vulnerable staff member took even more time off work than usual when his anxiety levels made managing his increasing workloads too difficult. The service was moved into an open-plan office and when the old manager left, a new part-time manager was appointed. The new manager permitted his staff to attend my group, but did not wish to attend himself. Two weeks ago, a staff member brought the following problem to the group:

I went to supervision with my manager. We met for 20 minutes and during that time he took two phone calls and he spent at least 10 minutes referring to his computer screen as I told him about my work during the past few days. He informed me from the data on his screen that I had only had 140 patient contact meetings during the past month and that I needed to increase my numbers. He asked about one patient 'in your view, has she improved on your scales for depression would you say?', 'Yes', the counsellor replies; 'then discharge her', the manager comments. The supervision session took place in an open plan office and it was possible to hear an appraisal of a service counsellor going on just a few metres away in the same office.

What are we to make of this example? Everyone is under pressure clearly, both counsellor and manager to meet targets and to manage the inevitable persecutory anxiety generated by new systems carefully monitored by our Trusts. But this example illustrates how some basic human needs and values are being compromised. The psychological connective tissue of relatedness that is at the heart of the work is absent. There is the need first of all for confidentiality, for a safe container or frame in which a relationship of trust can develop. There is the need too for engagement; for the kind of concentrated attention for the counsellor, even if for a short period of time. Where is the empathy, the concern, the eye contact in this session of supervision? Where is the interest in the counsellor from the manager? And perhaps of most importance, where is the patient, recognised here only as a figure on a scale? From Shedler's seven features, there is no space for feeling, no possibility of a free ranging discussion to make plans jointly, and within the transference (the here and now relationship between manager and counsellor) what seems to emerge is a dictatorial approach based on power and authority rather than relationship.

In the title of this paper, I use the term 'mindlessness'. It reminded me of the principles behind the mentalisation-based treatment developed originally by Antony Bateman and Peter Fonagy. This aims to treat patients with borderline personality disorders where patients have failed to develop a capacity to mentalise within the context of an attachment relationship. They define mentalisation as the ability to make and use mental representations of their own and other people's emotional states. I do not particularly like the word, but I guess it is a short hand way of describing what I see as a process fostering the kind of thinking and reflection about patients and organisations necessary in General Practice but which risks being squeezed out where quantity rather than quality is the order of the day and symptom categorisation more significant that what lies behind the symptoms.

Some of you here are GPs; others counsellors or therapists and others nurses. We have all spent many years learning our trade and developing our craft. I use the word craft here intentionally. Recently I read a book by a sociologist and philosopher called Richard Sennett (2008). His book is called *The Craftsman*. Sennett talks of craftsmanship as 'an enduring, basic human impulse, the desire to do a job well for its own sake. He emphasises how complicated craftsmanship can be because of the continuing conflict for the craftsman about standards of excellence, which can be affected by peer pressure, obsession or frustration. Sennett's ideas can easily encompass the models of thinking underlying psychodynamic psychotherapy in different contexts of health care as well as the ways we try to enhance our skills and later protect them from deterioration. He contends that the craftsperson's essence is 'the special human condition of being engaged'. Sennett makes a helpful distinction between what he calls 'embedded knowledge', which is learned from good teaching and plenty of practice, and 'explicit knowledge', a self-awareness about what we do and what we know, which brings with it a need to

put this knowledge into words for others to ensure the transfer of knowledge. The difficulty with explicit knowledge is that it is not always easy to put into words. Sennett uses Stradivari's workshop as an example. Stradivari's approach to making violins and cellos was highly original, a factor that contributed to his difficulty in passing on his knowledge to future generations of violin makers. He could not foster in his apprentices an ability to become innovative violin makers themselves. Stradivari's house doubled as both workshop and home for his apprentices and was open 24 hours a day; his team slept under their workbenches. Because his approach was hierarchical, tasks were carefully allocated. However, Stradivari, the master, would himself add the finishing touches at every stage and was thus involved in all aspects of the production of a violin.

In the end, Stradivari's secrets died with him. His two sons could not sustain the business, which collapsed several years later. Something in Stradivari's genius was not (or could not be) communicated and so it passed into oblivion. No one pestered Stradivari to unpack his knowledge in a way that helped his followers to find something unique of their own; the embedded could not be made explicit. Sennett alludes in his book to problems of authority and community and the effects they have on craftsmanship. We are in a different cultural era and environment than Stradivari of course, but his remark brings into sharp focus the idea that cultural influences have the power to either promote or inhibit the skills involved in a craft. I doubt whether the present NHS environment is doing much to promote our craft as professionals.

I hope that during today, we will develop some of these themes and engage with each other about our craft and the internal and external connective tissue within and between our disciplines. It seems to me that we surely must not allow the rigid systems to which we have all had to adapt in these troubled times to undermine the embedded knowledge of our craft; neither should we allow protocol to prevent us from making explicit to new generations of GPs and counsellors creative ways of understanding our troubling patients.

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Balint / case based discussion groups in psychiatry training: a CPD day for group leaders

Ceri Dornan

Report from a one day meeting held on 2nd March 2012 in Manchester, organised jointly by North West England Psychotherapy leads and the UK Balint Society.

