JOURNAL OF THE BALINT SOCIETY

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Editor:
Tom McAnea

Cover image: *'The Agnew Clinic' by Thomas Eakins (1844-1916)*

Sligo Balint Weekend Participants.

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.

Balint weekends are held each year in Northumberland, Whalley Abbey, Lancashire and Oxford. Balint study days are also supported around the United Kingdom.

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 Calendar of Events 2015-16

An up to date calendar of events can be found on the website:
http://balint.co.uk/category/events
Members of the Balint Society automatically receive email notification of new events.

Balint weekends
Weekends offer the option of residential and non-residential participation and both ordinary Balint groups and Leadership training and supervision groups. Subsidised places for medical students are available.
2nd – 4th October 2015: Corpus Christi College, Oxford.
13th – 15th November 2015: Weetwood Hall, Leeds.
11th – 13th March 2016: Whalley Abbey, Lancashire.
17-19th June 2016: Newcastle weekend.
9-11th September 2016: Oxford weekend.
There will be weekend meetings in settings across the UK. Details will be posted on the website once available.

Group Leader Peer Supervision Workshops
These are now established in London, Newcastle, Leeds and Manchester, offering those who lead Balint groups a chance to meet with peers, present their groups and discuss problems. For dates and contact details see: http://balint.co.uk/category/events

Confirmed workshop dates are:
Balint Group Leaders & Allied Professional Workshop
The Tavistock Clinic, 120 Belsize Lane, London NW3 5BA, 8-10pm
Thursday, November 12th 2015
Tuesday , March 8th, 2016
Thursday, May 19th, 2016

One day events
Several events are being planned – watch the website for details.

Annual Dinner and Study Day
Friday 5th February 2016, London

International Balint Federation events
Leadership conference 2016, details to follow.

The Balint Society and Social Media

The Website, Facebook and Twitter are important means of communicating with both our members and those who want to find out more about Balint work or attend our events. Your Hon. Secretary is working on these at the edge of competence and feels sure that amongst the membership there are some untapped talents who could do a better job. If you are one of those, please get in touch (contact@balint.co.uk). Access to your skills would be much appreciated.

New on the website this year:

- Interested in Leadership Training and Accreditation? Look on http://balint.co.uk/leadership
- Want to know how to start a new Balint Group? Look on http://balint.co.uk/find-a-group/how-to-start-a-new-balint-group

For photographs of events, look on Facebook: http://facebook.com/pages/Balint-Society/260364547406441 to see examples of the restful environments in which events take place and the reactions of those who attend.

Editorial

'The Agnew Clinic' by Thomas Eakins graces the cover of the Journal this year-perhaps an unusual choice for a text dedicated to the nature of the doctor-patient relationship? I first saw the painting in an exhibition some years ago and was immediately struck by the image of a lecture theatre full of men, observing several other men (and one token woman) performing surgery on an anesthetised female patient. It seemed to me to embody the notion of patriarchal power: the male medical doctor in complete control over his helpless patient, the latter passive and complicit.

Those roles can feel reversed in modern general practice. Some of my patients often make me feel helpless, passive, unable to respond to their demands, their complex needs. Their helplessness becomes contagious, making me feel besieged and stuck-I just have to listen and accept nothing will change. With the most complex and chronic patients it can seem as if they will never get better: we are both doomed to act out the same drama every time they consult, our roles determined and the dialogue well rehearsed. Of course, there is another way.

Sotiris Zalidis, an experienced GP and Balint Group Leader, sets out just this scenario in his powerful account of a patient whom he treated over some years. By understanding her, listening to her and recognising the effects she had upon him she slowly emerges from being a prisoner of her symptoms and emotions, to a place of greater understanding and perhaps even liberation. Joseph Simpson, our essay prize winner, explores similar themes in his description of his interaction with a patient diagnosed with cancer. He poses a very apposite question about professional boundaries and what they mean for clinicians in an era of appraisal, revalidation and ever increasing regulation of doctors. Can you ever regulate or legislate for the complexities of the doctor-patient relationship?

The increasing popularity of Balint work is apparent in its growing presence in the undergraduate medical curriculum. Tom Stockmann, a psychiatrist, offers an interesting paper which analyses his work with medical students and their experiences with Balint work. It makes a convincing argument for extending the model to provide students with a forum for emotional support and understanding at a time when they deal with complex and challenging patients which can have a profound effect on their own emotional state. Judy Malone, a psychotherapist in the south west, makes a similar case in her account of the psychiatry trainee-led groups for medical students.

In many medical schools Balint work remains relatively unknown to most students, and indeed staff. Fiona Sweeney, a trainee clinical psychologist, offers the perspective of a novice in her experience at the Whalley Abbey weekend.

The 2015 Journal is testament to the growing popularity and influence of Balint work around the UK. There is interesting work going on in most cities as reflected in the regional reports. Of course, there will be groups and Balint activities that we are not aware of so please do get in touch and let us know about the work going on in your area. We are keen to promote the activities of all groups, both in the Journal and on our website.

Tom McAnea
Editor
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An Introduction to Balint-Psychodrama

By Jean-Pierre Bachmann

History and Description[1]

Balint psychodrama stems from the partnership of two practices: the classic Balint group on the one hand and psychoanalytic psychodrama on the other. Following work begun with Guy Bruere-Dawson, Anne Cain, a psychoanalyst and psychodramatist from Marseille, began to apply the practice of psychodrama in 1973 in the Paris Balint group of Charles Brisset. He had requested her help in breaking out of a stagnant situation. This desire for "a refreshing impulse from a technique that puts things back in movement, revivifying situations in the sense of mobilising affects on the verge of dozing off" (Cain, 1994) inaugurated the method. The same desire will be found very often in those stretches where a classic Balint group approaches Balint psychodrama, but also in groups where there is particularly strong pressure toward the didactic on the leaders.

The passage from one form to the other is summarized by the leader's, "Don't tell it, show it!", a formula that often punctuates the session and engages the practitioner in retrieving, in action, moments in the relationship with the patient presented by one of the participants at the start of the session.

Balint psychodrama is distinct from role-playing, a technique stemming from the work of Moreno (1892-1974) who was the inventor of psychodrama. In psychodrama real situations are played out, whereas in role-playing scenarios are specified in advance or constructed with the help of all participants and what is produced represents a general situation.

