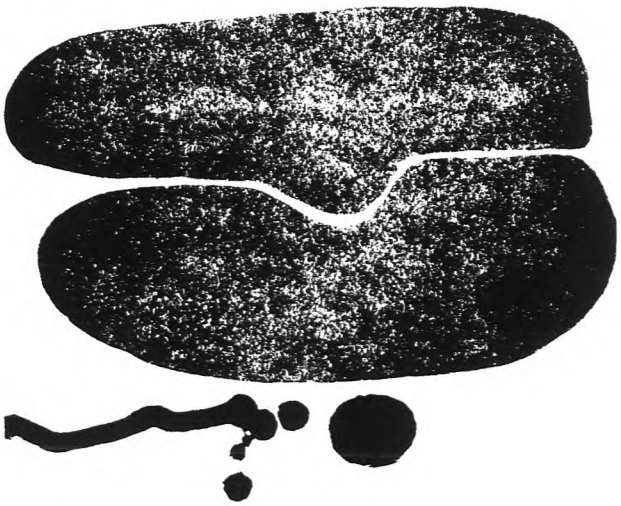
Journal
of the
Balint Society

2013



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JOURNAL OF THE BALINT SOCIETY

Vol. 41, 2013

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.

Balint Society Programme of Events 2013 / 2014

Further details of meetings and application forms where relevant are published on our website a few months before each event.

Balint Weekends (option of residential or non-residential)
All weekends include both ordinary Balint groups and leadership training workshops.

27th – 29th September 2013 — **Corpus Christi College, Oxford**

1st – 3rd November 2013 — **Sligo, Republic of Ireland (supported by the UK Balint Society)**

21st – 23rd March 2014 — **Whalley Abbey, Lancashire**

6th – 8th June 2014 — **Longhirst Hall, Morpeth, Northumberland**

Balint Society Annual Dinner — **Friday 7th February 2014**
Will be preceded by a study day. Details and venue to be decided.

Group leaders' workshops
Tavistock Clinic, 120 Belsize Lane, London NW3 5BA
For presentation and discussion of on-going groups. Meetings start at 8pm.
Thursday 14th November 2013 (Seminar room 1)
Thursday 6th February 2014 (Seminar room 1)
Tuesday 13th May 2014 (Seminar room 3)

Newcastle leaders' group
Meeting about supervision (for active Accredited Balint Group Leaders)
Friday 11th October 2013 (09:30 - 4:30) London. See website for further details.

International meetings
The International Balint Federation (IBF) Congress is held in alternate years to an International Leadership Conference. Details can be found on the IBF website http://www.balintinternational.com
The 2013 meeting is a Congress year, held in Heidelberg, Germany.

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

Editorial

I am delighted to introduce the 41st volume of the Journal of The Balint Society, 2013. The work of Michael Balint continues to interest and inspire clinicians across the world, as shown by some of the submissions for this year. In particular, our essay competition attracted three excellent contributions, all of which are published in this year's journal.

Eve Merry, our prize winner, is a clinical medical student at University College London. She writes with feeling and compassion about her experience working with a patient with cancer, as part of her training. UCL medical school run Balint groups for students and she writes about how this forum provided her with a valuable source of support and opportunity for reflection. I am sure you will enjoy her moving account. John Prosser is an experienced GP with a long interest in Balint work, working on the south coast of England. He recounts an interesting exchange with a patient of his who recalled their experience of the 'Blitz' in wartime London. John describes how his experience of Michael Balint's work helped him understand his patient, and ultimately help him. Finally, Balint work continues to transcend national borders as a Ukranian colleague, Dr Tatiana Tkachenko, describes the work of her Balint group over the past two years. It is an interesting and heartfelt account of how the Balint group can provide emotional sustenance for doctors of all specialties.

Other personal papers submitted include an amusing, though very truthful, account of the major pitfalls associated with setting up and running a Balint group. Anthony Froggett speaks from painful experience as he explains 'How to fail at running a Balint group'. Valuable lessons lie therein for us all. The Longhirst weekend in the north-east of England is a well established Balint annual retreat – Christina Blackwell describes how they altered their approach this year using poetry as a means of opening up discussion and reflection, in a powerful and moving account using two poems from a local writer, sadly now deceased.

In the UK, over the past year, I believe we have entered dark times in General Practice. A new health-care act passed in 2012, combined with a number of scandals in hospitals, has put the NHS under the spotlight as never before. GPs have come in for particular criticism regarding pressures on Accident and Emergency departments, Out of Hours care and access to GP appointments. This is in the context of increasing constraints on budgets and a sense that our workload is increasing exponentially as more hospital services are now deemed for delivery in the community. I see my colleagues working at their limit and know from personal experience that there is little left to give, yet we continue to do our jobs, providing care for our patients. The emotional needs of doctors are rarely mentioned, yet are incredibly important. In this climate, Andrew Elder's Michael Balint Memorial Lecture 2013 entitled 'Balint at the cutting edge: contributing in a changing world' is a welcome and timely account of how Balint work can help practices face this incessant change and sustain themselves for the future. A podcast is also available through our website.

David Watt, Vice-president of the society and Secretary for many years, continues this theme of doctor and patient in his address to the Oxford conference in 2012. An experienced GP and Balint group leader, David gives a thoughtful, reflective account of how Balint work can be a powerful force for good at both an individual and organisational level. He reflects on his long career and the role that Balint work has played in his development, since he was a trainee on the Whittington VTS in north London – my own alma mater.

Within the UK, beyond London, Balint activities continue apace, extending to colleagues in Northern Ireland. This year we include reports from the north-east, north-west as well as from further afield in Budapest and Kampala in Uganda. Dr Manjit Suchdev, a GP from Newcastle, currently working for VSO in Africa, gives a brief account of his attempts to introduce Balint work to our colleagues in Uganda. It is an indication, should we need it, that the fundamental principles of Michael Balint speak to clinicians across the world, irrespective of language or culture. The doctor-patient relationship is a powerful one, wherever it exists. I am grateful to all our contributors for this edition, as well as those colleagues who work hard throughout the year keeping the work of the society both vibrant and successful. I hope you enjoy the Journal for 2013 and look forward to hearing your comments and reading your submissions for 2014.

Tom McAnea
Editor

The Balint group and the clinician-patient relationship: a medical student's perspective

Eve Merry

The Balint group has been an important forum in which I have been able to discuss memorable or challenging interactions with patients encountered in my first clinical year. It has been reassuring to have a place to express emotions or concerns that have arisen, and to know that they can be discussed in confidence with my peers, who may offer advice to help guide my response to certain situations. In particular, I have often discussed the medical student-patient relationship in the context of my experience with a patient suffering from cancer. For me, this relationship has been of huge value, however, I have found it challenging for a multitude of reasons. This patient has been pre-eminent in my thoughts throughout the year. I wish to write about why this patient has been so absorbing, issues that I have discussed at the Balint group and how these discussions have helped me to acknowledge and understand the emotions I have felt.

Prior to meeting this patient, I was given a quick overview of her history by a specialist nurse. I was briefly told that she was a young woman with a form of cancer, which had a poor initial prognosis of 18 months. From just an introductory sentence, I was instantly struck by the tragedy of her situation. With little prior patient contact, and very little exposure to cancer, I was uncertain of how to approach her, and doubted she would want a medical student to intrude on her treatment. I think the apprehension primarily stemmed from the young age at which she was diagnosed. Being of a similar age, I began to put myself into her shoes, and could not begin to imagine the cascade of emotions she must have felt. With hindsight, I feel that my apprehension was justified. It has been emotionally challenging to hear her story. Yet, the opportunity to build a relationship with her has gone beyond teaching me about cancer, it has also provided insight into the complexities of the doctor-patient relationship.

Fortunately, it became quickly apparent that she was an extremely charismatic and open individual, who was happy to share details of her history with me. This allowed me to provide a thorough introduction of her medical history at the early Balint groups, to set the scene for discussions to come. Whilst sitting with her at her chemotherapy appointments I gradually heard her moving story. She presented with a sudden onset of symptoms, which led to imaging that revealed her cancer. This was devastating for both her and her family, who could neither believe nor accept it. She refused immediate treatment and asked for a second opinion, which sadly confirmed the diagnosis. It was concluded that she had a very malignant tumour. However, in reality, it has behaved more like a low-grade tumour. Over the next few years her symptoms were well-controlled. During that time she decided to raise money for charity and was most successful. Four years on she started experiencing worsening symptoms prompting further investigation, which showed tumour progression. This led to the initiation of further treatment, which was well tolerated and gave encouraging results, with a significant reduction in her symptoms. At present, she must wait and see how her tumour responds without treatment. Although she finds it unsettling to have lost regular contact with the cancer team, she is pleased to be free of the hospital, and is embracing all opportunities that accompany this independence.

Unsurprisingly psychosocial factors are prominent in her case. After hearing an overview of her medical history, the majority of our meetings centred around discussing details of the illness that were most difficult for her. She had been depressed for some years, and was receiving psychotherapy. Her mother also provided essential support. Over the past 6 months, I felt I had also taken on a role in her psychological support. Her family encouraged our meetings, saying that it was 'therapeutic for her to talk through her problems out loud'. I was pleased to be of use, and felt that listening was one of the few skills that I, as a medical student, could offer her, or any patient for that matter. However, I soon noticed my susceptibility to being absorbed by her emotions and found it difficult to remove her from my mind at the end of a day. I realised that I was becoming too attached to her, and was relieved I could discuss this in the secure setting of my Balint group.

On discussing this I began to understand why I cared about her situation so much, and why I met her so regularly. The most obvious reason was her age. I felt a connection with her because of our shared youth, and because I could feel the terror of such a devastating diagnosis at such a young age. I also began to see similarities in our personalities. She is an extremely competitive and motivated person, which led her to get a job in a top firm in her industry. On receiving her diagnosis, and more importantly her poor prognosis, she left her job and decided to do voluntary work. It is apparent that most of her sadness and frustration stems from being 'blocked' in succeeding. I can feel this frustration, as I too have a desire to be successful in my medical career, and can imagine that losing control over her future was a harsh position to be forced into. It also saddens me that she was given such a poor prognosis, which forced her to make certain decisions. I can't help but wonder what choices she would have made if she had known she had more time.

Life satisfaction, and her lack of it, again exposed some of my own fears. Of course no one wants to die. But I always hope that when I do, I will die feeling totally satisfied with the life I have led, without any regrets or unfulfilled ambitions. It has therefore been extremely sad hearing the endless list of things she hopes for, which the cancer has prevented her from doing. In spite of this she maintains a very active social life, and has many friends. But understandably she has felt easily disappointed that she is not able to keep up with them in all areas of her life.

Her longing for a close relationship has been a recurring theme. This led to another discussion at the Balint group. Having identified why I was finding her case particularly emotional I began to consider my role as a medical student. She began to ask me advice about dating to which I responded. On my walk home, I began to question whether I, as a medical student, should be offering advice about her romantic life. I was concerned that our relationship was becoming more like a friendship, and that I was losing grip of my professional boundary. At our Balint group I was reassured that sharing my thoughts on the matter was not the wrong decision. I realised that as long as I was aware of issues like this, I would be able to maintain control of the boundaries, and felt confident that I had just responded in a natural way as any professional would.

She had demonstrated her trust in me through sharing such personal information, and even asking for advice. Given her tragic situation I was pleased to be able to offer some support. The question that arose next was how long should I provide this support for? I realised that I didn't want to say goodbye. It seemed unfair to disappear given all she had shared with me and after providing ongoing support. I felt I had a responsibility to continue this. Independently of my own thoughts, she expressed how important I had become to both her and her family and her desire to keep on meeting. I became torn as I wasn't sure how far my support could go, and was concerned that I would become too emotionally attached, which was best avoided given her prognosis.

I was relieved when one of my peers at our Balint group revealed a similar dilemma with another patient. Following comparison of our patients, I saw how important it is to maintain a professional boundary, and to be a friendly professional, not a professional friend. It also highlighted the subtle difference between the relationship that the patient has with a doctor and with a medical student. As a medical student you have the luxury of time to listen to patients and to really get to know them. Since medical students are not directly involved with treatment, it is easy for patients to become confused by their role and they are liable to place a medical student in a different box to a doctor. Indeed, I feel that to some extent, both the other student and I became more like friends to our patients and their families. However, I was reassured at our Balint group that this was no mistake of ours, in fact maybe it was of credit to us that we had gained such trust. What is important is to be aware of your own emotions and the patient's emotions, and through this awareness you will find the best way to proceed in any situation. With the advice of my peers, I decided that I would continue to see her, but that I would see her less often and maintain contact through email. This would ensure she didn't rely on me too much for psychological support, which would be both beyond my emotional and time limitations, and equally would protect me from becoming too attached to a single patient.

Through discussions about this patient, and hearing my peers' experiences I have seen the value of being part of a Balint group at this early stage and throughout my medical career. The variety of reactions we have had to different situations has highlighted the emotional challenge of medicine. As pre-clinical students we focused on the academic side of medicine, but now we are faced with the multitude of emotions that patients can evoke in us. Our lack of experience makes us even more vulnerable to this, a recurring theme being the problem of becoming too attached to patients, who somehow we feel we connect with. I have learned the importance of discussing difficult situations, and acknowledging my own emotions. After all, it is only human to respond emotionally. However, as doctors we must learn to manage our feelings in order to remain emotionally independent from our patients, so that we can provide objective advice whilst protecting ourselves.