Introduction

The idea for this meeting arose from a discussion about common ground between training and professional development and support in psychiatry, and Balint work as promoted by the Balint movement. Case based discussion (CBD) group attendance is a mandatory requirement as part of the psychotherapy training undertaken by all core trainees in psychiatry and is assessed. The core curriculum of the Royal College of Psychiatrists (RCPsych 2010) includes the requirement to: 'Show a clear understanding of the doctor/ patient relationship and its impact on illness and its treatment', which is the essence of traditional Balint work. However, the CBD groups are not unambiguously called Balint Groups and it is known through informal discussion that there is variation in the way groups are conducted and leaders' views of their purpose. We agreed that a study day to bring group leaders together to discuss these issues would be worth exploring, as few such opportunities are available. Inclusion of input from the Balint Society would provide a basis for comparison between CBD and traditional Balint groups.

The meeting

Thirty four people attended, including the four facilitators. Six GPs came to be part of a demonstration Balint group. CBD group leaders included psychiatrists, psychotherapists and psychologists. People came from widely spread geographical locations within the UK.

The format was brief presentations followed by small group discussion interspersed with whole audience facilitated feedback, the intention being to keep the day as open for free discussion as possible. Discussion was encouraged around interpretation of the nature and purpose of CBD groups, comparison of local processes, successes and concerns, issues of leadership such as role, training and support, and the requirement for assessment. A demonstration of a 'live' traditional Balint group was given by members of the Balint Society followed by a facilitated audience discussion about the process.

Participation was active and lively and discussion was wide ranging. By the end of the meeting, as many questions had been generated as answered, but it was clear at the time and from feedback that the opportunity to meet and have these discussions was valued. Within most themes there was a spectrum of experience and often views, though organisational issues surrounding attendance, timing of meetings and identifying leaders were common. Group size ranged from 8 to 20 although low levels of recruitment rates into psychiatry has threatened the viability of groups for core trainees alone.

The themes

What is the task of the group?

Groups operated in different ways demonstrating lack of consensus about the main task. Some were run as traditional Balint groups with focus on the emotional content of doctor-patient encounters and self-development of professionals, some focussed on teaching of psychodynamic and psychological aspects of presentations and some as preparation for psychotherapy training. Some leaders used a mixture of teaching and experiential approaches. There was interest in discussing the different approaches, though some strongly held positions about a teaching versus developmental function, and mixed views about having a specific curriculum. There was concern about the contrast between what was discussed in the groups and what was experienced in real life psychiatric practice, where there was often a strong medical model.

Leadership

A number of different professionals led groups, often for reasons of staff availability or of a historical nature. Preparation for leadership was variable, sometimes absent, though the opportunity to give senior psychiatry/ psychotherapy trainees a chance to co-lead was thought to be a good idea. Leaders from general psychiatry practice thought that their involvement was important in closing the gap between approaches discussed in the group and experience in practice and giving credibility to discussions. Questions concerned who should lead, one or two leaders, doctors or therapists, and what preparation and support should be available to leaders, particularly in view of the heavy emotional load which might be experienced as a group leader.

Assessment

The requirement for group members to be assessed by the leaders was a contentious subject for many leaders and methods of assessment varied. The recent RCPsych curriculum designates the competencies which could be assessed in Case Based Discussion Groups and includes a framework describing these competencies and standards expected. Leaders' concerns were the tension between developing trust with group members to encourage openness

and the detached, top down nature of assessment. Examples were shared and welcomed, particularly those which focussed on formative approaches, sharing of the competency framework with trainees and their involvement in self-assessment. The discussion explored the question of who the groups were for, overlapping with what the task was, and the need to keep the focus on trainee development. The mandatory nature of both group attendance and assessment caused discomfort for many.

The Balint question

The demonstration Balint group generated a lot of discussion and interest, especially where groups did not usually run on Balint lines. Techniques such as the presenter sitting back during discussion were new to some. The experienced nature of the demonstration group participants was contrasted with that of inexperienced trainees, but brought out sharing of some of the problems encountered in trainee groups, such as steering the focus away from solving problems and giving advice, helping reticent members to participate and tackling overt disinterest.

Conclusions?

This meeting felt like the beginning of something which many attending wanted to continue and was a demonstration of the level of commitment to, and value placed on, helping psychiatric trainees develop emotional and psychological awareness in their work. The isolation of many leaders in this work was evident. There appears to be a lack of confidence in some leaders that they are doing a good enough job. The feedback comment, 'Importance of trusting the process', of what would be taken away from the meeting, illustrates the value of bringing people together.

The feedback of what was gained and what was unanswered in the meeting generated enough material for many future meetings, developing themes mentioned above and enlarging on the tensions revealed. It is likely that future meetings will happen, including Balint Society participation.

Some interesting ideas emerging from the day included the possibility of multidisciplinary groups, co-leadership with GPs, leadership training with Balint Society leaders, and assessment of the effectiveness of groups. This report is my personal perspective of the meeting and one intention is to encourage Balint Society members to seek active links with those leading groups in psychiatry, for mutual benefit.

Meeting organised and delivered by:

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Valuing the Doctor-Patient Relationship

Keynote address at the Balint Society Oxford Weekend, September 2011

John Salinsky

When I started as a GP in the 1970s, I had had no proper training except for a six-month assistantship with my elder brother.