The reintegrations that accompany the reconstitution of a real professional scene, though the exactness of it may not be known, allow the reflective work on the practitioner and his countertransference called for by Balint, to occur within a new dynamic. While Balint psychodrama is not an educational activity, it allows practitioners "to learn more efficiently the meaning" of professional situations that present them with problems. This happens when they are moved to share such situations, "more nearly reliving their acts." As with psychoanalytic psychodrama the point is not to provide a secondary rationale for past experiences, nor to acquire control, much less cathartic discharge, but to bring to consciousness unconscious aspects heretofore disavowed and with the group's associations and the leader's interventions, to begin their elaboration.

Ann Cain (1989, 1994) proposed naming the four phases of a traditionally hour and a half session "movements."[2] The first movement begins when the group meets in a circle and after some seemingly banal exchanges a case presentation emerges or is prioritised by the leader. The second movement is marked by the placement of the principal players in the enactment space in accordance with the case presentation. In order to discover the real life experience of the moments evoked in that presentation, the leader asks the practitioner to use his body to act them out. This second movement also roughs outs the relations between the presenting practitioner and the setting. During the third movement "the acting allows the subtext to become known" and lets associations lead to further enactments. The fourth movement, an exchange among the protagonists and the leader

1 The complete version : "Le psychodrame Balint" was published in the "Revue suisse de médecine psychosomatique et psychosomatique" 1995- no 1, 17-22. Dr Jean-Pierre Bachmann, psychiatrist and psychoanalyst (Swiss Psychoanalytical Society), is a Balint leader of the Association Internationale du Psychodrame Balint (Paris) and of the Swiss Balint Society. He works in private practice in Geneva. Translation made by Katherine Knowlton, clinical psychologist (Seattle) and Secretary of the American Balint Society.

2 Translator's note: The French is "discours", which might be rendered many ways, and which is most closely associated to verbal matters, speeches, conversation. The author and translator chose "movements" for its allusion to parts of a single piece of music and for its evocation of motion, celebrating the kinetic component added by Balint psychodrama.

with all the group, "allows the revelation of that which had been overlooked." It should be noted that many groups work with two leaders, one of whom takes the role of observer during the session.

Particularly in the course of the last ten years the practice of Balint psychodrama has extended to include many different kinds of practitioners. Until her death in 1994, Anne Cain worked to deepen the method and to widen its application, coordinating both efforts by founding the International Association for Balint Psychodrama, *l'Association Internationale du Psychodrame-Balint*.

The Technique of Balint Psychodrama

Balint psychodrama has recourse to a certain number of techniques belonging to psychoanalytic psychodrama, except insofar as they may contradict the strict rule of group work in the spirit of Balint: not to intrude on the practitioner beyond the sphere of professional activity or identity.

The layout and the construction of the imaginary setting: Particular and specific attention is given in Balint psychodrama to the description of the physical setting in which the scene to be enacted originally took place: the doctor's office, hospital room or the patient's home. Certain elements or characteristics of the setting and its décor lead to vivid memories in the protagonist and are prone, in the course of the enactment, to become revelatory: of the relationship of the practitioner to the space in which she works; of the distance he establishes with his patient (or indeed with his colleagues); of the privacy maintained, or not, in the therapeutic relationship. In this way objects acquire symbolic meaning, becoming foci for condensation or displacement of aspects of the problem being dealt with. Objects may also sometimes enter into the atmosphere of sharing and exchange between the practitioner and the patient.

> In the description she gives of her office, Doctor X mentions the presence of a picture of a violin, a picture dear to her which she places facing her patients. The situation she describes is marked with malaise, even irritation, toward her adolescent patient who after some time has presented her with recovered memories that are contradicted by the clinical findings. In the final sequence to be enacted she expresses her irritation in an intervention centered on the relationship between the patient and her father, himself a violinist, and on his disapproval over the patient's having abandoned her study of the instrument.

The setting, represented by the use of several chairs, quickly acquired an imaginary and symbolic dimension in the course of the acting, and this served to support the associations of all the participants and of the leader.

Doubling and Splits: Psychoanalytic psychodrama has recourse to different forms of splitting or character doubling: a split-off speaker in dialogue with its source character; a split-off speaker as total or partial mirror to a player; and a double to the side or behind a player. It is this last technique and practically only this one that is commonly used in Balint psychodrama. The participants in the group, and more rarely the leader, may provide a kind of voiceover to express thoughts and fantasies not only of the practitioner, but also of the patient or other players in the scene. While the use of this doubling technique varies as a function of the situations portrayed and with the degree to which the group work has evolved, it encourages fantasy in the practitioner and in group members and can have a real interpretive function. After the recreation of the remembered scene the leader will ask each participant who has doubled a character to comment on his voiceover. This permits not only explicit explanation of the doubler's

personal understanding of the enacted situation, but also of any actions or movements made in identification with the doubled character.

Role reversal: This is extremely frequent in the course of the enactment in order to retrieve most realistically both the spoken language of the patient and his body language. While this is sometimes hard in practice, or indeed restricting, both for the protagonist and the other players, role reversal becomes a thread in the work of the group that leads to action spontaneously proposed by the protagonist. Changing roles permits the practitioner to see himself in the role of the other, to be confronted by gaps, which for him and all the group may be quite revealing. Particularly telling are the inability to put oneself in the role of such a patient and surfacing of slips of the tongue.

The difficulties tied to these role reversals, often attributed by the participants to their inexperience with the method, may also be a reflection of the dynamic being enacted. Thus, in a recent session the participant chosen to play the role of a patient found herself repeatedly unable to recall or repeat the words of the doctor, as the leader was asking her to do. She was astonished as well that this major difficulty seemed not to be tied to playing a person of another sex. The progress of the session and the sequences enacted demonstrated that since the first meeting with this patient and his family, fifteen years before, the doctor had had to struggle against forceful restriction and control the patient had tried to impose on him. The group member, in an unconscious identification with the doctor, bore direct witness to this problematic dynamic.

The soliloquy: By this device often used at the beginning of a scene, the practitioner is invited to make known the thoughts that were present prior to his meeting with his conversational partner, typically the patient. Soliloquies serve also as transitions between scenes, punctuating the acting at the request of the leaders. They may also be responses to the doublings or voiceovers mentioned earlier, showing acceptance or rejection of the thoughts, affects and fantasies proposed by the other participants.