Balint essay competition

Dr John Prosser

The long interview espoused by Balint is a useful tool for general practitioners. Our long relationship with patients and their families creates a layered understanding constructed over the years to include not only directly acquired patient information but also tangentially from family members. In turn this informs a psychodynamic formulation of the patient that could be termed "knowing a patients character". In turn this supports diagnostic intuition about when and how to reframe incongruent narratives.

Balint described how deeper understanding is achieved with the "long interview" coupled with empathic understanding. It is with this incisive dynamic that I have been able to read situations and come to conclusions that would otherwise remain hidden. One such patient I saw recently comes to mind.

Mr Z, an elderly man, had lived with the consequences of polio since early childhood. His life has been a series of physical and psychological challenges as a consequence. His stoical and independent character had a self-reliance that defied his disability.

Mr Z complained that recently he had been waking in the night and staring motionless and frozen at the ceiling. He was unable to move and fearful of impending doom. "What is happening to me and why now?" he asked.

As we talked about this it seemed clear that there were elements to the history that would satisfy a diagnosis of post-traumatic stress disorder. There was no new physical finding and whilst he had grown steadily weaker he had long since thrown away the callipers he had as a boy. He has steadfastly refused any aids that might help.

Over a few consultations we managed to peel back these experiences, reassured by normal serology and neurological examination. Eventually we both arrived at the memories of him as a young boy in hospital with an iron lung surrounding him. During the 'Blitz' many raids passed over but on one such occasion a heat lamp was left on during a raid which had provoked an evacuation to the shelters. He was left lying motionless and staring at the ceiling in much the same way as his flashbacks. The bombs fell as he lay gradually being burnt by the heat lamp!

As we discussed this, it was clear his lifelong cast-iron defences were not going to allow a stranger the same confidence. So we have talked at times about these flashbacks. As we have done so over time they have become less frequent and intrusive and I too recognise and respect his defence mechanisms as vital as psychological callipers. I encouraged him also to talk to his wife about these early experiences.

As a GP mindful of the techniques espoused by Balint I feel that creating a deeper understanding of this man in the context of his early experiences, and being able to reassure and act as a sounding board, I have helped him towards safer territory. This has all been enabled by the Balint principles and the trust in the "mutual investment fund" that is the Doctor-Patient relationship.

Dr John Prossor
MBChB DCH DRCOG FRCGP FPcert
PGCE med ed.

A Balint group as the realisation of Tavistock ideas

Dr Tatiana Tkachenko

I would like to start my reflections on the two-year experience of our Balint group with clinical examples.

Case 1. The doctor, a children's anesthesiologist, referred with a worrying problem: why patients, children and adolescents, have such strong aggression during the recovery period. It was observed in most of them. Carers and relatives often have no warmth and patience. Why is there no warmth? Why is the aggression of injured patients so strong? Patients are rude, even if they are confused. She said: "There is a feeling that I am to blame, though I do everything that is necessary ...".

Following the presentation of the case in the group there was silence for a while, and then an expression of sympathy and support. The causes of aggression and its relationship with physiological and psychodynamic processes were explained.

Case 2. A male psychologist told of his attempts to give psychological help to a young woman aged 34, who had problems with her brother, a 24 year old. Their mother left them when the patient was 10 years old, and her brother - 9 months only; then their father left them. The children were then brought up by their grandmother, and left alone; they were able to survive because of the early marriage of the patient, when she was aged 16. The marriage was a failure, because the husband was a man with a "difficult character". After the divorce, the patient remarried and, it seems to her, again unsuccessfully. She sought out the father and the mother, and is trying to take care of them and her brother ("He's like a son for me ..."). The situation worsens by episodes of violation of the law by the brother, and his propensity to theft. In this case, the patient actually does not appreciate her family life, turning a blind eye to the positive. The psychologist was left with the feeling that the patient is keeping something back, a feeling of helplessness due to unfinished treatment.

In this situation, the group found connection with the film 'Breakfast at Tiffanys'. Different opinions were expressed about the life situation in which the patient found herself. The participants supported the reporter in that they felt he had helped the patient, that, in fact, he had given her the opportunity to say so much about herself, thinking that perhaps this was her main goal in searching for therapy.

Case 3. A female psychologist works with a 7 year old child. The boy's parents divorced. After a lot of sessions the boy continues to reflect in pictures and in play therapy the conflicts that took place in the family. The psychologist said that she is already tired of these endless reflections of parental quarrels by the child during the sessions. She had a feeling that she could not help in the way she wanted to, and that positive changes occur very slowly, if one can notice them at all ...

This causes complex feelings in the group. Everyone starts their speech with pauses, sighs, with their own memories. By the end of the group meeting the reporter noted relief, a feeling of non-verbal support, a sense of confidence and strength to continue her work.

Aggression, love, fear - these basic emotions are reflected in the clinical cases considered at Balint groups, and most often lead to feelings experienced by therapist-reporters. Freud wrote that "from the outside danger it is possible to run away, but an attempt to escape from the inside danger is a difficult matter" [1, p. 318], referring to "the fear of the threatening external danger and the merger of both types of drives of Eros and Aggression". The patient passes "the difficulties in the transfer of anxiety, stress and frustration" [2, p.78] to the therapist who can "feel confused when confronted with problems that are not associated with physical illnesses or deformities" [3, p.166]. Bion teaches us a great deal about how significant it is for the analyst (and any doctor) to accept the patient's hate and to be in touch with feelings such as this [4]. In this case, the therapeutic situation should be safe: "only when there is no fear, love flourishes" [4]. Michael Balint wanted to spread psychoanalytic thinking more widely for the benefit of patients and called his groups "training cum research" [5, p.30]. Thus, "creative ways to understanding our troubling patients" [6, p.36] are necessary. Since "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". Balint groups also provide a focused and opened 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?" [7, p.15].

I think that in answering these questions and working in a Balint group in general, through our consciousness we refer to functions, the value of which was allocated by C.G. Jung. They are: perception, reasoning, feeling, intuition. In "The Tavistock lectures" he noted the importance of ectopsyches and endopsyches, and emphasised the particular role of intuition in the work of a doctor. [8] Working with the Balint group drew my attention to the value of these functions and the need for their development. Given the therapeutic aspects of a Balint group, I came to the conclusion that at each of our meetings, there

are elements of the four stages of psychotherapy, which C.G. Jung described as catharsis, elucidation, education and transformation [9, p.385]. Perhaps the intensification of all these issues is involved to create the atmosphere of a "harmonious crossing" [10, p.76] in the group, and between the reporter and his patient, which is characteristic for the optimum function of a Balint group, and thus for the achievement of emotional awareness.

A group takes over regression of a speaker and the leader's task is to maintain "a climate in which this regression could become a common experience" [10, p.76], to help to avoid professional "burnout" [11, p.20] . This is facilitated by the fact that "the aim of focusing on these issues was to enable the physician to recognise his feelings, his behaviour and reactions to his patients, and by understanding their dynamic meaning and then modifying them. Balint called this process "a limited though considerable change in his opinion, one of the main goals of the group work. We share our thoughts about the Balint process:

- How it works;
- What it can do for our patients and ourselves". [12, p. 4]

Answering these questions, I estimate the experience of two years of work of our Balint group, which includes doctors, psychologists, psychoanalysts, and students of The Regional Institute of Psychoanalysis. During these two years we examined 19 cases, one of which had been raised three times, and one case, twice. In work process the participants experienced different feelings – from the feelings of depression, anxiety, desire to escape, boredom, to pride, satisfaction with the work of a patient and his therapist. Fortunately, at the end of each group meeting (we met once each month) all the speakers noted a positive feeling due to help from the group.

Concluding the article, I would like to cite another case report. A male psychologist addressed the group to allow him to report a "positive case" from his practice. This is a case of a patient aged fifty, an engineering graduate, who was forced to work in another field for a long time to help his family. He had depressive feelings, difficulties and failures. However, all these years he had a dream to become a good master of car repairs. He decided to become a student in order to fulfill this dream. At the session in which he confirmed his decision, he told the psychologist about a book he read about Stradivari and his skill. The psychologist noted the calm state and confidence of the patient, which transmitted to him, so he decided to talk about it in the Balint group. I felt the experience that led to him sharing this story in the group represented "the positive group member's countertransference" [13, p. 7]. Probably, it is important for any Balint group to share sometimes positive experiences, that prevent burnout, and kind feelings are experienced by the majority of people in the same way. It seems to me that the expression "Tavistock ideas" in the title of the article came to me to represent a place that saw very important developments in psychotherapy.

I think the term "Tavistock ideas" led to the creation of this text as a tool for analysing the causes and conditions, and armed me with a new vision of humanity [14], and the creative space which the Balint group can be.

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This article is written as a response to a very friendly 'Journal of the Balint Society' editorial offer to take part in the annual essay contest 'The Balint Society Prize 2013'. For me it was an invitation to engage in a dialogue and to reflect on the functioning of the Balint group primarily as "training cum research". To work on the essay was a valuable experience, which I wish you to go through also, dear colleagues. I express my deep gratitude to Ceri Dornan, and Thomas McAnea, and my other colleagues for their kind help in publishing the essay.

How to fail at running a Balint Group

Anthony Froggett

Introduction

I like to think of myself as something of an expert when it comes to running groups that fail. Several years ago I was asked to set up a 'learning set' group for locum GPs for a year. This group stumbled along, typically with two or three members each time, before coming to a close. I've set up a private Balint Group that started with eight GPs and closed after a year because of low attendance. I also co-led a group with Ceri Dornan for junior doctors at a local teaching hospital. This group had nine people signed up for it on paper. Four people attended the first couple of sessions but the numbers quickly dwindled to the point where we were sat by ourselves eating the sandwiches that had been ordered for the group!

Talking to other Balint Group leaders, I don't think these experiences are uncommon. Many groups are enthusiastically conceived but few reach full maturity. Why is this the case? What are the factors that lead to a group not enduring? Thankfully I have also conducted groups that have managed to survive, including a private Balint Group that has met for the past ten years. So, what is the difference between groups that thrive and those that limp along or close after a short period?

In *The 'essential' and 'desirable' characteristics of a Balint group* (1994), Paul Sackin gives a helpful outline of the core elements that are necessary to run a successful Balint Group. He describes the task of the group and gives helpful tips about things such as the size of the group and not using case notes for presentations. He refers to "the standard rules for small group working" such as confidentiality, but what are these rules? They are omitted perhaps because a list of all the things one had to think about in order to lead a successful group would be long, tedious and perhaps rather obvious. I doubt a complete list of "rules" would be possible. In this short article, I have set myself the much easier task of listing some of the ways to get things wrong when running a Balint group.

Here is my list of ten ways to run a group in order to demoralise participants, encourage drop-outs, and to ensure the early closure of the group.

10 ways to run a group that will fail:

1. Run the group as soon as possible without minimal planning. Allow yourself to get carried away by your own enthusiasms. Assume that each enquiry about the group is someone who is committed and willing to join. Start with low numbers if possible and assume that others will soon be joining the group.
2. Isolate yourself professionally from others if you can. If it is a private group – don't bother to network with colleagues - send out an email to a general email list. Better still, get someone else to do this on your behalf.
3. You may be asked to run a group to fail in an organisational setting. Although this may not always be explicitly stated – look for signs such as the group being optional, last minute organising, and clashes with other meetings. If you are asked to run a group in an organisational setting then assume that all practicalities have been sorted out beforehand. Turn up on the day and see what happens. Don't speak to tutors or managers; especially do not speak to secretaries, caretakers, or admin assistants. Assume everyone in the organisation knows what you are doing and are fully supportive of the group.
4. If you are setting up a private Balint Group try to avoid any discussion of money. Wait until the last minute to mention fees and then ask, in an embarrassed way, in order to communicate the lack of value you attach to the group. If possible don't ask for money at all and pay all expenses yourself. This will ensure that you are left resentful and do not want to continue running the group.
5. Choose an inappropriate venue if possible – medical settings are best, if these are not available choose another venue with strong emotional feelings attached to it (I know of a course that was successfully closed by running it in a hospice for several years). Venues that are obscure, or with poor parking, or that are very busy are a good option. Choose a room that might get double-booked or where you might be interrupted.
6. Don't have any 'selection' or induction process for the group. Let anyone who wants to join come along, regardless of their interests or suitability.
7. Don't ask for any commitment from participants – be as flexible as possible. Let people come for a trial period rather than making a commitment to attending. If people do not attend the group don't follow them up by email or telephone. If this is not your style, then alternatively you can anxiously contact each member about the group to check if they are going to attend the next session – in order to communicate that you don't think the group will survive without their unwavering commitment and attendance.
8. Choose a co-leader who is unknown to you, or (even better) someone whom you actively dislike or distrust. Don't take time to discuss and plan running the group together. Dynamics of competition and rivalry are very helpful in getting a group to fail.