I came straight out of hospital and saw myself as a missionary, bringing the gospel of scientific medicine to GP land. With my up-to-date, hospital-acquired knowledge and clinical skills, I was looking forward to diagnosing all the major illnesses that the GPs had been missing. I soon realised that serious illnesses were relatively rare, although of course you had to keep an eye out for them.

But, at the same time, I was discovering the doctor-patient relationship.

To many people I was becoming 'My Doctor'. I was amazed to find that patients were pleased to see me again and seemed so grateful that I was looking after them, even when I thought I was doing nothing.

There were some people whom I desperately wanted to help. Their feelings were distressed and distressing. Their lives were messed up. I wanted to do something for them, beyond providing basic medical services.

Can your doctor be your friend, I wondered? I undoubtedly got too close to some of them. I was aware that there was a boundary between patients and doctors; but when these special patients tried to tempt me to cross over the border, I had difficulty staying on my own side. I would make daring little excursions into their territory and then jump back to safety. Or so I hoped.

Young doctors today don't seem to take these risks. They are too well trained in professional ethics. I think they are also much more worried than I was about patients becoming too dependent on them. I have to agree that there is something to be said for this sort of cautious, correct attitude. But, sometimes, I wonder if the present organisation and culture of general practice gives young doctors the freedom to make lasting relationships with patients.

Continuity and the appointment system

These days, it can be very hard to book a follow-up appointment with the same doctor. Practices are bigger; there are more doctors and nurse practitioners. More doctors are part-time. Your doctor may not be there when you need her. And the appointment system favours reserving a large number of appointments to be released only when the surgery starts. You may have to phone up first thing in the morning. By the time you get through to the receptionist, all the appointments with 'your doctor' may have gone. And so have the small number of 'advance appointments.' But you can always try again tomorrow. Kafka, if he were still alive, might be writing about it in a story called 'The Appointment'.

It seems that quick access to any doctor is valued more highly than a continuing relationship with a particular doctor. The Royal College of General Practitioners has got round this problem by redefining 'Continuity'. You can now see any number of different practitioners, they say, because the electronic record will tell a doctor who you have never set eyes on before, everything she needs to know.

Can this be true? The record certainly gives you the facts; or a selection of the facts. But does it really reproduce the nuances and the emotional currents of the relationship with the last doctor, or the one before that? Can you, as a doctor, slip effortlessly into the mind of your predecessor? I don't think so.

In spite of these difficulties, in my practice, many patients have a doctor they regard as 'my doctor' and they manage to see him or her most of the time.

Is personal continuity really necessary? Ask yourself whether you prefer to see the same doctor each time. Or even the same car mechanic, or the same plumber.

I think it does make a big difference to patients, especially those who need to see their doctors frequently, for whatever reason.

As patients, we may have a chronic illness or psychological and social problems. Or those worrying symptoms that won't go away and the doctor can't find anything wrong. But at least he listens to you and agrees to a few referrals. We have different crises at different stages of our life: childhood, adolescence, maturity. An acute illness rears up suddenly, perhaps needing surgery. If cancer strikes, we will need a quick diagnosis and lots of support. Then, as we get older, we collect more symptoms. Our organs, which have performed nobly and silently for so many years, one by one, begin to falter. Things fall apart. It will happen to all of us.

With all these medical needs, accelerating with age, it is so much better to have, as your doctor, someone with a deep knowledge of you, gained from many encounters spread over time. Someone who knows your strengths and weaknesses, your fears and your odd beliefs. Perhaps a few of your secrets? A doctor who is someone you can trust, who is pleased to see you and cares about you as a person-someone who is on your case.

This means you

The doctor-patient relationship is one of the pleasures of general practice and also one of the ways of making sense of it. If you are going to enjoy it, it is very important to understand at least some of the things going on beneath the surface.

The crucial thing is to realise just how important you are in your patients' lives. It's not only psychotherapists whose patients have fantasies about them. It happens to GPs too. All the time. In every surgery in the land, the most sensible, down to earth patients are having fantasies about their GP. So watch out.

Who has a case?

Now I would like to tell you about some of my patients and my relationships with them. The majority are not very intense. But if you stay in the same practice, they deepen over time. People come in and say, 'Are you still here? I thought you had retired.'

A woman will bring a child and say, 'I remember when my mother used to bring me to see you as a little girl.'

Then there are the meetings in the street or a shop. Some doctors dread these encounters, and will cross the road or hide in a doorway to avoid them. But I enjoy them. Last week, a lady caught me in the supermarket, just beside a shelf with a display of cough mixtures.

'I couldn't get an appointment with you,' she said. 'I still have this terrible cough. Now, which of these do you recommend?'

Other people just stop me in the street and say, 'How are you? You are looking well. I must make an appointment and come and see you.'

I have been asked for my clinical opinion by my car mechanic while my car was having it's MOT; by my barber while cutting my hair; and in a restaurant run by a young couple who brought me an extra dish 'on the house' and then brought in for consultation their two young children, who had coughs and colds.

More problematic relationships

I often felt that certain old ladies were trying to control me and get me in their power. They would somehow trap me into regular visits. They were not the most ill or the most needy: just those who were cleverest at entangling me with feelings of responsibility. They would offer me tasty things to eat; and drinks, even alcoholic drinks. One old lady always offered me a glass of whisky whenever I visited. I was happy to accept it, especially on a cold day, but her husband disapproved.