The body and Balint-psychodrama

The reintroduction of the body into the report of the practitioner manifests the originality of Balint-psychodrama, an originality not completely understood until after the fact, but which answered certain concerns of Michael and Enid Balint. According to Michael Sapir (1982), they were persuaded that one of the dangers of distortion in the Balint method rested in its avoidance of the body's use in the relationship. Certain things which can be said about the place of the body in this method are in keeping with observations made about the practice of psychoanalytic psychodrama. Mobilising the body has the effect of permitting a lifting of repression, favoring the reemergence of buried motor memory and its accompanying affects (Amar, 1988). In this way psychoanalytic psychodrama restores the importance of the role of affects, all the more so when they may not be entirely amenable to verbal expression (Green, 1984). Words, which are linked to bodily functions, assume the role of liaison between emerging affects and their representations. The bodily involvement of the leader and of the other participants asked to play different parts has the effect of lessening the anxiety inherent in the method over seeing and being seen, and reduces fears of intrusion.

While the mechanics are the same in the two methods, psychoanalytic psychodrama and Balint psychodrama, the intensity of the mobilization of affects is often different: it stays relatively controlled in Balint psychodrama, without mastery becoming the goal, because of the professional character of the approach. Despite the aspect of make believe, the enactment, in its realisation of the relationship, highlights the particular bodily responses of the practitioner - his corporeal countertransference. For example, the

avoidance of a look or the hands that never meet in the moment of greeting. A certain form of censorship is at work here, which concerns equally the real-life bodily experience of the practitioner, as well as the phenomena of primary and bodily identification with the patient and his symptoms.

> A young woman doctor presented her relationship with an older patient suffering from a head tremor. She was very moved by this man, whose body and vitality of spirit contradicted this sign of aging. In the role of her patient she enacted this trembling, and she did not stop it throughout the rest of the scene, whatever her role. The participants in her group insisted on aspects of identification in their colleague with her patient, without ever mentioning her unconscious identification with his symptom.

Vignette I: Resident A is one of a group of young doctors who participate regularly in a Balint psychodrama group. She is bent on presenting her situation, saying right away, addressing the leader, that she hopes for a consultation about the advisability of maintaining medical confidentiality and the limits of that confidentiality. She reports that she is working temporarily in the setting of a jail. She says the work the group has done has made them more attentive to influences that may come from other caregiving disciplines in the way of preconceptions about patients. Pierre X is a young drug addict who came to be detained for the nth time because of petty offences. She had to meet with him for a medical exam and in order to discuss his withdrawal options during an incarceration that would be very brief. When she heard his name and surname pronounced she remembered a former patient, Mrs. X. This very aged lady, presenting with signs of dementia, had a prolonged hospitalisation until her death where Resident A was working. Mrs. X had several times spoken of her only grandson, named Pierre, and expressed to the whole treatment team the importance he held for her. Before meeting Pierre X, resident A asked herself if this could be the cherished grandson. Nothing could be done to settle this question and she thought of the need to respect the confidentiality of the former patient and not to mention the acquaintance she had with Mrs. X. She reported as well that she had never met Pierre, who had made only three widely spaced visits to his grandmother – a situation which naturally left a gap in her information of a potentially grievous character for Mrs. X. (his addiction and his run-ins with the law).

The leader suggested to Resident A that she remember a scene with Mrs. X in the course of which Pierre was discussed. Resident A chose a participant, Resident B, to play the role of Mrs. X. This scene took place in a dayroom of the hospital. Mrs. X was sitting, a book in hand, reading or pretending to read. In connection with the interest Mrs. X purported to have in recent events, the topic was the very recent and certainly exceptional visit made by Pierre to his grandmother. Frequent role reversals allowed us to grasp how the recollection of Pierre created a transformation in Mrs. X. When Resident A took the role of her patient her face lit up, and she abandoned a certain psychic slowing down to reminisce about the adorable grandchild. Whether playing her own role or that of her patient, Resident A used at times the present tense and at times the past tense in speaking of Pierre, without however, ever becoming aware of it. This scene created a very deep feeling in the participant chosen to play Mrs. X, as well as in the whole group. The intensity of the response of Resident B encouraged the leader to interrupt this scene.

Resident A was surprised and embarrassed by the emotion that this scene had produced. The more moved participants made reference, by allusion and recalling their respect for the rule of this work (not to question the practitioner on matters beyond the professional), to the fact that this situation reminded them of non-professional experiences marked by bereavement. The associations of the group had the quality

essentially of feelings of connection, of closeness induced by long accompaniments and the care exercised with patients like Mrs. X.

The second scene enacted was that of the recent meeting with Pierre X. Resident A, after having described him, chose one of the participants to play the role of Pierre. Her colleague, Dr. B, who had played the role of Mrs. X in the preceding scene, accepted the role of the nurse who assisted in this consultation. The scene was set: a medical office in a detention centre. In the course of a soliloquy before meeting Pierre, Resident A asked herself if this next patient was the grandson of Mrs. X. Whatever happened, she told herself, she would not violate the confidentiality that bound her to her former patient.

The nurse introduced the patient. Resident A welcomed him and very quickly and spontaneously replayed a sequence centered on the exchange of looks between herself and Pierre, while taking the place of her patient. Resuming her place she began very quickly to ask Pierre if his grandmother had been hospitalised. The answer given by Pierre led Resident A to tell him that she had been the woman's doctor and had known her in her last years. This information provoked astonishment filled with pleasure and a lively curiosity from Pierre. Again in the verbal exchanges, time references were marked by shifting from present to past. The consultation finished on the subject of the very strict conditions of withdrawal Pierre would have to submit to during his incarceration. During the whole of the scene the nurse remained silent. The group members were all identified with Resident A, insisting on the important positive effect in their eyes of the liberty she had taken with the rule she was thinking she'd broken. Resident A did not otherwise display any real discomfort in the face of what she had presented as a transgression.

Commentary: The early request to resolve an ethical problem, which could have come out in verbal exchanges marked by generalisation, even rationalisation, was quickly short-circuited by the suggestion to play a scene which didn't involve Pierre but rather an older memory. At this moment in the meeting neither the leader nor the participants knew clearly whether Resident A had already answered her ethical dilemma, nor whether family ties really existed between Pierre and Mrs. X. The first scene, apparently very banal, was marked by confusion between the present and the past, giving evidence of a reunion with a cherished and lost object. Not only the presenter but also the rest of the group experienced feelings linked to bereavement with unexpected intensity. The leader hoped with his intervention to control the group's regression, but also to assure himself of the group's pursuing work that did not encroach on the private lives of the members, all the while having them associate to real life. In the face of the uncertainty about an eventual violation of confidentiality by Resident A, group members responded to this possibility by giving nothing but suggested responses, while the most intense reactions were linked to their personal life and not their professional experiences. They also watched themselves closely in respect to this rule, especially in the moments when they were all playing on "a very narrow crest" (Montgrain, 1993) in terms of finding a way to explain a countertransference without involving themselves in the personal life of the practitioner.