9. Don't have any system for taking notes about the group. Do not record attendance, apologies and notices of future absences. Do not write down your thoughts about how the group went or ideas that you have had about the group.
10. Finally, avoid reflecting on how the group is going. Arrange your schedule so that you have to immediately dash off after running the group without speaking to your co-leader. Do not arrange any form of supervision or consultation to help you with thinking about the group.

Conclusion

I have listed above ten of the things I have done that have resulted in the failure of Balint and other groups that I have conducted. There are, of course, many other ways to fail at running a Balint group. You may even have done some of these yourself. Most of the ways of failing stem from not wanting to think about the ordinary difficulties of running a group. Paradoxically, by trying to avoid the feeling of failure we often inadvertently bring it about. By avoiding awkward conversations with colleagues we temporarily feel less anxious, but we are also no longer in a position to learn from our experiences. Running a successful Balint group requires many of the same attributes needed for being a participant in a Balint group – one must learn how to reach out to others in order to achieve something that is not possible by oneself, to be tolerant of one's own and others' mistakes, and to have the courage to learn from these. Instead of trying to avoid failure we should perhaps consider how we might embrace it; that is to celebrate our mistakes, stumblings and mishaps as we learn. In the words of Samuel Beckett "Ever tried. Ever failed. No matter. Try again. Fail again. Fail better."[1]

1. Samuel Beckett, Worstward Ho (1983)

Antony Froggett is a training analyst and training supervisor with the Institute of Group Analysis. He was the Director of Training for the IGA training courses in group analysis in Manchester (2007-2012). He leads two on-going Balint groups for GPs in Manchester – one co-led with Ceri Dornan and the other by himself.

Longhirst Conference 2013

Christina L Blackwell Clinical Psychologist

The organising group felt that the usual format of asking a GP to go through their caseload as an introduction to the Balint weekend had become predictable and we wanted to do something more creative this year - in particular, something arts-based. We had the idea of using poetry to help us get past the day to day and into the layers of communication and feeling that pass between doctor and patient.

The first poem I thought of was Julia Darling's 'Sudden Collapses in Public Places'. Julia Darling was a much loved poet who lived and worked in the North East of England. She developed breast cancer and died in her 40s. She wrote a series of poems about her experience and, 'Sudden Collapses in Public Places' brilliantly expresses the universal dread of both physical and psychological collapse. I then decided to use a second Julia Darling poem, 'Too Heavy', in which she addresses the doctor directly and speaks about the power of the Doctor's words and how they impact on the patient.

This being Balint, we then needed a poem from the Doctor's perspective. This was initially more difficult to track down and then, out of the blue, our friend and colleague Manjit Suchdev, who is not with us this year as he is doing VSO in Kampala, wrote a poem which expressed his feelings about the limitation of words, and how powerless the Doctor can feel.

Finally it seemed correct to include a poem that is about the doctor as patient - because of course we are both. So we ended with 'Like Me' by Marc J Straus.

Dave Morgan and I read the poems to all conference delegates who were then given a copy of the poems to read and digest. The consensus was that this was a useful and powerful experience for delegates. It got us out of the day to day and into the realm of feelings and I found that material from the poems found its way into the work of the Group I co-facilitated with Gordon Shiells throughout the weekend.

Poems For Longhirst 2013

Julia Darling –
Sudden Collapses in Public Places

Like buildings people can disintegrate
Collapse in queues, or in a crowded street
Causing mayhem, giving kids bad dreams
Of awkward corpses, policemen, drops of blood
But I'm stood here, a miracle of bones
Architecturally balanced in my boots

I feel each joint, each hinge and spinal link
Jolting to the rhythm of my breath
Aware of each tremor in my joints
And yet I'm scared I haven't done enough
To be re-enforced and girded. Christ I
Fear those flowers tied to lampposts. Fear the crash

Julia Darling – Too Heavy

Dear Doctor,
I am writing to complain about the words
You have given me, that I carry in my bag
Lymphatic, nodal, progressive metastatic
They must be made of lead. I heave them everywhere.

I've cricked my neck, I'm bent
With the weight of them
Palliative, metabolic recurrent
And when I get them out and put them on my table
They tick like bombs and overpower my own
Sweet tasting words
Orange, bus, coffee, June
I've been leaving them
Crumpled up in pedal bins
Where they fester and complain
Diamorphine, biopsy, inflammatory
And then you say
Where are your words Mrs Patient?
What have you done with your words?
Or worse you give me that dewy look
Poor Mrs Patient has lost all her words but shush,
Don't upset her. I've got spares in the files
Thank god for files!
So I was wondering,
Dear Doctor, if I could have
A locker
My own locker
With a key
I could collect them
One at a time,
And lay them on a plate
Morphine-based, diagnostically
With a garnish of
Lollypop, monkey, lip

Manjit Suchdev – Untitled 17th May 2013 – Kampala – Uganda

Her eyes bright & white
Angst in her face
Fearful she looked
You want to die?
You want to die?
You want to die?
The doctor cajoled
A teacher
Tends to small children
In primary years
Only 25
Had not come to the clinic for 6 months
It is the smell she said
Smell of the tablets
Or was it smell of death?
The will to defy HIV
The will to defy death
Defiance
Tinged with a small sense of failure
She did not say much
But her eyes
Her face
Her silence did the talking
Brought in by her Mum
Dignified
In her advancing years
Wiser than her years
Her eyes
They have seen a lot
A resignation so deep
But also desperation
To keep her daughter alive
It's the eyes that do the talking

Like Me – Marc J Straus

Doctor:
When I was two, my doctor
Had a large house
On Cortelyou Road. The exam room
Smelled like a dead frog
And my temperature was taken
Rectally. By age five
I was injected with tetracycline
Monthly
By Dr Ryan. He later died

Of lung cancer. Who influenced me the most, a
medical school
Interviewer asked. Thirty years later
I still don't know. Today
A sixteen year old girl said
She'd like to be
Just like me as I pushed
Her 3rd course of chemotherapy.

CLB 11th June 2013

20th Michael Balint Memorial Lecture

Thursday April 25th 2013
The Medical Society of London
Dr Andrew Elder

Balint at the cutting edge: contributing in a changing world

Thank you very much for inviting me. It is a great honour to be invited to give the Twentieth Michael Balint Memorial Lecture. There is no body of work that means more to me.

I remember well the anxiety I used to feel before presenting my cases in the first Balint Group I attended in 1972 at the Tavistock Clinic. After offering a case, an atmosphere of attentive expectation would soon settle on my fellow members of the group - their heads turned – all ears. I suppose the experience of presenting (a case) is always to a certain extent one of vulnerability and personal exposure. At least on this occasion I'm allowed my notes! I have felt quite a lot of anticipatory anxiety whilst preparing this lecture and thought I ought to start with A Balint Health Warning! Five years after retirement, what have I got to say? I wanted to make it relevant to the present changes but do I know enough about them? How would my choice of subject fit with the tradition of previous Michael Balint Memorial Lecturers? Particularly if I decided to take us into what, at first sight, might appear to be slightly unusual Balint territory: the role of practices and the role of Balint groups within the organisational structure of GP practices as they may need to evolve in the new world. I shall also talk a little about Attachment Theory. Lurking behind this subject lies a subtitle: "Balint in a changing world". Before we start, perhaps we should remind ourselves of what Michael Courtenay said at the end of his talk 'Renewal through Reflection' given in Oxford in 2010, '*It may well be that the best is yet to come!*' (Courtenay 2011)

Michael and Enid Balint

I want to begin with a few words about the Balints themselves. This may seem unnecessary in present company but my purpose is to remind us of the breadth of their influence. This lecture primarily honours Michael Balint but Enid also made a very significant contribution from the outset.

My reason for starting in this way is to emphasise that all the principal strands that stem from the Balints' innovations remain highly relevant: the centrality (indeed in some senses, the inescapability) of understanding clinical work as a two-person activity; the almost *marital* nature, or to use a Balint term, the *interpenetrating mix-up* (not necessarily harmonious!) of long term doctor-patient relationships; the profound *understanding of the setting* as the principal determinant of the effectiveness of therapeutic work, whether undertaken by a psychotherapist or a GP; and of course the development of what we now call the *Balint group* as a method of research and training in professional work.

Michael Balint died at the end of 1970 and Enid Balint died in 1994, almost twenty years ago. A lot has happened since that time.

The changing context

From the 1990s onwards, the Health Service has been subjected to wave after wave of 'reform' and organisational upheaval that has affected morale and the role of GPs in a fundamental way. If metals can fatigue, human beings certainly can! One of the most striking changes since the 1990s is the massively increased organisational complexity that now surrounds all professionals in the present Health Service. Long gone are the days when Michael Balint could refer to GPs as 'undisturbed and unhampered, sovereign masters of their own surgeries' (Balint 1957). Clinical Commissioning Groups (CCGs) have been launched this very month and are beginning to navigate in the turbulent waters created by the new Health and Social Care Bill (2012), and severe financial constraints. Will they bring yet another layer of organisational anxiety and control to their constituent practices, or manage to reconfigure services in a helpful way towards a better balance between primary and secondary provision, possibly even seeking to strengthen the containing function of practices in pursuit of cost saving?

Many other changes have been introduced in the last few years: since the introduction of the Quality Outcome Framework (QOF) in 2004 the GP contract has become increasingly weighted towards a disease-centred approach; collaborative teamwork with mental health professionals has all but gone from the majority of practices; GPs now have virtually no freedom of referral in mental health and are beginning to face increasing restrictions on ordinary medical out-patient referrals as well. Practices have to manage a complicated set of relationships involving their paymasters, the requirements of clinical and financial governance, commissioning bodies and of course, patients. Larger confederations of practices are beginning to emerge, some under the umbrella of private companies and corporations, others under the NHS. We may be entering a much more

commercialised and competitive era in primary care with pressure to deliver more specialised services and a larger proportion of salaried doctors employed by these organisations. There are many aspects of the recent changes that could be highlighted but it is the growth of organisational complexity, within practices and without, and the balance that needs be held by practices between the containment of anxieties or their aggravation, that I want to underline.

And the Balint world is changing as well. The third generation of Balint doctors - those of us lucky enough to have had personal contact with either Michael Balint (unlikely) or Enid - are now members of the grandparent generation! Balint group experience is mandatory for psychiatrists in training; a fourth year of GP training has been agreed and there are thoughts about including a Balint group experience in this, possibly in a joint endeavour with psychiatrists. Our society has the beginnings of a formal link with the RCGP and recently participated in an event hosted by the College called 'Time to Think' at which 100 GPs attended. Many more colleagues with an analytic background are showing an interest in Balint group leadership and a recent day about leadership held by the society was oversubscribed. There is not yet a formalised leadership training programme but there is a well established series of annual weekends which all include leadership workshops. The International Federation now holds regular conferences on Balint group leadership; and we have a President who lives in Newcastle!

A semi-permeable membrane?

Prior to the 1990s, practices were left largely to their own devices. Since then there has been a steady escalation of the extent to which the external management of the Health Service impinges upon a practice and dictates much of what goes on. Just as Balint groups need their leaders to provide a secure boundary so that the work of the group can be undertaken, maybe practices now have to develop something similar: a more actively managed organisational boundary, a kind of semi-permeable membrane? If I remember correctly, a semi-permeable membrane is one that is able to select and permit the passage of certain molecules but not others. By serving as a barrier between the interior and the exterior of a cell, it protects it from foreign bodies that might be harmful. A great deal of energy is required to maintain the inner environment in the desired state. In the case of practices, the gradient between internal and external seems to have become considerably steeper and potentially more toxic than it used to be. The old more or less porous boundary between a relatively benign environment outside and a laissez-faire one within is no longer sufficient. In her paper 'Mindlessness in Troubled Times', my colleague Jan Wiener states, "As ever, there is a danger of the kind of thinking and reflection that is helpful in general practice being squeezed out where quantity rather than quality is the order of the day and symptom categorisation more significant than what lies behind the symptoms" (Wiener 2012). The problem arises out of an irreconcilable contradiction between ideals and practical values. In his book The Craftsman (2008), the philosopher Richard Sennett puts it particularly well....'trouble is caused by conflicting measures of quality, one based on correctness, the other on practical experience. These conflict institutionally, as in medical care, when reformers' desire to get things right according to an absolute standard of quality cannot be reconciled with standards of quality based on embedded practice.' I like the sound of embedded practice! It takes us to what really goes on in practices and how that might translate at a much higher organisational level.