'Hugh,' she said to him once, 'Where is the whisky?'

'I don't think we have any,' he replied.

'Nonsense of course we have. It's in the cupboard. Go and get it and find a clean glass. Doctor must have his glass of whisky.'

At first I hated the old ladies and the power they had over me. But, gradually, I grew to love them. Clearly, the whole thing had something to do with my mother. I think being in a Balint group helped with that.

Then there was a depressed young man with whom I used to have long consultations in the surgery. One day, I was waiting in my car for the lights to change, when he appeared on the pavement beside me. I wound down the window and he asked where I was going. I was going down to central London on my day off. (In those days you could easily park in the West End.) He said he was going down to town too, and could I give him a lift? When we got to Shaftesbury Avenue, or thereabouts, he invited me to come to a club he belonged to, which was just nearby. In the club, which was cosy and full of red plush, the barman greeted him like a long lost friend.

'This is my doctor.' said my patient.

'Pleased to meet you,' said the barman.

My patient ordered drinks for us both and then discovered, to his horror, that he had left his wallet at home. Naturally, I offered to pay.

When we had finished our drinks and had a chat with the barman, my patient said, 'What shall we do now? Shall we have a walk in the park and see if we can find some girls?'

And at this point, a little red light came on in my head. I had been enjoying myself up to this point but the red light told me that things were now about to go too far, and it was time to move back to my side of the boundary. So I did.

Longstanding relationships

Now, I'd like to tell you about some more recent encounters with patients whom I have know for many years. Of course, I have changed their names and disguised their stories.

Maria. She is a 60 year-old woman whom I have known for 30 years. When she was young, she had a very volatile personality and used to fly into terrible rages at reception, sometimes screaming at the staff and alarming the other patients. On one occasion she was about to be removed from the list, when I intervened and rescued her. After that, I was her hero. She used to come and tell me about her disastrous love affairs. These were invariably with men who exploited her, made dazzling promises of marriage and then dumped her. Since then, she has had bad arthritis and other chronic illnesses. She is often depressed but has always refused antidepressants. She tells me that, without me as her doctor, she would never have survived.

'When you retire,' she said once, 'I shall kill myself.'

'In that case,' I said, 'you have two years to live.'

She laughed, then thought for a moment and said, 'You know, doctor, it's a good thing I have a sense of humour.'

Paul is a young man I have been seeing monthly for about 8 years. The consultations usually last about five minutes. Alcoholism and hypothermia nearly killed him, one cold winter, when he fell asleep in the snow. Sometimes he hears voices in his head. His life consists of watching television, going to the pub and shopping for his mother. I sometimes ask him if he wants anything more from life but it seems that he doesn't. If I ask about girl friends he just looks

embarrassed. Antidepressants help him sleep and a small dose of olanzapine keeps the voices away. He tells me that his drinking is under control with only occasional weekend binges. I think the monthly visits have kept him out of trouble, but never managed to interest him in stopping alcohol completely. Do I like people being dependent on me? Only up to a point.

My third patient is called **Robert.** He is 48 and suffers from what we now call 'medically unexplained symptoms.' Every few years, he develops a collection of these symptoms, which are associated with great anxiety. Robert is very good at transmitting his health anxiety to me. He often thinks he is losing weight and tells me that all his friends and family have noticed how thin he is. And when I look at him, he does look thin; his cheeks are hollow and he has a gaunt, starved appearance. But when he stands on the scale his weight is just the same as before... This time, in addition to weight loss, he has breathlessness with nasal blockage and choking feelings. He has, of course, been examined and we have done the appropriate investigations. He has somehow managed to see three different ENT surgeons, which is quite an achievement in these days of restricted referrals. All three of them have told him there is nothing wrong with him. So he comes once a week and sits glumly, looking at me, waiting for me to do something. He is on an antidepressant but I am not sure if he is really taking it. He is waiting for a psychology appointment for what I think are panic attacks. I am getting panicky too. I want him to stop coming every week. I make a speech about how busy I am and how I'm only part-time and he should perhaps come fortnightly. He looks at me despairingly.

'What difference does it make? I say. 'You don't seem to feel any better.' 'You've known me a long time,' he says.

'So does ten minutes with me help you to get through another week?'

He nods glumly and gives the ghost of a smile.

'OK,' I sigh. 'I'll see you again, next week.'

I'm such a softy, really.

A couple of weeks later, Robert asked me if I would be one of his friends on Facebook. I agreed. That evening, as I switched on my computer at home, I began to fear that I was going to be deluged with email messages. But there was only one message, wishing me a nice evening. There was also, on his page, a picture of Robert and his wife at their wedding, two years earlier.

So I sent him a message that said, one day, I hope to see you looking as happy as you do in that picture. That went down really well. He was touched. And it was a genuine reaction on my part. It's the doctor-patient relationship in action. Just over the boundary.

The following week the GMC issued a statement, warning doctors that they should never agree to be a Facebook friend with a patient.

In conclusion

Some of what you have heard today may send shivers down your spine and make you think that it's better to stay out of these close relationships. But if you're like me, you can't avoid them. It is part of what draws you into being a GP. It's true that it can be very irritating and it has its dangers. But it's also fascinating and rewarding. When you get to my age, you can feel the warmth radiating back to you from all those patients you have cared for over 30 years.