At the point of the second scene Resident A showed how the encounter with Pierre reconnected her with her relationship to Mrs. X. She found it again within herself in an identical look that erased time, separation and death. In taking the role of Pierre she had the same intense look that she had had previously playing the role of Madame X. The temporary muting of her watchful questioning about maintaining confidentiality seemed to be linked to the effect of an illusion shared by Pierre. Each retrieved through the other an object of emotional investment, the loss of which was partially and temporarily annulled. It was this aspect of the relationship which the leader pointed out. Resident A thought that this whole recent incarnation of Pierre was not unfamiliar with her

relationship to Mrs. X. It was the other members of the group, in particular two participants who, through identification, experienced most intensely the affects of bereavement, who connected Resident A and Pierre.

The group, the place of the leader, the role of the participants

The preceding vignette testifies to the importance that the group can take in the elaboration of a situation and in the phenomena that occur during a session. While Anne Cain was always very attentive to the reaction of the group and in particular to the transference relationship of the members of a group, she nonetheless always refused to see the group in Balint psychodrama as a whole, made of projections and the subjective reorganisations of the participants. For her "the group as a unit is constituted by so many individual remarks to each person and it is from this multiplicity of remarks that the exchange is born." (1994, p.31) In the work of the group "the enacted scene is the fertile moment to the extent to which all the participants identify with each other in a movement which combines as well the transference dynamic." This conception of the group is quite far from that developed by Gosling and Turquet (1982) in applying the ideas of Bion and group dynamics to Balint, or from the ideas of Anzieu (1982) and his school. Cain's interest focused "solely on the individual in the group and not on the group itself" had obvious repercussions for the technique used to lead scene enactments during the session and on her conception of the place of the leader. The leader's interventions and interpretations, such as she recommended, are addressed to the presenter and never to the group and must, of course, be offered prudently.

While pursuing this approach it nonetheless seems to us that allowing attention to range to the group's dynamics, and the understanding of this by the leader and the observer, are complementary. This awareness by the leader will influence him in the choice of scenes he suggests for enactment, in the direction of the acting itself, without necessarily spilling out to group interpretations.

The richness of group work, even in concentrating on the presenter's case, depends on the playful and phantasmal contributions of all the participants, on their capacity to identify, indeed to regress. We will illustrate this last point with the following vignette.

Vignette 2:

A group of public health nurses meet regularly. Their clinical activities with babies and families, the work difficulties they have experienced, and their questions around matters of professional identity have pulled them together for many years.

The babies described often live in families in great psychological distress. They are also the objects of projections from their parents, but, sometimes as well from the practitioners. The introduction of Balint psychodrama has allowed these babies to be not just the subjects of a discussion, but also to be represented in the enactments of treatment scenes. After enactments the participants who embody them customarily begin to describe the babies' affects, their muscle tone. They talk about their sensory perceptions of the surrounding world, of a world perhaps still little differentiated. The talk of the adults around them, who loom over them, often has no precise meaning. The qualities of their perceptions (their intensity and emotional tone), the phenomena of distance and proximity, are in the foreground of these reports.

The speech of the group's infant, that is to say the adult playing the part of the real life infant in a preverbal state in the psychodramatic sequence, does not recapture the projective representations of which he is so frequently the object. The infant's speech does not deny nor contradict these projections. It is another message, a counterpoint otherwise

unattended, capable of provoking important modifications in the meanings the group (and the leader) make out of the situation.

Isabelle, a young nurse, presents to the group, hoping to understand why she was the object of a massive rejection on the part of a father, for whom she also cared, who accused her of having destabilised his wife Francoise following their two meetings. Francoise has a baby of ten days. She is anxious, depressed, at a loss with her son. She feels herself to be incapable of exclusively breastfeeding him, and complains of his crying continuously. She weighs him at the end of every feeding session and again after the food supplement given by bottle. She is in tears at the time of the nurse's visit to her home, which is reenacted in the first scene of the session. The baby sleeps at the time of this visit. Despite the recognition of the depressed state of this mother and the nature of the maternal anxiety displaced onto the subject of feeding, the nurse proposes the mother come to the consulting office, "to weigh him, to measure him," she says. The first scene stops with these words.

Second scene: the feeding consultation, the next day. The accent is placed on feeding and on weight. Francoise's mother accompanies her daughter and her grandson. A nurse colleague weighs the baby. When he is undressed Isabelle approaches the mother and baby. She tries to mask her visible reaction at the sight of the baby: Daniel is frighteningly thin. Painfully, in a soliloquy, she says that he is "scrawny, a baby from the third world on the television." The consultation continues in a heavy atmosphere; everyone seems to be on guard. The grandmother expresses her disapproval of the methods chosen by her daughter to feed her baby. Isabelle writes in the health chart that it is necessary to follow the type of diet prescribed by the pediatrician.

The nurse who has played Daniel, the baby, astonishes several participants when she says: "I cry when I'm hungry, but I'm doing okay." Isabelle herself is not astonished. "It's true. She's right. This baby is doing okay. He has low weight, but he has regained his natal weight. He gains weight regularly. The problem is not there." In effect, the problem was not there and the group could pursue its work of elaborating where it might be.

Such frequent sequences, in contrast, often permit the group to disengage from its projections on the baby, projections that agree with those of the parents, through their identificatory impulses, or those of the practitioners themselves. This is all the more important in that the intensity and the quality of these projections will play a determining role in the physical and mental health of the infant and their maintenance. The speech of the baby to the group regularly has the effect of establishing a new emotional direction, often overlooked, in the work of the group.

Conclusion

Balint psychodrama, like all enterprises which raise questions about the self, arouses a certain number of resistances, all the more because it involves the practitioner in his countertransference, in his physical and emotional experience. While its usefulness and its interest are more and more recognised, at least by a large part of the participants in groups, the method must remain a subject of research, both for its depth of theory and in the application of its clinical methods in working with groups. It is without a doubt this which will allow it to avoid some of the pitfalls encountered by Balint groups, of which it is an extension.