Unorganised and organised illness: primary and secondary care

Many of you will be familiar with the work of Barbara Starfield, a paediatrician and Director of Health Policy at Johns Hopkins University who died in 2011. Her research was particularly concerned with the determinants of inequity in health and she became an active champion of primary care after demonstrating clearly that health care systems with strong primary care result in **greater cost effectiveness, lower mortality rates** and **less health inequity** than in systems which are more weighted towards specialist care. Present trends in the UK seem to indicate that we are beginning to follow global trends and are moving towards a greater proportion of hospital consultants. In 2004 the balance of specialists to General Practioners tipped in favour of specialists for the first time. By 2010, GPs only represented 27% of all doctors working in the NHS (Heath 2011). Why does this matter? Somewhat against expectation, Barbara Starfield's research shows that an increase in the relative proportion of specialists leads to an increase in premature mortality (Starfield 2009). Her figures relating a strong primary care system with a reduced number of premature deaths are consistent across 18 OECD countries. (Organisation for Economic Cooperation and Development). It remains to be seen what the affects of the Health and Social Care Bill and the advent of CCGs will be on this critical balance. Our system of first access to a generalist (GP) may come under increased pressure in a more competitive world with private providers coming into play. But surely the impact of QOF has already pushed GPs significantly into a more disease-centred approach within primary care? After all, where does this all-important balance between primary and secondary care *really* lie?

One of Michael Balint's most useful concepts is the distinction he makes between organised and unorganised illness. He first discusses this idea on page two of 'The Doctor, His Patient and the Illness' (Balint 1957) and

once introduced it runs throughout the book. Here's what he says (as with so much in that book, it's worth reminding ourselves) : 'We know that in many people, perhaps in all of us, any mental or emotional stress or strain is either accompanied by, or tantamount to, various bodily sensations. In such troubled states, especially if the strain increases, a possible and in fact frequently used outlet is to drop into one's doctor and complain. I have deliberately left the verb without an object, because at this initial stage we do not know which is more important, *the act of complaining or the complaints that are complained of. It is here, in this initial, still "unorganised" phase of an illness, that the doctor's skill in prescribing himself is decisive*.' Isn't this really where the dividing line between primary and secondary care often lies – in the heart of every consultation and within the doctor-patient relationship – not only at the more easily measured gate of referral? In addition to the doctor-patient relationship, this balance will be influenced by the degree to which 'advice' is available to the doctor, both actual advice within the immediate primary care team and reflective 'inner' advice within the consultation, and of course the degree to which the doctor feels supported by his practice and secure in being a generalist, a true general practitioner. To what extent will CCGs ponder these connections and examine ways in which front-line clinicians can be supported? This balance between organised and unorganised illness, so important and so easily lost, runs through everything and as Michael Balint reminds us, it is one of the places where 'the doctor's skill in prescribing himself is decisive.'

A new kind of doctor

When Michael Balint's work first appeared, it represented a radical advance but one that seemed synchronous with the then rapidly developing field of general practice. However, *the nature of the change* recommended by Balint has proved more difficult to grasp, and certainly more complicated to absorb in practice. Unlike most other approaches to improving doctor-patient communication, the Balints' approach involves a change in the doctor and therefore brings the potential for a genuinely 'new kind of doctor' into being: one more able to be self-aware and to attend to the emotions involved in a clinical encounter whilst also practicing medicine. The principal aim of Balint training is to provide a setting in which a doctor can make such a change. Not a simple matter.

The position could not have been stated more clearly than by Ian WcWhinney at the end of his paper 'The Physician as Healer: the legacy of Michael Balint' (McWhinney 1998). '*The implications of Balint's ideas for medical education have not yet been addressed. We speak of adding skills and competencies, but not of teaching a new way of being a physician. The difference between these two ideas is fundamental: one is additive, the other transformative; one assumes that the status quo is adequate but incomplete, the other that the status quo is fundamentally flawed; one sees the solution in terms of additional tasks, the other in terms of a transformation that will affect everything the physician does. Once we learn to listen, our clinical method requires us to attend to the emotions in every case. It cannot do otherwise*.'

If made, this is an enduring change. It is important that we do not lose sight of this as our principal aim, although it is true that many groups – particularly those for doctors in training – may have different aims. A genuinely 'New Kind of Doctor' is likely to remain largely unrealised without the major cultural change indicated by McWhinney.

Listening

In Balint groups, participants learn to listen more deeply to their patients through the experience of being listened to in the group. Listening is the heart of the matter. In a more general sense, too, if professionals do not feel listened to themselves they will not be able to listen to their patients; and worse, if they feel poorly treated themselves they are more likely to treat patients badly. As a psychoanalyst working with doctors, Michael Balint invited us to include a much deeper account of the emotions involved both in illness but also within the relationships of medical practice. The limitations and fall-out from an over-applied medical model (albeit with some add-ons) surround us all too painfully at the present time. No wonder there are calls for a change in 'culture' as a result of the mid-Staffs inquiry (Francis 2013). But how deep will the diagnosis go?

Attachment Theory

I now want to take a short detour into the less familiar territory of Attachment Theory and the work that has followed from Balint's contemporary (but not close colleague), John Bowlby. You will remember those rather wonderful single word titles of Bowlby's major publications: Attachment (1969); Separation (1973); and Loss (1980). Although there is a vast literature of research which has arisen from the applications and developments of attachment theory, this is largely unknown outside the fields of child development, psychiatry and psychotherapy. There is almost no mention of attachment theory in the literature of general practice. Michael Balint used the term 'mutual investment company' (Balint 1957) to describe the way in which 'capital' is accumulated in the doctor-patient relationship as a result of the regular meetings between doctor and patient. The capital in this mutual account can be drawn on, when needed, as the doctor-patient relationship develops. Through their contact with patients, the doctors and nurses who work in GP practices often contain knowledge of the significant events

and patterns of illness that have shaped the lives of their patients – in a sense this knowledge comes to reside in the practice itself, which then begins to take on some of the characteristics of a 'secure base' to its patients. This notion of the practice as 'a secure base – a place to which both patients and professionals become attached in characteristic ways' (Elder and Holmes 2002) - is noticeably missing in present day thinking about the Health Service. A sensitive recognition by the practice of a particular patient's pattern of insecurity, for instance, may well lead to a more secure attachment relationship to that doctor and the practice. Although built up through individual contacts over time, the attachment spreads out to be held by the practice itself, even by the physical space and presence of the building. After a time, all the staff who work in the practice inherit the mantle of what we might think of as a collective transference relationship.

The Practice as a Secure Base?

My main reason for introducing attachment theory at this point is to suggest that the characteristics of 'secure base' function might be developed into a framework for organisational thinking about the healthy functioning of practices. If there was a way of assessing the quality of 'secure base' provided by general practices throughout the country, and practices revealed the same proportions of security to insecurity as does the general population, then at least 30% would be classified as 'insecure' practices! (Elder 2009). It is intriguing to speculate what criteria might be included in such a test and what the resultant figures, in fact, might be! I think it is fair to say that if practices think about themselves as organisations at all, they do so mainly in terms of administrative structures, information systems, business practices and as organisations for delivering something called 'healthcare'. Certainly this is the impression gained from looking at the portfolio requirements for the RCGP Quality Practice Award which advertises itself as a standard in Organisational Excellence. Just as Balint training leads GPs to adopt a different conception of their role – moving away from one based solely on the medical model to one which is more complex and based on relationships – perhaps a similar change is needed in how we think about the role of practices? Such an approach would need to recognise the more demanding (and disturbing) aspects of life in a general practice. There is no better description of the emotional reality of front-line practice than that given by Tom Main at the beginning of his (much) earlier (1978) Michael Balint Memorial Lecture (Main 1989). After describing his trips as a senior army psychiatrist to the 'forward areas' in North Africa after D-day, and finding a 'lack of zest for hardship, dislike of danger, distaste for death, bitter grief about dead comrades, resentful alienation from people leading safe lives and so forth....' He continues in a memorable passage, 'Medicine and war are both serious, with issues of life and death, crippledom and loss, sadnesses and terrors about external dangers; and both are also complicated by anxieties from the inner world, unconscious fantasies of primitive sadism, punishment and so on...The front-line officer and the general practitioner are each regularly required, first, to contain high tensions arising from these two, inner and outer, sources and to withstand pressures from others in a similar state....'

Here then are some questions around a practice's function as a 'secure base' derived from attachment theory.

What does the practice feel like for those who work there? How securely attached do the professionals and the staff feel? Is there a sense of an organisation that 'listens' and begins to make a place for a member of staff *as a person*? I suspect many people will think about their practices as rather insecure places at present. Or the only secure place in a very insecure world, perhaps? Judging from my own experience, the main focus is now on the business side and attention is directed externally in trying to react to the government's plans, and less energy is left for looking after the practice's inner environment.

As the external environment in the NHS has become more demanding and in some senses hostile, do practices need a more effective outer 'semi-permeable' membrane than they used to? How is this boundary function managed?

Central to attachment theory is the role of play and imagination. One of the most damaging aspects of insecure attachment is its inhibition of exploratory play. If professionals feel secure this will enable exploratory and creative clinical work, as well as actual playfulness! Companionable interaction and the capacity for mutual pleasure is central to secure base capacity. Does the practice demonstrate narrative competence in an ability to tell and participate in its own story, the practice history - including founding principles, significant events, moving premises, characters who have worked in the practice, even a photographic history perhaps?

How does the practice cope with change and loss? Sometimes practices have to continue their work in the face of considerable trauma - sudden deaths, suicides, prolonged absences, serious illnesses, unexpected departures amongst key members of staff - all have to be coped with as well as trying to continue to provide a service for patients. Often such events land in quick succession and can lead to a traumatised organisation.

Most important of all and linking with the above – what is the capacity for thinking about these things? How does a practice express its need to be reflective? Are feelings permissible? Can conflict be dealt with constructively? Is there a team meeting, a multi-disciplinary meeting, or perhaps a Balint-type group? Or, do people hardly ever meet? And when they do, avoid discussion of their feelings about work. I suppose this is the

central question. What characteristics and structures does a practice need in sustaining itself so that it can – itself – both provide secure professional attachment for its staff, and then, in turn, is able to provide something of a secure base for patients?

Life in Practice: Take a minute or two...

Take a minute to think through the history of your practices from two perspectives: one, a historical one, perhaps return to your childhood GP, almost certainly single-handed, probably practicing from a converted part of the doctor's own house, and then slowly come up-to-date and arrive in the practice where you are currently registered or work, and consider the changes of the last few years and what future re-organisations might bring. This should provide you with an interesting journey that illustrates the growth in size and complexity of practices from the 1950s until the present day. And also, if you are a GP, take a journey through the various practices in which you have worked and think about the degree of shared discussion, ethos, tension and secure attachment that was fostered and how this was achieved. Or perhaps project forwards and think of yourself as a locum or salaried assistant doing the rounds in different practices within a large primary care organisation of the future. From their origins as part of the GP's home, practices enlarged but still often remained 'family' practices. Perhaps we are at a turning point in the development of practice organisation and it is time for more sophisticated thinking to be developed?

Balint and Practices

There was no significant organisational development of practices in Balint's day. It was the Doctor's Charter (1966) that stimulated the growth of group practice and partnerships. The 'collusion of anonymity' (1957) referred to patients getting lost through repeated hospital referrals; not as it might today, lost doing the rounds in their own practices! In 'Hanging by a Thread' (1999), John Salinsky describes the group of doctors who worked on the research projects with Enid and latterly with Michael Courtenay and Erica Jones as the 'core group'. Where has this group put its energies apart from participating in these research groups? Most obviously, our energies have gone into vocational training and other educational activities. Both the last two GP Michael Balint Memorial lecturers took these areas as their main subjects (Sackin, 2005; Julian, 2009), and the last psychoanalytic lecturer talked about the undergraduate scheme at University College (Schoenberg 2012) in which quite a few of the 'core group' are involved as group leaders. But has there been another largely unseen area, where our energies have also gone? Life in our practices seems to have been a more private unexamined area. There is very little mention of practices in our literature and not much in the wider GP literature either. Why is this? Is it because practices are 'family' and family life is private, not for general discussion? Looking back, it became clear to me that quite a lot of my Balint energy went into the life and structures of my practice. Was this true of others as well?

Tuesday Meetings

For as long as I can remember we had a weekly meeting in our practice: the Tuesday Meeting. This was attended by all clinical members of the primary care team – nurses, health visitors, counsellors, and if there were any at the time, physiotherapists, social workers and Community Psychiatric Nurses (CPNs). We had a sandwich lunch together (provided by the practice), fresh coffee or tea, introduced any new members, used first names, and rotated the job of (rather loosely) chairing the meetings amongst different members of the team. Each person took their turn to give a quick update on worrying patients who might call others out, ask advice or make referrals to other members of the team and answer queries about the management of their patients. This part of the meeting was of particular importance to the nurses and other staff who otherwise had to rely on corridor contact with the doctors. About thirty years ago, we introduced what was always known as the 'second half' extending the weekly meetings to two hours. Each week, the 'second half' alternated between a 'topic' or a 'case discussion' group – a Balint-like group - for those who wanted to stay. Most often 8-10 of us, health visitors, doctors and counsellors, did so. In the hour available we would discuss one or two cases. I cherish the memory of cases brought to that meeting which would trigger off – like a peal of bells – the thoughts and feelings of different members of the practice 'family' who were all seeing different members of the 'patient's' family! The Tuesday Meeting has become institutionalised and I came to realise that it was central to the culture of the practice, and to the degree of loyalty and attachment that staff felt. I don't think it would have happened without some of us having a strong Balint background. In general practice, a two hour space in the middle of the day needs actively defending.