So let's try and keep the continuing relationship with patients going. Let's find ways of staying with our patients from one appointment to the next and from one year to the next-maybe for a professional lifetime.

And if you find it perplexing and worrying, I recommend joining a Balint group, or even starting one.

What does the Balint group teach us? In a word: empathy.

The Russian author, Ivan Turgenev, wrote a wonderful novel called Fathers and Sons, which is full of all sorts of family conflict. One of his readers asked him, 'Whose side are you on?' Turgenev replied, 'I'm on everyone's side!'

And the great film director, Jean Renoir answered a similar question with the words, 'Everyone has their reasons.'

I think that the Balint group helps us to see that everyone has their reasons and to be on everyone's side. But please remember, at the end of the day, to go back to your own side.

Book Reviews

Sex versus Survival
The story of Sabina Spielrein: her life, her ideas, her genius
John Launer
Paperback. 110 pp. £7.95 *

Sabina Spielrein (1885-1972) had a pivotal position in the history of psychoanalysis; and yet she was largely unknown to the world in general, until her story was told in David Cronenberg's recent film, 'A Dangerous Method' starring Keira Knightly as the heroine. John Launer has now written a short account of her life and work which is both scholarly and very readable. John believes that Sabina is an important figure in the history of 'talking cures', not least because she came up with a theory, which, although not quite on the right lines, came very close to aligning psychoanalytic theory with the biological facts of evolution.

Sabina came from a professional Russian-Jewish background. She was a bright child and did well at school, but suffered from serious psychosomatic symptoms. At the age of 16, she had a breakdown following the death of her six-year-old sister. Two years later, she was admitted to the Burghölzli, a famous mental hospital near Zurich. Here she came under the care of Carl Gustav Jung, who found that she was severely disturbed with tic-like, jerky movements and fits of hysterical laughter and tears. Jung treated her with daily sessions of an early form of free association, which he had learned about from reading Sigmund Freud's papers. Sabina made good progress in therapy and was soon well enough to enrol as a medical student. Unfortunately, she also embarked on a tempestuous affair with the married Jung, which troubled him greatly (but not enough to make him break it off permanently). He wrote to Freud about this patient who was in love with him, without revealing that they now had a sexual relationship. Further correspondence followed. Of course, Freud realised what was going on, but tried, rather disingenuously, to support Jung by telling Sabina that she had imagined it. Later, he began to think seriously about countertransference. Jung was, at first, a grateful pupil but later turned away from Freud. So when these two legendary figures were coming together and then moving apart, Sabina Spielrein was right in the middle, influencing their relationship and their ideas.

But the story doesn't end there. Sabina trained as an analyst (it didn't take long in those days) and was accepted as a member of Freud's Psychoanalytic Society in Vienna. In 1911, she gave a memorable lecture to the Society. Sabina's big idea was that although the sex act was enjoyable, it could also be accompanied by negative feelings such as resistance, anxiety and disgust. There was something destructive about sex and especially fertilisation, she maintained. The man invades the woman's body, the sperm forces its way into the ovum and the nuclei of both germ cells are smashed up and reconfigured. She pointed out that reproduction predominated over the survival of the parents and argued that the emotions of the couple having sex must correspond to the conflicting drives of survival and reproduction.

Finally, she suggested that this biological and emotional correspondence could be used as a basis for a new approach to the talking cure.

Unfortunately, the audience were not impressed by this bringing together of psychology and biology. Nor were her mentors, Freud and Jung, although they both subsequently drew on her ideas in developing their own theories. Sabina, though no doubt disappointed, was undeterred. She continued to practice as an analyst and to write papers, at first in Geneva and later back in Russia. She married another doctor and had a daughter. Sadly, her family were eventually caught up in the holocaust and she met a violent death at the hands of the Nazis in 1942. By the time I read about this tragic conclusion to her life, I felt that I knew Sabina and had seen her grow from a bright child through a disturbed adolescent to a feisty professional woman who had original ideas and could stand her ground in the face of opposition from the older men.

It is clear from John's passionate advocacy of his heroine that he has a lot of affection for her as well as respect. He is also a better supervisor for her than those old analysts. He critiques her theory carefully, picks out and discards the errors, feeds in some modern evolutionary and genetic ideas and produces a neo-Spielrein theory which blends biology and psychoanalysis in a much more persuasive way. Reproduction is of course paramount in natural selection, but the parents have to pick their mates carefully and not waste their DNA on infants who will die because they are not around to nurture them. The tensions and conflicting feelings accompanying sex seem to have been a selective advantage that helps us to be cautious as well as eager in our choice of mates. Here might be the basis of a biologically based psychotherapy.

- *John Launer published this book to coincide with the movie, 'A Dangerous Method' and is now writing a full biography of Sabina Spielrein for Duckworth. Meanwhile, you can order a copy of this original version by contacting John at johnlauner@aol.com*

John Salinsky

Zero Degrees of Empathy: a new theory of human cruelty and kindness
Simon Baron-Cohen.

Penguin books. Paperback, 195 pp. £9.99

How are we to account for, and try to prevent, the appalling cruelty of which some human beings are capable? Is it all due to something called 'evil', which infests some people, as if they were possessed by the devil? Simon Baron-Cohen (cousin of the notorious comedian Sacha) is a psychiatrist and neuroscientist who is not satisfied with this explanation. In this excellent book, he puts forward his theory that extreme cruelty can only take place when there is 'erosion of empathy'.