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Interview with Gearoid Fitzgerald

Psychiatrist and Psychoanalyst, member of the Council of the British Balint Society with Magda Hatzidimitri, Psychologist, Psychotherapist and a member of the Hellenic Balint Group

MH: You have been a Balint group leader for 23 years. What first interested you in the Balint groups? How did you get involved? We would be very interested to hear an experience from your long journey that was very important in your development in the Balint field.

GF: Good question. When I was training in the UK there was a change in the curriculum for junior doctors and suddenly as a new consultant I had to do case discussion groups and looked around for something that might be useful. I went to a Balint weekend in Oxford and really liked it. It was held in an old Oxford college, all series and gardens and beauty. There were nice interesting people who had done unusual things. I remember one general practitioner who had worked in Papua New Guinea with head hunters for years. That led me to think about training as an analyst so I worked at doing that and it took a lot of time and money. I kept going to weekends and doing groups as they had always seemed to me a civilized way of exploring the relationship between the clinician and the patient. They assume competency and that something is getting in the way of a creative or therapeutic relationship and explore without telling you what to do. What has kept me involved are the people but also the theory of Balint groups: "What is going now? What am I doing as a leader?" I like the idea that one can never get it right and I am simultaneously irritated by it and the multiple viewpoints of the group, I think.

MH: Balint work is an established part of medical training in UK hospitals. What do you think is the greatest contribution of Balint to doctors?

GF: I think the greatest contribution is that it is so analytic without the usual off-putting trappings of analytic theory. Michael Balint introduced the unconscious into the relationship with the clinician in the consulting room. I think it is subversive. You see, it gets into areas that more formal psychoanalysis can't and wouldn't be allowed to get into.

MH: In your opinion, what are the greatest difficulties encountered in Balint work from the Leader's point of view? What about the difficulties encountered by the participants?

GF: I think for me as a leader the greatest difficulty is not imposing my view of what is going on. I am by nature a bit certain and bossy so the discipline of the Balint group structure stops me turning it into teaching or formulating which I think destroys the essence of a group. From a participant's point of view when I am in a group, my biggest difficulty is my irritation and impatience with the points of view of others and then my surprise and shame when the presenter says one of the things I had dismissed as nonsense, really struck a chord for them.

MH: In this cost-effective era of healthcare, do you think there is a place for the human-cantered approach Balint is proposing?

GF: Yes, I do, as intelligent people don't need the groups after a while to learn new

competencies and skills. It is the patients who are outside of those norms that usually "come" to Balint groups as they don't fit in with our patterns and we need to work to explore it, not force them into a package as it is. So many protocols in the UK are about doing something about risk but not about understanding the patient, which I think contains and settles them more. Like in the group with the neurological case that was presented at the 2nd Athens Balint weekend, it was in part about bearing the absolute unknown knowingly with the patient, I thought.

MH: You are a psychoanalyst as well as a psychiatrist. How are these roles contributing in your Balint work?

GF: Again, I think it is important with groups that one has to integrate both of those and subsume them into being a Balint group leader. Being a psychoanalyst in a group by which I mean functioning as a psychoanalyst usually would, I think would be unhelpful. But using the way of listening, formulating and then translating them into Balint work and using it in the service of the group does help. The same with being a psychiatrist or any core profession.

MH: Could you please share your experience from co- leading the Greek Balint group in the second Balint weekend?

GF: I thought it was great. I felt it was lovely to see a group of motivated thoughtful young people all engaged in proper Balint work. I thought the hospitable open nature of the culture and the group was very impressive. I don't know if I mentioned this, but one night on a walk from my hotel, I heard these pipes and drums coming from a narrow road leading from the Acropolis. Suddenly a group of men with furry suits on their lower legs and playing pipes with scary masks ran past followed by a huge crowd. It was linked with something to do with Bacchus and I was completely thunderstruck by actually being in the place where so many myths that underlie psychoanalysis come from. That colored my view of the weekend where there was something about the roots of psychoanalytic thinking and culture that was all around me. You are all used to it I guess. It was really striking the work in the group with a stranger essentially and the layers of culture all around. Maybe a bit romantic but that is how I felt.

MH: You trained a number of members of the Irish College of Psychiatrists when they were setting up Balint groups in Ireland. How was this experience? In your opinion, what steps could the Greek group take in order to disseminate the work in Greece?

GF: That was a strangely moving and disturbing experience as I have just come back from another weekend in the northwest of Ireland. It is odd to be both an outsider (trained as a psychiatrist in the UK) and an insider (Irish) compared to the other Balint leaders in the groups. It was like Greece, references to books and films and people talked. Silence is a big problem in English Balint groups. I loved meeting all these colleagues with a totally different system to work in and such similar ways of expressing themselves to mine. I wondered why I stayed in the UK at times. I don't know what it is like in Greece but Irish people find it easier to admire someone from another culture who has something they don't, but if it's the guy from the next town they can be a bit competitive and want to put him down. So it was strange and very moving. I saw more of Ireland than I had in years and loved the driving about. I think linking is really important in developments. I would

think about setting up a Balint society that is multi-disciplinary from the start in a way that reflects your group so it doesn't have to be owned by one profession. I think training leaders is essential as otherwise you can't expand and I know the UK society is happy to help. I would say do not feel you have to do anything but being in a group until you feel ready. That is a huge contribution to the culture of your professions as I think culture changes with small groups of people in rooms talking. All the leaders that have stuck in the society are those who had a lot of time in groups and then moved when they felt ready. I would not rush yourselves. I felt your group was unique in its composition and a small group with young people with children, being on call, in private practice can only ask itself to do what it can do. I would stick with it, enjoy yourselves first and develop when you feel you want to do some more, move forward realizing that things take ages to sort out and get going (the Irish are all very disheartened as how difficult it is to get groups going outside of psychiatry training groups despite loads of enthusiasm and energy).

MH: Thank you very much!

GF: My pleasure.

Introducing the theory and practice of Balint groups to Greek doctors[1]

by Lida Bitrou

Let me begin my introduction by saying that the doctor-patient relationship, which is the focus of Balint groups, has been fairly different in Greece than in the countries where the Balint method developed over the past six decades. Traditionally, in the Greek society, the doctor was seen as a distinguished power-figure who was highly respected by patients and fellow-citizens, rarely doubted, criticized or challenged by non-doctors. His place in the doctor-patient interaction has been clearly superior to that of the patient and this hierarchy determined the way in which doctor and patient related to one another. As a consequence, the Greek doctor was "immune" for quite some time from circumstances that would put him in a place of self- reflection and self-awareness regarding the way his personality and behavior affected his medical practice and his patients.