The actual leadership of such a practice-based group poses a problem. I'm not sure we ever found a satisfactory solution. Until there are Balint leaders available to all practices, it is likely to remain a problem! For many years we had no formal leader, or a member of the practice took the role, but that would be at the cost of having a space to discuss their cases, or we rotated leadership but not all had the background to do this. If we invited outsiders, who were they? Would they understand our strange ways? We had group analysts (too silent, too analytic), family therapists (too willing to help, or to teach or to take referrals). These days, five years after retirement, I am occasionally invited in as a locum if the local family therapist who regularly leads the group is away.

Survey of Balint Society members

I thought I'd conduct a very simple survey amongst other Balint Society members to find out how many have also had Balint-like groups in their practices. I'm very grateful to those of you who troubled to reply. Of course, nowadays, practices have a great many different work-related group meetings. In the questionnaire, to define whether a group was sufficiently Balint-like, I asked whether it gave time for discussion of feelings and relationships.

I have received **thirty-three replies** of whom **twenty-two** were from GPs. Of the twenty-two GP respondents, **twelve** had some sort of recognisable Balint-type meeting and ten clearly didn't. Quite a high proportion I thought in a deeply scientific study!

As with any enquiry, much of the interest lay in bits of unsolicited or additional information that respondents included. Here is a selection of those asides:

- Was Balint-type, until squeezed out by referral and QOF-oriented discussion. Partners did not really support it and the meetings ceased to happen. Lasted 2-3 years until it withered away.
- One partner was quite hostile to Balint-type meetings and tended to sabotage them. The seemingly more pressing demands of QOF and referral meetings allowed them to be quietly dropped (without any discussion).
- Whether feelings were discussed varied, depended on the type of case. Hierarchy in the team often prevented feelings being brought in.
- Have been a local Programme Director and trainer for many years and do not know of any local practice that has a Balint-type meeting as part of their practice.
- Used to have meetings with a neighbouring training practice – 5 trainees and 3 trainers for about a year until neighbouring practice stopped training temporarily.
- For 20 years we had a supervision group, Balint-like, led by in-house counsellor/ therapist. Weekly for many years now monthly
- Group met 6-8 weekly, led by GP for 5 years....difficult group to control in strictly Balint way as multi-professional and GP knows the patients, leader somewhat enmeshed.
- Asked to lead on my retirement... practice had earlier had strong commitment to this sort of meeting for 20+ years...at one point, beginning of 1990s, majority of partners (5 out of 7) had had a Balint group training outside the practice.
- Meeting lasted 18 months while in preparation for RCGP Quality Practice Award but didn't continue afterwards.
- Small practice, nothing formal but much informal exchange about relationships
- Weekly, at least 24 years...a most valuable resource...an opportunity for multi-disciplinary learning and led to excellent cooperation and teamwork in the practice.
- Occasionally we had explicit Balint-style groups led by me...I don't think anyone does them now...I think the general tone of our practice discussions was influenced by Balint awareness...
- Rather wish that I could have influenced the practice more to take on Balint ideas, but we were all individuals, with our own enthusiasms and I would not have wanted to force them into something they didn't want to do....I did feel free however and comfortable to talk about my own emotional responses to work with patients and felt the ideas were respected...

Discussion of Survey

It will be seen that there are a number of themes (not unexpected) that could be pursued in more detail: the impact of QOF and the culture change of the last few years; meetings needing to be defended, or fought for; making a big difference to teamwork in practices; hierarchies; power battles; wounded feelings; the question of leadership comes up clearly; hanging on to a past valued culture; RCGP motivation; sometimes groups seem over dependent on one person and stop when they retire or leave; not sufficiently incorporated in the organisational culture of the practice; and a clear adverse affect from the loss of counsellors and psychologists being attached to practices.

Practices: Linking back to Balint

Although Balint himself paid little attention to the role of the doctor's practice, there is another line of development which also originates from Balint and which does place the centre of its attention on the practice as a mental health organisation. In the 1960s and 1970s there was a general interest in exploring new ways of getting psychiatric expertise out to support front-line professionals whose work had a bearing on mental health. Much of this work originated from the Cassel Hospital but the presiding figure behind all these developments was Michael Balint. In 1961 Tom Main read a paper to the Royal Society of Health entitled 'New developments in the psychiatrist's role' (Main 1961). Alexis Brook, who was taking a case discussion seminar for GPs at the Cassel at that time, decided to visit the doctors' surgeries and see the patients for himself. This initial project (Brook 1967) led Alexis to develop a major interest in this approach and he later established the Tavistock Community Unit which inspired a generation of younger psychotherapists in a similar approach. Whereas Michael and Enid Balint were interested primarily in fostering a change in the individual doctors, Alexis' work can be understood as initiating a similar developmental change but in relation to the practice itself. 'The aim of our project', he wrote, 'was to study how a worker with psychotherapeutic skills could help general

practice to develop its resources as well as exploit its special advantages in the field of mental health (Brook and Temperley 1976). There is a clear similarity in the way the Balints described the role of a psychoanalyst while leading a group of GPs and the approach adopted by Alexis and his colleagues when visiting a practice: not teaching but listening; tuning in to the doctor's concerns; having an exploratory attitude and only introducing ideas that seem consonant with the doctors' own understanding of their role. Above all, his approach was respectful of the doctors' own expertise and knowledge of their patients. I quote, 'Our aim was to reduce the amount of splitting and dissociation that so often occurs in patient care when different professionals may be played off against one another. This splitting can be a reproduction of the patients' need to keep various aspects of themselves in separate compartments; it can also result from the staff's reluctance to bear looking at the patient's situation *in toto*' (Brook &Temperley 1976). Enid Balint was often concerned that general practitioners found particular difficulty in seeing and drawing pleasure from the work that **they alone can do**. 'Our aim', she wrote, is to get to the heart of the matter with general practitioners whose burdens are great and whose satisfactions can sometimes be hidden because adequacy continues to be measured, by both general practitioners and patients, in terms formulated by specialists' (Balint, E et al 1993). The extent of this phenomenon is not easily recognised, particularly where the research instruments employed to study outcomes are themselves too narrowly focused to reveal the individual narrative and contextual links behind the 'treatments' studied.

The approach to organisational thinking in primary care that followed Alexis Brook's work is under threat at the present time. The emphasis now is on short-term 'treatments' rather than relationships. Following the introduction and rather damaging impact of IAPT, the work of psychotherapists in primary care can also be said to be 'hanging by a thread'. But continuing evidence of the thread appeared only this month in a paper by Jonathan Smith (2013), '*A base for a new beginning: benign regression in a GP practice*'. The author makes use of Balint's psychoanalytic views from the focal therapy workshop and describes a patient seen successfully for brief psychotherapy in a GP practice, which is viewed as a secure base enabling such work to take place. In the haste to introduce IAPT therapists that followed the Layard report (2005), the wider role played by psychotherapists and counsellors within primary care teams has been overlooked and is now largely lost.

Putting the threads together

Before moving on to discuss some Balint groups in more detail, I want to pull some of the threads together. A social change has been effected in which security is no longer provided by external social structures and must be found instead internally and in smaller organisations. In the increasingly complicated organisational context of modern practices, it will become necessary to have an actively managed external boundary – on the one hand looking outwards, navigating in the more competitive waters that lie ahead, BUT ALSO, attentive to the inner environment of a practice. A boundary will be necessary – a semi-permeable membrane – that actively conceptualises an approach that supports the maintenance of a supportive and thoughtful professional culture within. Attachment theory may be one useful way of looking at this. And now I'm going to use some jargon. I know that Balint doctors – perhaps all GPs – have a healthy distrust of jargon so this is the Match of the Day moment. Cover your ears if you don't want to hear the result.....! In attachment theory 'mentalisation' is regarded as the key psychological capacity in a securely attached individual's mind. Peter Fonagy writes that mentalisation 'is based on, and leads to, the capacity for reflection on the states of mind of self and others.'(1991) Jeremy Holmes usefully describes mentalisation as 'the ability to see oneself from the outside and others from the inside' (2001) - surely, not a bad description of the aims of a Balint group. **I am suggesting that an in-house Balint group can be considered the organisational equivalent of mentalisation within a healthily functioning general practice.**

Now, for some groups...

An Israeli group: loss and separation

This account of a Balint group in Israel is from a paper entitled, 'Family Physicians Leaving Their Clinic – The Balint Group as an Opportunity to say Goodbye' (Shorer et al., 2011). The group has met for two years and meets every three to four weeks. A case is presented by a young woman doctor with three children who is shortly leaving her clinic and becomes unexpectedly aware of her anxiety about separation while presenting a case. The doctor describes her practice as 'very close-knit', like a family.' She begins (in a way that will be very familiar)... 'it's not urgent....I'm not sure if it's a problem at all, but if no-one else has a case....' She then speaks about a family whose eighteen year old son has been killed in a car accident. They are a family who don't consult often and she is unsure whether or not to visit them...'I'm not sure what to do,' she says... 'If I invite them in, what will be the reason? If the loss is the issue, is this my task as a doctor to open this issue up?' During the discussion the connection between her own suppressed feelings of imminent separation and the tragic loss of the son in the family becomes apparent to her. The authors summarise their report by saying: *The cornerstone of family medicine is the belief in both the continuity and availability of care. These beliefs are challenged when a doctor leaves his or*

her clinic because of personal reasons. In the example cited, the involvement of colleagues in a Balint group led a doctor to an insight into her conflicting feelings related to leaving her clinic. The group process helped her to prepare and deal with her own feelings and needs, as well as those of her patients and staff. Balint groups are a secure place to explore and gain insight into the emotional aspects of attachment and separation of physicians from their patients.'

Two further points before we move on. Think for a moment how many comings and goings, attachments, retirements, separations and losses, there are in a busy practice. Is there a better way for people to arrive, develop a sense of belonging and then take their leave than as part of a group process? If separations and losses can be discussed and dealt with in a practice (even to a small extent), it will be better for patients, colleagues and staff. Secondly, it is noteworthy that these authors define their Balint group as 'a group where it is possible and appropriate to bring up issues and problems that *arise from* the interaction between doctor and patient and the patient's family'. This seems to be a slightly wider description of the group process than is often given – opening the group to more discussion of personal issues arising from cases than is sometimes the case.

I want now to move on to a group based in a GP practice which itself seems to have arisen as a response to loss within the practice.

A practice-based GP group

In his 2009 Balint Memorial lecture (Julian 2009) Paul Julian described a Balint Group held in his Well Street practice in East London. It seems the group came into existence at a time when the practice was facing massive change and the prospect of traumatic loss. When Paul was about to retire (after 32 years), a woman partner and close friend and a colleague of 29 years, suggested that he 'come back' once a month to lead a Balint seminar. She reminded him of the pleasure and satisfaction they had got from weekly clinical meetings in the past, before the current climate in the NHS had eroded them. A month after his retirement, this same partner, was diagnosed with liver secondaries and was thought unlikely to live more than six months. It is perhaps important to add that this practice had experienced the death of one of its younger partners only six years earlier (and goodness knows how many other changes, losses, adaptations, crises) and now had to face the loss of its two most established partners who could be considered parental figures within quite a large practice organisation.

The group began in January 2007 and has met monthly ever since. In his lecture, Paul Julian movingly describes a sequence of sessions through which the group can be seen to navigate G's death. On the morning of one group session, Paul oversleeps and arrives to find the group listening to a young doctor talking about the good progress being made in uterine cancer screening (of all things)! As he comments in the paper, 'listening to this discussion it seemed obvious that they were also talking about G – the dying partner. Perhaps the pre-group discussion reflected an underlying feeling that the death of a strongly maternal figure could/should have been prevented?' He states, 'I had usually kept the group to task with a focus on their relationship with patients. But it then seemed quite appropriate that we all shared our thoughts and feelings in a more direct and personal way'. Paul Julian gives a clear account of how the focus in an in-house Balint group might shift between a discussion of cases and a discussion of the underlying issues that may be preoccupying the team. This in-house Balint group has now met for six years – sixty eight sessions.

The Well Street practice had a tradition of doctors who had been in Balint groups. Clearly a practice which is already mindful of the emotional dimension of its work and the need to find space for reflection is more likely to encourage the establishment of an in-house Balint group; but it will also be true that once the group is established it will have a further effect on the feeling of secure attachment within the whole practice: a mutually enhancing relationship between group and organisation.

And lastly, I want to move on to a description of an in-house multi-disciplinary Balint group.

An organisational (in-house) multi-disciplinary Balint group

Since October 2011, Anne Tyndale and I have been co-leading a monthly multidisciplinary Balint group in the Practitioner Health Programme (PHP) in London. Founded in 2008 PHP provides a service for doctors (and dentists) with mental illness, problems with addiction, or physical illness which interferes with their capacity to practice. It is an NHS programme housed in an ordinary GP practice in south London. The invitation to help establish the group came from the Director who was concerned about the arduous nature of the clinical work and tensions that might arise within the team. The Balint group is attended by the core staff: three GPs, three psychiatrists, a nurse trained in CBT and a psychotherapist all of whom work in the service part-time. The practice ethos is a strongly primary care-based one with an emphasis on continuity of care, a non-hierarchical multidisciplinary team with regular meetings and a focus on the professional relationship.