When we recognise another person's emotions and feel for them, our reaction is to want to help then and not to cause them suffering. We all have different amounts of empathy, but a small minority of people seem to have none at all. These are the people with 'personality disorders' and they come in three kinds: borderline, psychopathic and narcissistic. Psychopathic people are cruel and apparently without any kind of remorse. They can cunningly read other people's feelings, but are unable to respond emotionally. Narcissistic people are totally self-centred and feel that they are 'entitled'. But what does borderline mean? What borderline do they inhabit? Do we meet then in our GP surgeries? Yes we do and so do our Mental Health clinic colleagues. According to Simon, they represent 15 percent of mental health service clients, a third of suicides and up to 50% of patients with alcoholism, eating disorders and drug abuse. Do they also comprise a large proportion of patients presented at Balint groups? You bet they do. I shall come back to that point later.

In his book, Simon shows us that there is evidence from functional MRI studies that clinical zero-empathy syndromes correlate with abnormalities in the empathy circuits of the brain. These comprise no less than ten brain areas, so you can see how important empathy is. Lack of empathy may be inherited, as genetic studies and identical twin studies have indicated. But there is also a strong environmental component. Zero empathy patients are often found to have had really bad childhood experiences, including neglect, deprivation and abuse, physical, sexual and emotional. Simon quotes with approval the work of John Bowlby on attachment and loss in childhood. He tells us that a good experience of infancy and childhood gives us (if we are lucky) 'an internal pot of gold' that provides us with emotional and moral capital throughout our lives. The zero-empathy child has a pot that is virtually empty.

To cheer us up a little, Simon then tells us that zero-empathy can also be positive. People with Asperger's syndrome retain affective (feeling) empathy although they lack the cognitive component. This means that while they are unable to read other peoples emotions properly, they are kind and compassionate and have no wish to cause suffering. They also have a gift for numbers and pattern recognition which makes them valuable as scientists and mathematicians.

Having surveyed the field, Simon concludes that, while zero-empathy is not of itself the cause of cruelty (or evil) it is a necessary condition which must be in place before cruelty can occur. He finishes with a moving account of two fathers, a Palestinian and an Israeli, both of whose sons have died in the conflict between their nations, reaching out to each other in empathy. In the end, he says, empathy is the universal solvent, the solution to all our problems.

How should we respond as GPs to the concept of 'zero degrees of empathy'? As Balint doctors, we naturally avoid labelling people and for a very good reason. Empathy is what we use when we go to work with difficult patients, and when someone tells us that a patient is 'borderline' or has 'a personality disorder' there is a tendency for the heart to sink and our own empathy level to go down with it. Borderline patients are demanding and clinging; they want a close relationship but their love easily turns to anger and rejection. They make us feel bad and give us a hard time if we allow ourselves to feel for them. But there is hope. First of all, zero-empathy is an extreme case and even our really difficult patients still have some of the magic substance coursing round the amygdala and the prefrontal cortex. Most are really quite likeable. We need to be patient and generous with our time, while setting some boundaries like a good-enough parent. If we can do this, we can, I believe, help these sufferers to feel more secure and valued, less likely to behave impulsively and get into trouble.

And of course, the Balint group is there to help preserve our own empathy.

John Salinsky

Secretary's Report 2012

David Watt

The highlight of this past year has been the start of more co-operative work with aligned organisations, the APP (association for psychoanalytic psychotherapy in the NHS), the IPM (the Institute of Psychosexual Medicine), the RCGP (Royal College of General Practitioners) and members of the Royal College of Psychiatry, as well as strengthening of regional activities of the Balint Society.

The year began with a bang at the International Balint Federation Congress in Philadelphia, USA from September 7th to 11th. Participants from all over the world gathered for this scientific meeting, partly presented papers and posters, and partly Balint group work. Members attended from the UK, making us the second largest delegation after the host nation. It ran very smoothly and amicably, thanks to our American hosts, and the spirit of Balinteers worldwide. The next International congress will be in Heidelberg from September 7th to 11th, 2013.

Later in the month we were back in the UK in Oxford, from September 22nd to 24th, with the Balint Oxford weekend. We were again hosted by the beautiful Corpus Christi College. Participants were allocated in 3 Balint groups, including one group leaders' workshop. We hope for a larger conference in 2012.

On Friday November 4th we joined with the London Faculty of the RCGP and the APP to host a study day at the current RCGP headquarters in Bow Churchyard. This day was entitled "Troubling patients in troubled times", and included small group work, and Balint group work. It was attended by about 40 delegates, mostly GPs and psychotherapists, including the current Chairman of the RCGP, Dr Clare Gerada. There was very lively work, slightly dampened by the current state of uncertainty in work in general practice because of the government's sweeping changes. The day was repeated in the north east, via the North East Faculty of the RCGP. Both days felt successful, and the same model will take place in the north-west at a date to be arranged. In Manchester, on March 2nd 2012, Ceri Dornan organised a very interesting day, meeting with psychiatrists and psychotherapists who run the compulsory Balint-type groups for psychiatrists in training. There was much to talk about the problems of running training Balint groups where attendance is compulsory and slightly erratic, where members may not be keen on the method, and also about slightly different ways people run these groups. The vast majority of those that attended were trying to run groups along lines very similar to the Balint Society, and were keen to be in a forum where they could talk about their group work, as they do not have a network currently.