Patients on the other hand, were mostly ignorant about medical issues, often afraid to ask questions or make any demands, and unconsciously or consciously expecting the doctor to be superior, authoritarian and unapproachable. However, both parties seemed settled in this arrangement in which the patient took the role of a "compliant child" who executed doctors' orders without any objections, while the doctor took the role of the parent who knew best, and therefore didn't need, or even want to make the patient an active collaborator in his treatment.

At the same time, the "old-fashioned" doctor took his role in society quite seriously as a responsible caregiver and health educator. He developed close bonds with his patients whom he treated in a more holistic way that took into account their personality and individual needs. This of course, was more pronounced in some medical specialties than in others. For example, the pediatrician or the pathologist (who was the equivalent of the GP in the old days in Greece) developed closer relationships with his patients for whom he was responsible for a big part of their lives or during their childhood and adolescence. The same was true about the gynecologist who often treated two generations of women within the same family. This bond that developed between the doctor and the patient, made it easier for the doctor to see the patient as a whole person, and not just a sum of symptoms to which he would apply the appropriate treatment, make the symptoms or the disease disappear and move on to the next patient, almost forgetting the previous one ever existed.

This type of doctor, who established long-term therapeutic and humane relationships with his patients, bears many similarities with the general practitioner (also referred to as GP) of the British National Health Service, for whom Michael Balint - psychiatrist, psychoanalyst and son of a general practitioner himself- created in the 1950s the first groups that took his name. In Great Britain, the health system was based, since its establishment in 1948, on the function of the GP or family doctor, who was responsible for the health of the community and acted as gatekeeper to the rest of the NHS, referring patients where appropriate to hospitals or specialist treatment, and prescribing medicines.

In this health system, the patient had his doctor as a collaborator and guide, and, therefore, wasn't left alone to deal with his illness or symptoms, trying to figure out which

1 Paper presented at the proceedings of the *2nd Interdisciplinary Conference of Psychiatry* and Related Sciences that took place in Athens, Greece, on 20 October-2 November 2014, under the title *"Introduction to the theory and practice of Balint groups"*.

specialist he must go to, what medical exams to take or which hospital to choose, as it was the case in Greece or other countries where the GP was never established in primary care. There, everything passed through the GP who was responsible for the patient, often throughout his life.

Furthermore, the GP would educate the patient and encourage his involvement in his own care. This way the patient would become an active contributor in the safeguarding of his health or his treatment, instead of being a simple executor of doctor's orders, as we saw in the previous model of doctor-patient relationship with which we are probably more familiar. This kind of doctor, who was trained to treat many different conditions of the human body, was responsible for the whole patient and not just one of his systems or some of his organs. This, in itself, constituted the basis of an integrative health model on which Balint would develop his views on psychosomatic medicine and his "patient-centered approach", of which he was the first proponent. Also, in this context, it was quite common for patients to complain to their doctor not only about physical symptoms, but also problems of a psychological nature, psychosomatic symptoms or conditions that masked psychological problems, requesting from the doctor to be not just a physician but also a psychologist.

How difficult the work of a GP one might say and that was what Balint must have thought, when he decided with his wife Enid, social worker and psychoanalyst, to start in the Tavistock Clinic in London, their well known research and training seminars, also known as Balint groups.

At that time, after World War II and with the NHS in its beginning, many GPs often expressed dissatisfaction with their work and were under a lot of burden due to an overload of patients, some of whom presented symptoms that didn't have an organic etiology and left the doctor puzzled and incapable of helping. In this context, the Balints wanted to better understand the doctors' discomfort and see how they could help them. The groups that they formed consisted of eight to twelve doctors and one or two psychoanalytic leaders. They met every week for two hours and the groups went on for a minimum period of two years. Their original aim was to study the difficulties of general practice and find out the reasons why some patients didn't get well as they should, causing headaches to their doctors.

As Enid Balint wrote,

"The groups studied in detail what a general practitioner told the group about a patient with whom he was having difficulty, giving special attention to the relationship between the doctor and his patient, often at one particular consultation. We discussed human relationships: not in general terms but one particular relationship at one particular time".

In the beginning the doctor used notes from the consultation with his patient, but later on the Balints adopted the method of supervision used at the Hungarian Psychoanalytical Society which was familiar to Michael Balint from his psychoanalytic training. This was to encourage participants to speak freely without notes, contradict themselves if necessary, have second thoughts, remember things they thought they had forgotten, so that a complete picture with the feelings of the doctor himself emerged about the facts he was reporting.

This method of free-association is the one that we use today in Balint groups. The aim of understanding difficult or puzzling patients, or those who don't get better despite the doctor's or the therapist's effort, is still the main task of a Balint group.

The seminars in the Tavistock clinic continued for twenty years and were carried on by his wife after Balint's death. Their work with the groups was first published in 1957

in Balint's famous and widely read book that was translated in many languages, *"The doctor, his patient and the illness"*. In this book, he develops his ideas on the psychological aspects of general practice and the doctor-patient relationship, the problems that the doctor usually encounters, and the group training that can enable him to deal effectively with problems that derive from or affect the doctor's relationship with his patients. All these conceptualizations are accompanied in the book by cases of patients that the doctors presented in the group which demonstrate the clinical validity of his theoretical developments.

Balint's conceptualization regarding the doctor-patient relationship, which derived from his work with the groups, developed around this basic idea about the crucial role of the doctor in the outcome of any treatment and was resumed in his famous dictum "the doctor as drug". He also spoke about what he called "the apostolic function of the doctor" which describes the doctor's personal set of beliefs and preconceptions about how patients should behave and interact with him, which often makes the doctor overlook the personal psychological traits and individual circumstances of the patient in a "one-size-fits-all" philosophy. The mismatches and misunderstandings that often occur in the doctor-patient interaction usually originate from the "basic fault", as he called it, of each member of the relationship, a psychoanalytic concept that he later developed in his book entitled "The Basic fault". This concept describes the fundamental deficits of the personality of an individual caused by the inability of the environment to meet his early-life needs, which later interfere in the doctor-patient relationship and are related to the somatization that many patients present.