The group seems to flow between an organisational Balint group in which the discussion of troubling cases focuses on an individual client-professional relationship and something more resembling a combined case discussion in which attention is given to how the group and the roles of different members reflect the case. Inter-disciplinary tensions are around but don't surface as often as might be expected.

We offer the choice of sitting-out to presenting members of the team but only if no other member of the group knows the patient. Sometimes, a request is made to discuss an issue but rarely: these have included anxiety about a nurse leaving who had occupied a central full-time role within the service; and a disturbing complaint against the service from an outside colleague. Nearly always the group discusses cases. Underlying the work of the group there is an understandably strong concern with possible personal and professional confusion and associated boundary difficulties. Sometimes a case triggers the group into more personal reflection. On one occasion when the case of a seriously depressed medical student was discussed, the discussion seemed more cut and dried than was usual. When it was noted 'that it seemed hard for members of the group to remember what it was like to be that age and uncertain of your identity and professional future' the atmosphere changed and a much more reflective and personal discussion followed.

Co-leadership has been vital in this group. Many of the difficulties of the 'doctor-patients' presented are connected to omnipotent self-reliance and a denial of emotional need. The ethos of the team is deliberately designed to counter this with an emphasis on regular team discussion. The Balint group, and co-leadership, is part of that. The position of the leaders in an organisational Balint group is more of an outsider than in a traditional Balint group. We have been steering our way through new territory.

Conclusion

Balint work is primarily about individual change in doctors. Originally, groups were set up outside any particular context so that the group itself was free to establish its own culture. Members of the same partnership were discouraged from attending the same group. This was in keeping with the Balints' ideas about individual doctors being able to find the freedom to practice in a way that suited them through the group process. If groups meet within organisations or practices, the hierarchies and tensions within the organisation will all come into the group as an additional dimension, as will inter-disciplinary tensions as well. Groups in practices have the potential for benefitting the presenter but also the team and the organisation itself – as well as patients.

Will Balint groups play a part in fostering a more secure feeling of professional attachment in a world which is otherwise in permanent transition? Will practices invest in independent leaders for this work? Will practices recognise the need for more sophisticated organisational development in order to maintain a truly generalist approach to their work and preserve themselves as mentally healthy practices? What role will the newly formed Clinical Commissioning Groups play in supporting front-line professionals to hold the necessary balance between organised and unorganised illness and thus the balance between primary and secondary care? Maybe this is one of the new directions for our continuing Balint action-research-cum-training project in a changing world.

Thank you!

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Address to the 2012 Oxford Conference

Dr David Watt, Vice-President of The Balint Society

Each year we have a theme or title for the meeting to try to highlight some aspect of Balint work for the weekend. This year it is "Understanding ourselves and our Patients".

The Council of the Society agreed on this title and it was in print before I noticed that by word order we had given prominence to the understanding of ourselves, before understanding of our patients. What are we aiming to do in Balint work? What is the relative importance of helping patients or helping ourselves, or do the two just go hand in hand?

In the 1950s one could say Balint work began as a study by Michael Balint, a psychoanalyst, of the doctor-patient relationship. His method was to facilitate a group of self selected GPs to discuss their patients, and the way they felt about them, in an open and safe manner. The GPs were glad of this opportunity as many were troubled by patients with no clear medical diagnoses, and they wanted to learn more about psychiatry and psychotherapy. They wanted to help their patients-perhaps to understand them better, so that they could be more successful in their treatment. The doctors' psychological needs as doctors, that is, as professionals, were part of the work, but their personal needs were not included. If they needed personal therapy they should find it with a therapist.

The group tried to focus only on the doctor-patient relationship.

In the book, "The Doctor, the Patient and the Illness", reporting on this group, Balint also talks about how learning to listen to patients requires a "considerable though limited change in the doctor's personality". In the following years he felt that participation in Balint groups did produce this change, at least if the doctors were in groups for a sufficient time, perhaps two years. Doctors seemed to understand and cope better, or differently, with their medical world. In promotion of Balint work I think we should nowadays give this more emphasis. Balint work helps our patients, but part of helping our patients comes through the way the Balint group helps us to grow into better doctors, and perhaps slightly different people. A part of this may come just from being in a supportive, non-judgemental group, for a time, but I do think that the emphasis in Balint groups on listening is very important.

Understanding ourselves in Balint work can be a very useful part of the process, though not its prime focus.

To illustrate this a little I will talk about myself. I am coming close to ending my career in medical practice, a little early as I have been planning for a long time.

I am looking back over how Balint work influenced me. I was involved from the outset of my GP vocational training in London, on the Whittington scheme, led at that time by Drs Cyril Gill, and Marie Campkin.

When I took up practice 25 years ago in Newham (where the Olympics were held) I began making a weekly trip to the Tavistock Clinic in Hampstead, where I was in a group under Dr Sandy Bourne for four years. I talked about a lot of patients, as did the varied other group members. One of the things I noticed over time was that I presented a lot of middle-aged afro-caribbean women.

Another GP, a south Asian man, often presented patients that the group thought he should end his relationship with, but he always wanted to try harder! I learnt that women and men may have some differences in thinking as doctors, and also that one's age seemed to lead to different ideas. I learnt about professional boundaries, listening to where my peers thought they lay. I think perhaps I became a more complete professional. I also learnt to curb my overactive thoughts, and to listen to others, both colleagues in the group, and to patients. Becoming Secretary of the Balint Society soon after, and being encouraged to lead Balint groups, I learnt about my capacities as a leader and an organiser. Some years later when in my practice both a partner was dying, and the practice manager had left suddenly, I assumed leadership in the practice. My growth in Balint work made this seem natural, though very hard. I had to step up to the mark with the qualities I had learnt about myself through talking with colleagues about my patients. I was then able to gradually shed responsibilities as the new manager we appointed grew into his role, comfortable that someone else would do the work better than me.

I believe we should encourage participation in Balint Groups both to help patients, and to help ourselves. Some doctors may shy away from the idea that they may need any help, and need to reflect, but I think the ethos amongst younger doctors makes them much more able to accept this now than in the past. Balint work lies conveniently in the personal and professional development part of their work, which is now such an essential part of the portfolios of younger doctors, as well as in the appraisal and revalidation process in the UK. However some doctors still seem to feel that they do not need to understand their patients, that a very medical model remains valid.

Some of these may be exposed to Balint work in compulsory groups as part of their training, such as the Icelanders here on their VTS, or the FY2 doctors I lead at Newham University Hospital. With my experience there and elsewhere I remain convinced that exposure to Balint group thinking may have a positive effect on even the most sceptical doctors for the rest of their careers.

Hopefully, it may allow them to experi-

ence the doctor-patient relationship about which Balint once wrote: "It happens so rarely in life that you have a person who understands what you are up to and openly faces it with you. This is what we can do for patients, and it is an enormous thing".

So let us spend the weekend learning about ourselves and our patients!

Bergman's *Persona*: Balintian reflections on a famous Swedish movie

by John Salinsky

In our half-day release course for GP trainees at the Whittington Hospital, London, we include classic films as part of the curriculum. Each term we show a complete film which is followed by a discussion. The aim is to give our young GPs a different way of looking at human relationships, and also to show them some great films that they might otherwise never see. It is our view, as programme directors, that a really great film, like a great book, can become part of one's inner world, always there as a source of inspiration to draw on.

This term's film choice was *Persona*, made in 1966 by the legendary Swedish director Ingmar Bergman. Our trainees are by now accustomed to being presented with ancient black and white films in foreign languages with English subtitles. But Persona is one of the most difficult and disturbing films by a notoriously difficult and disturbing director and it still has the ability to shock.

Watching *Persona*

The film begins with a five-minute overture consisting of apparently unconnected images, rather like one of those art installations that you might puzzle over at the Tate Modern. At first we see the glowing carbon rods of an old-fashioned arc-lamp projector approaching one another at right angles and flaring into light. Then a length of film flutters in the gate of the projector and is lit by the lamp. This is followed by a few fragmentary comedy and cartoon scenes suggesting early cinema history. Now come the images 'that viewers might find distressing'. They include scenes of a sheep being slaughtered, a nail being hammered into a human hand, a very brief glimpse of an erect penis (blink and you'll miss it) and then, corpses in a mortuary. A thin adolescent boy, inert on a couch, turns out to be only asleep. He stirs, turns over, reads a book and stares coldly out at us. Finally, we see him sadly, delicately stroking the giant picture of a woman's face; or are they two different women? The story is about to begin.

A voiceover tells us that Elisabet Vogler, a distinguished actress, has had a breakdown in the middle of a performance of *Electra*. We first see her dressed and made up for her performance, a reminder that the word persona, meaning the face that a person presents to the world, has its origin in Greek tragedy. Now Elisabet has become mute. Unable to speak and hence to work, she is being treated in a psychiatric hos-

pital. Her psychiatrist, a rather formidable, dark-haired woman, has arranged for her to have individual care from a young nurse called Alma, who has only been qualified two years and is rather apprehensive about her assignment. Nurse and patient are played by two of Bergman's favourite actresses (and mine). Elisabet is played by Liv Ullman, well known to Bergman fans from *Scenes from a Marriage* and *Cries and Whispers* (1973). Sister Alma is Bibi Andersson, who memorably appeared in *Wild Strawberries* (1956) and *The Seventh Seal* (1957). Both actresses had live-in relationships with their director and Liv Ullman had a child with him. But you don't want to know this. (Oh, yes, we do!)

Sister Alma and her patient

Back to the film. After a brief period of hospital treatment, in which Sister Alma finds the one-sided conversation with her silent patient very awkward, the head of the clinic arranges for them both to stay together in a holiday cottage on an uninhabited island. In this informal setting, we see them both relaxing and their relationship flowering into friendship. They collect mushrooms, cook, eat, drink wine, read, go for walks. They smile at each other. They even sing together. But still Elisabet doesn't speak and Alma has to do all the talking. She talks about herself and Elisabet listens: it is as if she is the therapist and Alma the patient.

One evening, when they are both a little drunk, Alma relates a story from her past life. She and a friend were sunbathing nude on a beach, when two boys approached them. She gives a graphic but, by today's standards, tasteful account of the little sex orgy that followed and how much she enjoyed it. But she became pregnant as a result and had an abortion, arranged by a medical student friend who is now her fiancé. The story draws us in, but its conclusion makes us feel increasingly uneasy, as if this is none of our business. Alma is ashamed too, by the recollection. She collapses in tears and is comforted by her silent 'patient'. We realise that, underneath her brittle gaiety, Alma is really very apprehensive about her future life with her fiancé. She notes that Elisabet has been a good listener and can't think why she should find her nurse's life interesting. 'Really,' says Alma, 'one should be more like you... I think I could turn myself into you. If I made a real effort. I mean inside.'

Strange developments

Later we see Alma opening one of Elisabet's letters which she has been given to post. The letter briefly mentions Alma's embarrassing disclosure in a tone of amused condescension. Alma is dismayed and furious and the relationship between the two women begins to deteriorate. Alma leaves a shard of broken glass on the path so that Elisabet will cut her bare foot on it. After that, the film seems to break, jam in the projector and burn. It is as though the fracture in the relationship has been too much for the very celluloid to survive. Alma attacks Elisabet who slaps her face and Alma, in her fury, nearly throws a pan of boiling water over her. After that, she is filled with remorse and pursues Elisabet along the rocky strand, pleading in vain for forgiveness.

Elisabet's husband turns up and appears to think that Alma is his wife. She tells him, 'I am not your wife', but he wears dark glasses so perhaps he is blind. Now things get seriously weird. Alma and Elizabet's husband have (implied) sex.

Is Alma's prediction about turning herself into Elisabet coming true?

Then, in one of the most stunning scenes in the picture, we see Alma forcing Elisabet to reveal that she is concealing in her hand, a picture of her son, the melancholy young man from the overture. Then we hear Alma telling her, this is what you did, this is what happened to you. You fell pregnant, tried and failed to abort the baby and then had this son whom you didn't love and wished would die, only he didn't. He was cared for by others, but he still loves you. As this narration proceeds, Bergman has us watching the emotions chase across Elisabet's face, captured and held in close-up. Then, the whole narration is repeated, but this time with Alma's face in close-up. One side of each woman's face is in shadow. Then the two illuminated half faces float together and fit together, almost matching. Are they now the same person? How literally are we supposed to take all this? A brief shot of the two women, completely separate, being filmed by Bergman's camera crew, reminds us that we are watching a film.

At the end of the film we see Alma again in her nurse's uniform, apparently back at work. Does Elisabet go back to the theatre? Not clear. In the last few frames we see the arc light fading and the end of the film running through the projector. A last reminder that we have been gazing at an illuminated strip of celluloid.

The 'real meaning' of Persona?

That is a much longer summary than I had intended and still I have missed out some scenes that will surprise and intrigue you when you see it. And I insist that you see it, even if only a digital version on your home screen. But what does it all mean? Critics and filmgoers having been asking this question and coming up with theories ever since 1966. Are Elisabet and Alma just different aspects of the same person all along? Is it all a dream? Maybe the film is really about the relationship between art and life? Or is Elisabet a kind of vampire, swallowing up the soul of Alma, whose very name means 'soul'? What would a psychiatrist say? Daniel Shaw, a professor of philosophy and film, has even provided a complete psychoanalytic formulation of the case (Shaw, 2002) but I don't find it in the least convincing. Perhaps the best way, as most critics have concluded, is just to accept Persona for what it is.