On November 5th, the IPM hosted their autumn day meeting at the Medical Society of London, as a day for us to share experience with them. The title was "Back to Our Roots - the Doctor-Patient Relationship". 57 delegates attended, the majority from the IPM. The day consisted of presentations and group work, with either Balint group or psychosexual medicine groups, so that members of both societies could experience the other's group work. Though there was much in common, it is acknowledged that there are differences, the psychosexual work feeling more structured and goal-orientated, dealing with presenting problems more defined than in Balint groups. There were also 4 lectures, 2 from each organisation. Due to the indisposition of Dr Andrew Elder, I gave two talks, one on the historical perspective of Balint work and how it has changed over the years, and the second on my work with Balint groups for younger doctors, GPVTS scheme and FY2s (this paper will be published in the IPM journal). The IPM gave two wonderful talks, full of case presentations from their fascinating world.

There were two lectures this year, both taking place at the Tavistock Centre, which is still a gracious host to the Society, both for these and for the Balint Group Leaders' workshop meetings. On November 16th, the well known Professor Irving Kirsch spoke about his work on the placebo effect, "The Emperor's new drugs: medicine, placebos and the therapeutic relationship". It was a fascinating talk, centering on his meta-analysis of work on anti-depressants , which appear to actually show very little benefit to patients over placebo. He is continuing to work on the value of placebos and how they are intimately entwined with the therapeutic relationship. The second lecture was given by Dr Geraoid Fitzgerald on Tuesday 20th March 2012. He is a Psychoanalyst and consultant psychotherapist in Leeds, and has run many different Balint groups for different groups of doctors. Currently he is running groups for several different groups of psychiatrists in training, and also a consultants group. He compared and contrasted them, drawing on his past knowledge of the GP Balint group he ran in Sheffield for many years. Also at the Tavistock the Balint Group Leaders' Workshop met 3 times for members to present their group work, and to discuss leadership issues in general. We are always seeking people who wish to present their group work and, as at the meeting in February, are hoping that we may have more participants leading psychiatry training groups.

The Whalley Abbey weekend, organised by Dr Caroline Palmer, on March 9th to 11th, was as usual a great joy for all involved. Jane Dammers and I ran the group leaders group. As I write I am looking forward to the Northumberland Balint weekend from 28-30

June, organised by Jane and her group, and later on in September to the Oxford weekend.

The Annual Dinner of the Balint Society was again at the Royal Society of Medicine on Friday May 25th 2012. 29 members and guests attended to have an excellent meal, and to hear Professor Trisha Greenhalgh talk about her personal feelings about Balint work and the current changes in the NHS. The RCGP is moving to new permanent premises in Euston in the coming autumn, and we are planning to hold next year's Annual Dinner there, at a different time to the usual, on February 8th 2013, when we hope many members will come along with guests to test out their new facilities and catering!!

Four of us travelled in early June to Sofia in Bulgaria to a council meeting of the IBF, which was linked to a 2 day Balint meeting, introducing the Bulgarian Balint Society to the rest of the IBF. It was a fascinating meeting, learning a bit about pre- and post-soviet medical care, and that people from the edge of Europe think in a way firmly within the Balint framework.

My last words will be about work with the RCGP. This year, thanks to the persistent work of our past president Dr Andrew Elder, we became an Affiliated Society. We are not yet clear what the effect of this may be. We know that both the current president, Dr Iona Heath and the chairperson Dr Clare Gerada, are well disposed towards Balint work. I have been attending meetings at the CIRC (Clinical Innovation and Research Centre), where we sit alongside the RCGPs clinical champions at the Networking Meeting for RCGP Clinical Champions, as an opinion giving/forming group for the College. We are indeed a unique voice in this group, representing the doctor-patient relationship, running through the whole of general practice. The affiliation may also be making it easier to work with faculties round the country to put on meetings, though this may actually work on a more personal basis. Attending the annual Novartis Research Paper of the year dinner on June 18th, there was certainly opportunity for me to talk to many leading GPs in the country about the ongoing existence and virtues of our work. In addition we are trying to work with Dr Gerada perhaps to help facilitate meetings about the basis of general practice and how to survive/enjoy it better. I am not quite sure where this piece of work will go, but am interested to be involved with the RCGP.

Report on March Weekend Workshops at Whalley Abbey, Lancashire, 2012

Once again, in March this year, when the cheery daffodils were embellishing the grounds of Whalley Abbey, 20 of us met to consider our problematic cases. There was a good mix of GPs, psychiatrists, psychotherapists and group analysts attending this year, which made for fruitful cross-fertilisation of ideas across the disciplines. The comfortable conference house, of which we enjoyed exclusive use, is isolated by the old stone gatehouse and cobbled courtyard from the village, and engenders a spirit of introspection, and reflection on our working lives from a new and different perspective.

Fortunately, half of those attending the weekend wanted to focus on improving their understanding of the dynamics of their problem cases, while the other half were keen to focus more on improving their group leadership skills, so there was a natural division into 2 viable groups. The group leaders' workshop spent half the session on a 'normal' case discussion, and the other half of the session looking at how the group was led, with leaders in each session rotating, so there were opportunities to lead, observe and work on cases as a group member. On the other hand, the 'normal' Balint group provided an opportunity for each member to present their troubling case, and to hear the distilled responses of the other group members to their situation.