The doctor, according to Balint, must pay attention and try to control these difficult and often unconscious aspects of his interaction with the patient, as he must also make a "deeper or overall diagnosis" of the patient that goes beyond the medical symptoms, to include the psychological traits and environmental factors that determine the patient's attitude towards his illness. Only then will the two parties be able to establish a therapeutic partnership in what Balint called the "mutual investment company" which can be defined as the psychological investment of the doctor and the patient in each other over a long period of time. This way the so- called "collusion of anonymity", which results from the patient's bouncing from one doctor to another with no one really taking responsibility for him, can be prevented and the patient can benefit from a stable and substantial relationship with his doctor.

As you may remember, the groups were originally called "training-cum-research" seminars. We already saw their role in Balint's research on the dynamics of the doctor-patient relationship. But what about the training part? This was relevant to the practical value of the group work for the participants. Because Balint didn't just want to "use" the doctors in order to draw conclusions about the particularities and psychological patterns that characterize the doctor-patient interaction. He wanted to help them to better understand their patients and become more efficient in their work. Therefore, he believed that GPs could benefit from the learning of some psychotherapeutic skills that they could apply afterwards in their medical practice, and especially with those patients who presented psychosomatic symptoms or psychological problems.

However, this learning was by far different from the kind of learning that the doctors were used to from their training in medical school or the hospital, as it didn't involve actual teaching and wasn't based on a teacher-pupil relationship. Instead, it was a training that was based on the personal experience that the doctor acquired through his participation in the group. It should be reminded, at this point, that Balint was a psychoanalyst. And the most important part of a psychoanalyst's training is his personal

psychoanalysis. During his analysis, the future psychoanalyst has the opportunity to become more self-aware about his short-comings and blind-spots - and hopefully improve them - and put himself in the place of the patient, see what it feels like to be one and how a patient sees his analyst.

Similarly, in the group, the doctor presents his patient in a free and spontaneous way and then allows to the rest of the group to think freely and talk about his case, while he listens without being able to intervene for a while. This way, he can focus on what his colleagues think about his patient and his own handling of the patient. He can also re-listen to himself through the repetition of his words by the other members, and the impact that his narrative had on the group, the thoughts it brought out and the feelings that arose in them. This process helps the doctor to examine both his patient and himself from a different point of view and from a distance, sometimes identifying with the patient and feeling empathy for him, other times identifying with himself and justifying the negative feelings he has for the patient, and often realizing that both he and the patient had their reasons for reaching an impasse in their therapeutic relationship. And even though one cannot claim that the doctor will become an expert in psychotherapy just from participating in a Balint group, there can be a substantial change in a way he thinks about himself and his patients, after participating in such a group for some time.

After looking at what a Balint group has to offer, one could say "Yes but would these groups be useful in a health system that is different from the NHS? A system in which specialists and not GPs are mainly responsible for the treatment of patients and most of the times in the absence of a formal context that clearly defines the doctor- patient interaction and the obligations and rights of each party"? My answer would be "Definitely". In fact, Balint groups are even more necessary in systems like ours that lack a consistent frame of work and a culture of doctor-patient interaction. In these cases, the group can provide a frame to the doctor-participant and function as a substitute for what the system, the medical school or the hospital cannot provide both in terms of emotional support and psychological training for the doctor.

Moreover, every doctor needs to have some psychological skills. Some doctors are gifted in this area but those are probably the minority. Most of us have to be trained in order to be good at something even if we are talented in our work. The same applies to doctors regarding their ability to treat the psychological needs of their patients in a subtle and informed manner. And since everyday medical practice, especially in hospitals, is usually very intense, frenetic and often overwhelming for the doctor, his psychological skills have to be so well-established so that they come almost as a reflex reaction to an emotionally charged situation. And this can only be accomplished through training.

At the same time, many specialists are in great need of psychological support for themselves and their patients. Oncologists, neurologists, gynecologists -especially those who specialize in assisted reproductive technologies- and psychiatrists, are only some of the specialists that could benefit from Balint groups as their clinical work has a significant psychological burden. Sometimes the burden comes from the patient but at other times it comes from the doctor himself who doesn't know how to deal with the feelings that the patient arouses in him. He then becomes overwhelmed, defensive or aggressive, depending on his personality, depressed or disappointed with his profession. The participation of these doctors in a Balint group provides them with a context of solidarity and sharing, and, in that sense, I think that the group can function as a therapeutic setting for the doctor as it alleviates the frustration, loneliness and anxiety that are very common in the health professions.

And of course Balint groups will always have a place for general practitioners who

are historically linked with the method and have the privilege of treating their patients for a long time and in a more holistic way than most doctors. For that it seems only fair to close with the words of a GP and long-time Balint group member, Dr Jonathon Tomlinson, who writes in his blog entitled "A better NHS":

"We are trained in detachment and objectivity, and are afraid of intimacy. We are afraid of our patients being dependent on us, or becoming dependent ourselves on our patients. We are afraid of crossing professional boundaries, of becoming over- involved, of being paternalistic or meddling. Part of this fear is a fear of vulnerability and a denial that as social beings, we actually do depend on each other. If it is hard for us doctors to come to terms with actually hating our patients, it is even harder to admit that we need our patients to love, respect, care about and depend on us".

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Exploring the Feelings Behind Physical Symptoms

Alexis Brook Memorial Lecture
Tavistock Clinic
Dr. Sotiris Zalidis, GP and Balint Group Leader

Introduction

Every day in our surgeries, General Practitioners listen to our patients who complain of physical symptoms and who worry about the meaning of these symptoms. Our initial responsibility is to make an assessment of the possible medical significance of these symptoms, make a diagnosis, and treat or refer appropriately. However, there are some physical symptoms, that even after a careful clinical assessment, we can find no medical explanation for. It is estimated that a quarter to half of all primary care consultations concern symptoms for which conventional pathology cannot be identified. It has been calculated that the cost to the NHS is £3 billion a year.

Most patients are reassured when we tell them that we can find nothing seriously wrong, but some would like to know the reason why they experience these unpleasant physical sensations and will come back again and again. If we cannot understand the symptoms in a way that satisfies ourselves and the patient, there is the danger that the patient may attribute the symptoms to physical disease and seek a medical diagnosis and treatment repeatedly requesting more and more investigations and referrals to specialists, a behaviour consistent with somatisation disorder.