Certainly, if you do that, you will not go unrewarded, because *Persona* is a work of art, very absorbing and beautiful to look at. The two principals offer wonderful performances, both moving and subtle. Ullman's silence is mysterious, eloquent and tragic; Andersson's bravura vocal performance is even more impressive. And those faces! The two women are filmed in unforgettably moving close-ups by the master cinematographer Sven Nykvist. Even if you can't find any coherent explanation of the story, it certainly makes you think, and want to see it again.

What the audience thought

Now, let me remind you that this film was being shown to an audience of 20 or so GP trainees. They were all seeing it for the first time and had barely heard of Ingmar Bergman. How did they receive it? My impression was that nearly everyone was fully engaged, if not spellbound. The discussion afterwards was lively and I was glad to see that they took the film's strangeness seriously. There was praise for the acting and the cinematography, which was a revelation even to an audience familiar with the sophistication of today's digital techniques. The meaning of the film was puzzled over and most of the well-worn but obviously flawed theories were reinvented only to be discarded.

As we were a medical audience, we moved on, inevitably, to comparisons with psychiatric treatment in today's NHS. The idea of a doctor sending a nurse and mute patient off to her private island for an indefinite stay struck us as laughable. Or perhaps we are just a bit envious of a world in which such a generous and imaginative approach to therapy was possible? Then we started to think about the relationship between nurse and patient, between Sister Alma and Elisabet. Could you ever feel so close to a patient that your own separate identity was in danger of being lost? I reminded my younger colleagues that in our Balint groups (yes, we have them as a regular part of our programme) we frequently hear about patients who stay in the doctor's thoughts in a worrying and even disturbing way. It was agreed that this happened and in a sense you might feel a sense of psychic invasion. But young doctors are more wary of long-term relationships with patients than I ever was. They feel that such overdependence is unhelpful and should be firmly discouraged. This is partly because there is less continuity and getting a follow-up appointment with the same GP is no longer valued so highly, at least by the doctor. But every now and then, somebody gets under the doctor's skin and she feels sufficiently involved and concerned to feel that she is 'their doctor'. The doctor may find that she is increasingly preoccupied with thoughts about this patient. Her need to change the patient's life may become as important as her need to solve her own problems. We hear about this in the Balint group and we get involved too. More of this shortly.

Further reflections

As for me, I continued to think about *Persona*, on my way home. It had found its way into my mind and was not going to be easily dislodged. Had I ever felt that a patient was taking me over, and that my identity was in danger? Not quite, but there are certainly some people whose problems stay in my mind. Some of them I have known for many years, and when they have a crisis, I think about them a lot. They are in my head and sometimes it feels as if I am in theirs.

But then, I thought, are we not encouraged by so many of those who have inspired us as GPs, to use our capacity for empathy? And is not empathy, according to Carl Rogers (Rogers, 1961) entering the mind of the other person and experiencing their feelings as if they were our own? The consultation experts, including Roger Neighbour (Neighbour, 1987) all advocate empathy and our Royal College of General Practitioners awards or withholds marks for empathy in the Clinical Skills Assessment (CSA) examination.

The distinguished American GP and major modernist poet, William Carlos Williams, in his autobiography (Williams, 1987) records that when he was with a patient,

I lost myself in the very properties of their minds: for the moment at least, I actually became them, whoever they should be, so that when I detached myself from them at the end of a half-hour of intense concentration over some illness that was affecting them, it was as though I were reawakening from a sleep. For the moment, I myself did not exist, nothing of myself affected me.

Psychoanalysts talk of experiencing their patients' projections as if they were their own thoughts and feelings. Freud at first considered that this counter-transference was an obstacle to treatment; later it came to be recognised as a valuable source of therapeutic insight. Michael Balint, of course, never used the terms transference and counter-transference in his GP groups and would quickly jump on anyone who did. Nevertheless, his doctor-patient relationship is really all about these powerful, unconscious, slightly eerie phenomena whereby one mind invades another.

And anyone who has been in a Balint group for a while will have observed that, when the presenting doctor is telling her story, she is in many ways, behaving like the patient and even talking like the patient. This is sometimes called 'the parallel process'. I have also noticed that, if I am 'sitting out' having just presented a patient, I begin to feel as though I *am* the patient listening to all the wise doctors discussing my case. One way in which the group can be helpful is to enable the presenter to detach herself from this identification with the patient; to take a step back, wake up from the dream and become her professional self again. If the doctor (or nurse) is

not able to do this, she will continue to feel trapped and tormented by loss of professional identity.

You will have noticed that at the end of his half-hour, even old Doc Williams comes out of his total identification with his patient and reverts to being himself. And Enid Balint, in her essay, 'Research, change and developments in Balint groups' (Elder and Samuel eds 1987) says:

Once an observer has identified himself with someone or something he will find it difficult to think objectively about that person or thing again. So he must first identify and then he must withdraw from that identification and become an objective professional observer again. The identification must have a biphasic structure.

Bergman and Balint

Did Ingmar Bergman have some inkling of these ideas when he was dreaming up *Persona*? We know from his autobiographical book (Bergman, 1995) that he wrote the script while recovering from a prolonged stay in hospital with pneumonia. During his illness, he would have been in pain and discomfort, surrounded by beautiful nurses and at times in a feverish delirium. Who knows what thoughts went through his head? And yet, when recovered, he was able to use these experiences objectively to create an enduring work of art.

What about Sister Alma and Mrs Elisabet Vogler? What future can we imagine for them? At one point, the psychiatrist tells Elisabet that she should eventually discard her role as the mute patient, just as she has dropped all the past other roles in her acting career. We don't know whether she achieves this or not, but we have the uncomfortable feeling that she has added the 'role' of anguished sister Alma, whose behaviour doesn't fit her beliefs, to her repertoire.

And Alma herself? Near the end of the film she says, 'I'm not like you. I don't feel like you. I'm Sister Alma, I'm just here to help you.' When we finally see Alma, back in her nurse's uniform we feel some hope that she has managed to detach herself from identification with Elisabet and become herself again.

If she managed it, it can't have been easy. Perhaps Sister Alma should have had a Balint group as well as a Bergman group. Balint or Bergman? This leads me to the curious association that Michael Balint's surname was originally Bergsmann. If he hadn't changed it to Balint, we would be talking about Bergsmann groups and you would be reading the Journal of the Bergsmann Society.

I am grateful to my colleagues, Caroline Dickinson and David Price, for their enthusiastic support of the film programme.

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Persona (1966) in monochrome with Swedish dialogue and English subtitles is available on Tartan DVD

Balint Society Secretary's Report 2013

Dr Ceri Dornan

My first year as secretary has been a lively and interesting experience, as well as a learning one. David Watt made the job look deceptively easy, which is a testament to his smooth organisation, although I did tease him about having to organise the contents of a memory stick into recognisable folders. It is interesting what comes to the secretary. There are the expected queries about joining the Society, meetings, finding groups etc., but I did not expect to correspond about whether it was 'our' Michael Balint who wrote a letter to the Times about the meaning of the middle initial of Jerome K Jerome (of Three Men in a Boat fame). No firm conclusion was reached, but the Society did get a mention in the bibliography of the paper discussing the subject. There was also a discussion with a TV producer who was piecing together some GP history as part of the groundwork for a programme in which a GP surgery from the 1960s might be reconstructed. I don't know what became of this, but they might have had a lot of volunteers willing to go back to the days when listening and talking to patients was the expected GP role.

Membership

The membership continues to grow at a steady rate, especially from psychiatry and psychotherapy and we have introduced a new 'free membership year' for those attending a Balint group led by at least one accredited Balint leader. It is hoped that at the end of the year, people will wish to join us in the longer term. We have a small international membership, from Austria, Australia, Greece, Iceland and the Ukraine.

Events

The Society has continued its programme of weekend meetings, leaders' workshops, lectures and annual dinner. In addition, there has been a focus on leadership training, working with other organisations and widening membership. We recognise a need to be clear about, and show that we value what we can offer to members and interested parties at a time when there seems to be so little space for health personnel to think about their work or themselves.

Activities are mentioned in outline below, but there will be a longer report separately about what has happened regionally.

Annual Dinner

This year's dinner was held in the new premises of the Royal College of General Practitioners, in Euston Square. Rather appropriately, our speaker was Dr Clare Gerada, Chair of the College. This year, a study day called "*What makes a Balint group leader?*" was held on the day of the dinner. This was a popular event bringing GPs, Psychiatrists and Psychotherapists, many new to Society events and some of whom stayed on for the dinner.

Weekends

In addition to the weekends in Oxford (September 2012), Whalley, Lancashire (March 2013) and Longhirst Hall, Northumberland (June 2013), colleagues in Ireland arranged a weekend in Belfast in November 2012. This attracted practitioners from all over Ireland and Britain and another Irish weekend is scheduled for November 2013, this time in Sligo. The format of weekends includes classical Balint groups, a leaders' training group and a 'fish bowl' demonstration group followed by a large group discussion about the process. The 'fish bowl' continues to stimulate a range of opinions about its value, but so far it survives. Weekends are also social events and we are lucky to have some lovely venues, and organisers who put much effort into making the events a success. People have attended from a number of other countries and we welcome this and the enrichment it offers to the meetings. Details of all weekend events can be found on our website.

Working with other organisations

Links between the Society and the Royal Colleges of Psychiatry (RCPsych) and of General Practice (RCGP) have strengthened, with Balint members speaking at Annual Conferences, putting on meetings for RCGP Faculties, and leading Balint groups at meetings. As psychiatrists in training are required to participate in Balint work, the Balint Society's leadership training programme has attracted increasing attention and day conferences are well attended.

Leadership training and development

The IBF biennial Leadership Conference is a welcome addition and a number of people from the UK have attended. We are fortunate to have Andrew Elder, who is involved with this development, as a resource. A sub-group of Council is currently reviewing our leadership training approach. Society members have contributed to training workshops in Ireland and a Leadership day was held in the North East in April. Leaders are able to present their group at the Tavistock Leaders' Workshops in London and a Leaders' group now meets in the North East.

Balint Society Council

We have been alternating Council meetings between Manchester and London, which has worked well so far. Another new event has been the appointment of Joanna Huddart as a part time Administrator. Joanna is currently finding out more about what the Society does and how we do it, but clearly has a wealth of experience in all the necessary areas of running an organisation effectively. You are likely to hear from her at some stage during the next year, as we work to bring our mailing lists etc. up to date.

Website

The new website has been well received and its development continues. We have moved into Podcasting, with the first being a slightly edited version of Andrew Elder's Michael Balint Memorial Lecture, titled "Balint at the Cutting Edge: Contributing in a Changing World". To hear this thoughtful reflection on the effects of a changing NHS and GP world and a potential role for Balint work, go to our website page http://balint.co.uk/the-society/lectures-discussions-and-meetings/

Look out for more Podcasts, or follow us on Twitter or on our Facebook page.

Contact us

Do let us know if you have ideas for development of the Society, feedback for us or questions. We are keen for members to be as actively involved as they would wish.

Ceri Dornan, Secretary
(ceri.dornan@gmail.com)

Report on Whalley Abbey Weekend Workshop March 8th to 10th 2013

This year we had 21 attendees arriving at the peaceful contemplative, conference house in the courtyard and grounds of Whalley Abbey. Fortunately both the numbers and preferences worked out, so that we could run two Balint groups, and also a select leaders' workshop.

What was really exciting was the fact that many attendees were new to Balint work, and were in the main young GPs who were also relatively local, with many from Lancashire or Yorkshire. We also had some old stalwart friends returning for their annual fix of Balint thinking and insight. We still however managed a touch of the exotic, as we had a Psychotherapist from Athens too!

Although the weather was rather damp and chilly, most managed a walk along the River Ribble on the free Saturday afternoon. We also enjoyed plentiful wholesome food in the crypt refectory, and also the warmth of a wood fire in the grate in the splendid Regency-style lounge during our free time.

The groups seemed to pursue their own specific themes: one case often linking on to the next. In one group, the cases tended to be about the difficulty of maintaining a professional boundary with the patient, and the ensuing unease in the doctor when this is somehow breached. This then caused the doctor to feel that they lost control of the situation, their self-confidence was sapped, leaving them to feel emasculated. All presenters said they found the experience of being in a group both helpful and illuminating, allowing them to come to understand the situation better. Some could begin to see how changing their own stance, might re-establish equilibrium in the relationship, thus restoring a therapeutic dynamic once more. The cases often also reflected the tension for control between the doctor and their partners or practice organisation, or between the doctor and the NICE guidelines/government agenda.

The second group, dealt with cases in which most were long-term patients with whom the GPs felt chronically stuck. Being reminded to have 'the courage of our own stupidity' in dealing with this seemed helpful. Having a Psychotherapist within the group also helped move the group away from the 'default GP setting' of practical problem-solving towards understanding the relationship better. The feedback from this group afterwards was also very positive.