The Group Leaders' Workshop was spirited, with all involved eager to lead the group in their turn, and cases were volunteered with alacrity. Some tried using the 'Pushback' method, to deter cross-examination of the presenter, while others did not, and managed to preserve the thinking and listening space for the presenter in other more subtle ways. It was the first time that Jane Dammers and David Watt, (our President and Vice-President) had collaborated as facilitators of the Group Leaders' Workshop, but they clearly enjoyed working together, and seemed to keep the group feeling pretty safe, but open to interpretation, and with room for constructive criticism.

The Balint group ran the gamut of emotions, cases switching one after the other, from animated anger at feeling powerless, to extreme compassion; from frustration and confusion, to a sense of guilt; one case counterbalancing, or being the balm or salve to the last. The common Fishbowl exercise in the late Saturday morning session, which engendered a sense of outrage in the group at a cruel early death, and in which the presenter seemed to hold all the sadness, appeared to have a considerable effect on the next session. The cases presented that evening, seemed to take on a ghost-like, nebulous, in-limbo quality, which was hard to get to grips with. The last session, however, saw a resurrection of animation, anger, passion and fireworks!

Each day there was a session that included all attendees. On the first evening there was a brief welcome, introductions, and 'scene-setting', by way of a GP giving a brief synopsis of her last surgery, her fluctuating moods often in line with her patients' mood, and demonstrating a deep and compassionate knowledge of their lives. On the Saturday, we experienced a 'Fishbowl' together, with a smaller central demonstration group, surrounded by the others, and which allowed intermingling of people from the Group Leaders' Workshop and the Balint group. On Sunday, there was a plenary session, with feedback shared from the Balint group and the Group Leaders' Workshop, and ideas generated in common for improving or fine-tuning next year's Whalley Weekend.

The general feedback from the weekend was very positive, with glowing remarks about the gorgeous venue, and the balance between group work, common sessions, and free time. So I have already booked the Whalley Abbey Conference House for 8th/9th/10th March 2013, and hope to see many of you there.

Caroline Palmer.

Relaxing at the Whalley Abbey weekend workshop.

Report of Balint activities in the North East 2011–12

We have a staff group of GPs and Clinical Psychologists, all experienced Balint group leaders, who meet regularly to co-ordinate and promote Balint activity in the North East of England. We are

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Over the last year we have been keen to promote collaborative working with colleagues from other disciplines and organizations, including making much stronger links with psychiatry where Balint training is mandatory for psychiatry trainees. Also with clinical psychologists and counselors, the local RCGP faculty who were very helpful in arranging a joint study day, and continuing our contact with the Northern Deanery and GP trainers.

We have been involved in leadership training at our annual Longhirst Balint weekend and were also invited to go to Dublin to train consultants in psychiatry as Balint has recently become compulsory for psychiatry trainees there. Esti and Jane were very warmly received and given great hospitality at St Patrick's Hospital in Dublin, founded by Johnathan Swift who bequeathed a sum of £12,000 on his death in 1745 'to build a house for fools and mad'. The two day training was very well organized by Dr Marie Naughton and the eighteen participants showed a keen interest in Balint and developing leadership skills. Thankfully in Ireland, unlike in England, there is no requirement for assessment of trainees participating in Balint groups, just a register of attendance.

Balint groups

We have two Balint groups for GPs running at the moment in Newcastle and Cramlington.

We hope to start two more groups by the end of the year. One of the new groups has developed out of discussion with members of the North East Locum Group several of whose members have shown an interest after we explained that Balint is not only for doctors with very long term relationships with patients but is a valid and useful approach to thinking about any encounters with patients. It will be interesting to see what this brings. The second group is in collaboration with Dr Chris Brogan at the Regional Department of Psychotherapy and grew out of the joint Squiggle conference last year – see below. We hope this will be a mixed group of experienced GPs and Consultants in psychiatry.

All our groups in the NE are co-lead by a GP and a psychotherapist/clinical psychologist. This is a model we are very keen to hold onto.

STUDY DAYS AND BALINT WEEKEND

'Using a balint approach in training' One day workshop at the GP educators conference Northern Deanery October 7th repeated Nov 9th 2011. This workshop for GP trainers used a Balint approach to explore the relationship between the GP trainer and trainee, furthering the work described in our paper in this journal.

'Troubling patients in troubled times' Joint Balint, RCGP and APP workshop Nov 4th 2011 London and Feb 3rd 2012 Durham. We participated in the staff group in London and then repeated the workshop in collaboration with our local RCGP faculty. It stimulated a lot of interest in Balint work and joining a local Balint group.

'Mind and body over the life cycle' Joint Squiggle Foundation NE and Balint conference Nov 25th 2011 Newcastle up on Tyne. We presented a demonstration Balint group in a goldfish bowl and discussed the use of Balint in General Practice and Psychiatry, including some of the issues around leadership.

'Longhirst Balint Weekend' June 29th – July 1st 2012 Well attended by a mix of GPs, counsellors and therapists. Included a trainers' workshop. The sun shone and we had great BBQ on the beach.

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

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