The leaders' workshop was brilliantly managed by John Salinsky, who led a masterclass with only 6 others within the group. All said they had found this very focussed experience hugely valuable.

Next year, 2014, the Whalley Abbey Weekend Workshop will run from Friday 21st until Sunday 23rd March. We hope for a good mix of GPs and therapists, for a good local following amongst the grassroots Northern GPs again, and also for a few more men!!

Caroline Palmer. June 2013.

Relaxing at the Whalley Abbey weekend workshop.

Balint activities in the UK

There appears to be increasing Balint activity in the UK, some of which is lead by psychiatry as trainees in psychiatry now have to spend time in a Balint group as part of their training. Along with this is an increasing interest in leadership training. The Balint society is keen to help with networking, support and leadership training. We have four main centres of activity that focus on the four Balint weekends which are now held each year – Oxford with London, the North East (Newcastle), the North West (Manchester) and Ireland.

The following are descriptions of work in these geographical areas. This is not intended to be a comprehensive report of all activities and we are keen to find out what is going on in other areas. Please contact our secretary Ceri Dornan – details on the website.

Balint activities in the North East 2012 – 13
Staff group
We have a strong staff group of seven Balint group leaders – GPs, psychotherapists and clinical psychologists who meet every 2–3 months to discuss the work and develop Balint activities in the North East. This is a forum in which we can discuss leadership issues and we have decided to dedicate more protected time to this, along the lines of the Tavistock leadership seminar. The members are Claire Appleton, Christina Blackwell, Chris Brogan, Jane Dammers, Dave Morgan, Esti Rimmer and Gordon Shiells. We miss Manjit Suchdev who has gone to work for VSO in Uganda and is hoping to bring some Balint into his work there.

Balint groups
Two new groups started last year, making four thriving groups in the North East. There was considerable interest from locum and salaried doctors who have joined the South of Tyne group. Locum doctors may initially feel that Balint is not relevant to them because they often don't have long term care of their patients. At the same time they are often rather isolated and have few opportunities to talk about patients. Balint is as relevant to them as any other practising clinician and we should reach out to them. The second group is held at Claremont House, Regional Department of Psychotherapy and is made up of half consultant psychiatrists and half GPs and is proving to be a lively and interesting group. All our Balint groups are co-led by a GP and psychotherapist/clinical psychologist, a model we have adhered to in the NE and found to work well.

Leadership training
Esti and Jane were invited to deliver leadership training with psychiatrists in Dublin. Balint has become part of the psychiatry trainees' core curriculum and there is a lot of interest in developing Balint leadership skills. We had a very lively and productive two day workshop, organised by Dr Marie Naughton, and received good feedback. Gearoid Fitzgerald has also been involved in leadership training in Eire and we hope to link up together more in the future.

We participated in the successful Balint Leadership Workshop in London in January 2013. Christina and Dave presented their group and we helped in running the day that brought together people from many different disciplines.

Esti, Jane and Gearoid ran a leadership training day at Claremont House for twenty psychiatrists, GPs and clinical psychologists who are leading groups for trainees. Again there is considerable interest locally in developing leadership training. We will be running another days training in December 2013 and are setting up termly workshops for Balint group leaders in the region where they will be able to discuss their groups.

Longhirst Balint weekend
We hosted a hard working and enjoyable weekend at Longhirst in July 2012. This annual event was held again in June 2013 and was well attended particularly by people interested in developing leadership skills so that we had two leadership workshops as well as an ordinary Balint group. Leadership workshops are now a feature of all UK Balint weekends and contribute to leadership accreditation.

Work with the Northern Deanery and GP trainers
We continue to deliver workshops about Balint to GP trainers looking at both the doctor-patient relationship and trainer- trainee relationship. Gordon has introduced Balint work into his GP registrar group. We would like to introduce more Balint into the GP registrar curriculum.

Links with other professionals and organisations
We have made stronger links this year with local psychiatrists who are leading Balint groups for trainees and have good links with clinical psychologists also running groups for trainees. We link with the Squiggle foundation through Dr Chris Brogan who runs an annual Squiggle conference in Newcastle, and the North of England RCGP faculty.

Programme of events

Longhirst Balint weekend	June 14th-16th 2013
Leadership training day Newcastle	April 26th 2013
Leadership training day Newcastle	December 2013
GP trainers plenary workshop	March 20th 2013
Ashington GP Balint group	Monthly on Tuesday lunchtime
South of Tyne GP Balint group	Monthly on Tuesday lunchtime

Claremont GP Balint group	Monthly on Tuesday evening
Claremont GP / Psychiatrist group	Monthly on Wednesday morning
Leaders group meetings	Every two to three months

Jane Dammers April 2013

North West Balint activities 2012 / 13
Balint groups involving Balint Society members

Preston: Group for psychiatry trainees – Caroline Palmer and Phil Brown

Kendal: GP group – Sally Wraight and Jenny Davies

Bolton: multi-disciplinary group in a psychiatry department and a group for Consultant Psychiatrists– Helen Sheldon

Manchester: GP group – Antony Froggett and Ceri Dornan (Antony also leads a longstanding GP case discussion group which he describes as 'Balint-like')

New ventures

Ann Evans, a GP in North Wales, is hoping to start a GP group. There will be an open meeting in Wrexham in June, which Ceri Dornan will attend, to talk about Balint work with interested GPs.

Some Future opportunities for Balint work

Manchester Medical School

There is work underway on a new curriculum in Manchester and the possibility of including some Balint experience discussed but there has been no recent contact. This needs to be followed up. An attempt to interest students in the Preston section of the clinical school was not successful.

NW RCGP Faculty

Ceri Dornan responded to a questionnaire sent by the Provost to NW RCGP Fellows, which was seeking ways in which retired GPs could offer support to the Faculty. There is due to be a meeting in the near future. CD offered Balint work as a possible development.
Ceri Dornan 20.5.13

London Balint Activities 2012/13

Lectures and conferences

The biennial Michael Balint Memorial lecture was given on 25th April by Dr Andrew Elder at the Medical Society of London and was well received. You can listen to a podcast of the lecture on the Balint society website www.balint.co.uk

The evening lecture/seminar series ended some 2 years ago, due to the move of the RCGP, resulting in loss of a free educational venue, and also because of relatively poor attendance.

This winter there were two conferences at the new RCGP headquarters in Euston. The first was organised by the RCGP President Dr Clare Gerada, with the society as an associate. Called "Time to Think" it offered discussion about maintaining the healthy functioning of GPs at this difficult time. Andrew Elder and I facilitated a Balint group as one of the workshop sessions.

The Balint Society ran a study day on group leadership, followed by the Annual Dinner, also at the RCGP headquarters, on Friday 8th February. The Society will repeat this model next year, with a study day, followed by the annual Dinner, on February 7th 2014, at the Medical Society of London.

Dr Sotiris Zalidis and I, both London GPs, participated in The Royal College of Psychiatry Medical Psychotherapy Faculty Annual Conference at Stratford upon Avon on April 18th & 19th, having been asked to demonstrate Balint group work as GPs.

RCGP affiliation

The Society is directly involved with the RCGP as an affiliated society, having a place in the CIRC, alongside the clinical champions and specialist societies. This is not very active, but does give us a voice in their research area, allowing a patient-centred voice in a rather disease-orientated atmosphere.

Balint Group work in London

There is currently only one "ordinary" GP group in London, in Brent, led by John Salinsky and Tessa Dresser. There is more strength in GP Vocational Training Schemes. Groups are run in schemes by accredited leaders at the Royal Free, University College Hospital, Whittington Hospital, and in Tower Hamlets. There are also Balint-type groups at Northwick Park, and in Hackney. Paul Julian and I lead a Balint Group at Newham University Hospital for the whole FY2 year. There are ten Balint groups for medical students at University College Hospital, run through the Psychotherapy department there as a Special Study Module for over 10 weeks. Also, Dr Andrew Elder runs a Balint group for private GPs in South London, a group for counsellors in Brent and a staff group for the Practitioner Health Programme. At least two of us, Dr Paul Julian and I, also lead Balint groups within general practices.

Leaders workshop

As Vice President I also coordinate the longstanding Balint Group Leaders Workshop 3 times a year at the Tavistock Centre where those running Balint groups can present their groups for discussion with colleagues.

David Watt May 2013

Balint in Budapest: Reflections on Balint weekend in Budapest May 2013

Dr Esti Rimmer

The annual Balint weekend for the Hungarian Balint Society took place in May 2013 in a beautiful monastery south of Budapest. Over 60 doctors, psychotherapists, psychologists and psychoanalysts joined together for an intensive weekend which included Balint groups, fishbowls and leadership training. We were warmly and tenderly looked after by the nuns of this working monastery who provided us with delicious homemade traditional Hungarian cooking. Favourites were the homemade jams which came from the fruit of their very own orchard as well as the homemade cider prepared following an old Hungarian recipe. In the coolness of the evenings, while participating in various Balint groups, we would wrap ourselves in the beautifully handmade patchwork quilts lovingly made by the sisters. Truly a perfect containment!

In this atmosphere of serenity and beauty, the work itself was as intense and as demanding as ever. Difficult feelings were discussed openly in the fishbowls and in the small groups, which at times were quite challenging. The pressures that the doctors were under, both from external sources such as the Hungarian health system and current economic crisis, as well as those inherent to the doctor-patient relationship were very much in evidence. So much so that you could almost describe the theme of the weekend as 'where is the patient?', since so much of the presented dilemmas involved doctor-doctor relationships. The weekend was greatly enriched by the presence not only of a wide variety of professions – a truly multi-disciplinary gathering; but also by the diversity in ages: we were treated on the first evening to a meeting with veterans and early founders of the Hungarian Balint society reminiscing, and by the presence of very young junior doctors who were just beginning their career. Groups were running from 8 in the morning until 8 in the evening with great enthusiasm and energy but before collapsing in bed in our beautiful monastery rooms, there was still enough energy to enjoy a fantastic wine tasting evening and to a nocturnal Nordic walking session led by Peter, a multi-skilled speech therapist. The sound of the Nordic sticks gently 'tap tap tapping' on the hilly path, heard from my balcony on a sweet evening, will forever accompany Balint in Budapest.

The first Balint Group meeting in Kampala

Saturday 22nd June 2013

Dr Manjit Suchdev

I am working as a family medicine Masters course coordinator at IHSU- International Health Sciences University, Kampala, Uganda. Part of my work has been to arrange meetings of teachers who teach on the course. We have had two meetings to date.

The areas covered in the meetings have been on issues of house-keeping, filling forms for claims for teaching, giving and receiving feedback, and teaching on the giving of bad news. The group includes senior doctors from O&G, Surgery, Internal Medicine, Psychiatry, Family Medicine, ENT and Paediatrics.

The group appeared to work very well. I included 'Balint group work- a taster' at the end of the last meeting. I sent the introduction from John Salinsky, 'A brief introduction to Balint Groups' for reading beforehand. The psychiatrist brought a case. It turned out to be a classic Balint group case with issues around boundaries being blurred, the troubled marriage of the patient, husband working away, the doctor giving his mobile number to the patient and more. The group took on the case and worked with it. As usual no solutions were found at the end but the group functioned well.

Even the surgeon, especially the surgeon, found it helpful!

I had a realisation that issues are similar across the globe and Balint work is relevant everywhere!

We hope to meet again.

Balint in Belfast 2012!

The President of the Balint Society, Dr Jane Dammers, had been encouraging us to hold a Balint Society weekend in Ireland, so we finally decided to see if we could attract people to Belfast. The process was initiated by Dr Glenda Mock, a general practitioner with Balint experience and subsequently involved Dr Marie King, another general practitioner, and Christine Christie, a psychoanalytic psychotherapist. On 16th-18th November 2012 Jane's wish came to fruition: Ireland held its first Balint weekend at the Hilton Hotel and the Waterfront Hall in Belfast.

Forty one delegates attended from Great Britain and Ireland. Attendees included general practitioners, psychotherapists, psychiatrists, counsellors and teachers. The conference was supported by the Balint Society UK; the opening address was given by Jane, the President.

The delegates either attended four 90 minute Balint group sessions or a Leaders Workshop, the latter catering to those either leading or aspiring to lead Balint groups. In addition, a "fish bowl" session was held. This involved a group of delegates taking part in a Balint group, observed by other attendees.

An informal conference dinner on Saturday night was held at The Galley Restaurant, Belfast's only floating restaurant on the Lagan. The entertainment consisted of a harpist, good food and, of course, great craic. Some delegates ended the night in the renowned John Hewitt pub close by!

The meeting ran on a "not for profit" basis with most delegates covering their own expenses. Feedback was positive regarding the group sessions and the opportunities for interaction between the different professions.

Many delegates had never visited Belfast before and were surprised by the beauty of the city and the friendliness of the people. The weather did not disappoint and the Lagan sparkled in the sunshine. A further weekend is planned for Sligo in November 2013 and promises to be every bit as enjoyable!

The Balint Society Essay Prize 2014

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 2014 and sent to: Dr David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS.

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.

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