We tend to think of these symptoms of unknown medical aetiology as functional. It has been observed that functional somatic symptoms tend to occur in clusters and several clusters have been identified as functional somatic syndromes according to which symptoms predominate. So we talk of hyperventilation syndrome, irritable bowel syndrome and fibromyalgia. Although these symptoms cannot be explained in terms of a conventionally defined medical disease, in some cases they can be understood in terms of the physiological mechanisms that mediate emotional arousal.

It is thought that the unifying factor behind the functional somatic symptoms and syndromes is the difficulty these patients have in recognising, controlling and modulating their emotions. The patient I am going to present is a typical somatiser and is still under my care today. She has given me written permission to write about our consultations.

Our present relationship has been shaped by the way I have responded to her physical symptoms when we first met in 1988, four years before I met Alexis Brook.

Alexis's research at Well Street Surgery influenced my response to her when she presented with an eye symptom in 2001.

LAURA

I first met Laura in 1988, four years before I met Alexis, when she was 47 years old. She had already been registered with our practice for eight years before I started working there. She had suffered from a variety of psychosomatic symptoms such as: allergic swellings of the face, hay fever, severe headaches, bouts of abdominal pains, recurrent attacks of diarrhoea and vomiting, dyspepsia, breathing difficulties, generalised aches and pains. A few months before we met, the frequency of her requests for appointments and the intensity of her complaints had increased dramatically and my colleagues felt drained, puzzled and stuck. I was the junior partner at the time and my colleagues felt

relieved that Laura had started to come and see me in order to try me out.

Laura is short, and plump, has a permed hair style, dresses neatly and speaks English fluently with an attractive Spanish accent.

At the start of our relationship she used to complain of her symptoms with exaggerated intensity. Her face would display an anguished expression and she would dramatise her suffering by wincing at every twinge of pain and rubbing the part of her body that hurt. The opening gambit in every consultation was that she was no better and that the pains were killing her. I remember being filled with dismay at the beginning of every consultation when I realised that none of my conventional remedies worked. Soon after we met she also started having occasional falls and developed a fear of going out of her flat. My first thought was that a psychiatrist might diagnose agoraphobia and hopefully take over her treatment. However, the psychiatrist I referred her to, concluded that she did not have any identifiable psychiatric condition. What stopped her from going out of her flat was disgust: her repugnance of dirty, scruffy people who spit in the street. She was almost crippled by her intolerance of anything smelly or dirty.

As investigation and treatment of each physical complaint had given no result, I decided to adopt a different approach. I offered to see her in a double appointment, that is 20 minutes, every time she wanted to come and see me, so that we had time to talk. My aim was to have a conversation with her and give her the opportunity to talk about her feelings and ideas so that the physical symptoms would stop being the main form of communication between us and hopefully would lose their intensity.

The concept of mentalisation had not been coined yet but there was a consensus among psychosomatic doctors that helping patients identify and express their feelings in words could reduce the physiological arousal of their emotions and therefore the intensity of their somatic components (Zalidis 1994).

Gradually I learned that Laura was the one before last of 16 children and was 21 years old when she arrived in London from Spain where she was born. She lived alone with Sally her 17 year old daughter, since her divorce, two years after Sally's birth. She had always lived with her daughter in a close mutually-dependent relationship, but recently seemed to feel increasingly threatened by Sally's developing independence and budding sexuality. She said that she could not keep up with her brilliant daughter and preferred the relationship she had with her, up to the age of 15. She would get furious with Sally for smoking, or coming home tipsy after a few drinks with her friends. After a row with her, she would develop a number of frightening physical symptoms which would intimidate Sally into submission. Sometimes she would have a fall after such a row. The clamour of her rage and the accompanying physical symptoms would protect Laura from experiencing any anxiety about the changing relationship to Sally, or from thinking about it in order to adapt to her new circumstances.

I saw her regularly and frequently for four years and would like to present a few sessions from the beginning, the middle and the end of this period of time to illustrate how the investment of my time and effort paid off in the end and helped this somatising patient achieve a modest degree of integration.

THE BEGINNING

A few weeks after we had met, Laura developed severe back pain and stayed in bed for about a month. I had to visit her at home a few times, prescribe painkillers and refer her for domiciliary physiotherapy. Sally had to do everything for her during this illness: bathe her, cook for her and when she became constipated she even had to give her enemas. When she recovered, she started coming to see me regularly.

One day she came to the surgery complaining of severe headache. When I started exploring the circumstances in which it had started, it emerged that her downstairs neighbour made a lot of noise and when Laura complained, the neighbour swore at her. Laura became very annoyed and when she was annoyed she worried and got a headache. I asked what the worry was about? She said that she worried that she might crack up in the same way that she had done at the council, several years ago before she moved to her present address. She had gone to the council to complain about her neighbours whom she described as "blacks, Irish, madmen" who made a lot of noise and with one of whom she had had a fight. She "lost it" in the housing officer's office and "went mad", screaming and shouting, overwhelmed by her rage.

I told her then, that she was probably suffering from a tension headache and tried to reframe the symptom by giving it a positive meaning and saying something like: "it seems to me as though you are trying hard not to lose your head this time".

Laura's symptoms deteriorated. She missed the following appointment because she was too ill to get out of bed and came to see me a week later in an agitated state of mind. She complained of a multitude of physical symptoms. She had a chill from the top of the head to her toes as if "somebody was walking on her grave", constant headaches, a tickly cough, a pain in her throat and breathlessness. She was breathless all the time but she would also wake up in the middle of the night and gasp for air. She said that **"IT"** woke her up at three o' clock in the morning and she could not breathe. The air would not come out because there was a knot in her throat as if someone was strangling her. Sometimes she developed a heaviness on her chest and then she could not take a deep enough breath. It felt to her as if the chest had sunk into her tummy. She wanted me to examine her and find out what was wrong with her chest.

Her anxiety about the bizarre and frightening symptoms was overwhelming. I examined her and all I could find was tender spots on the ribs near the breastbone. I told her that the symptoms were probably related to muscle tension due to her anxiety and listened to her anger about the neighbour who was annoying her so much recently. At this early stage Laura found it easier to talk of her rage with the neighbour than with her daughter, and considered the neighbour responsible for her state of mind. When Laura said that **"IT"** woke her up at three o'clock in the morning she was also expressing the belief that she had no responsibility for her symptoms. She was the passive victim of something alien out there which attacked her in the middle of the night.

In retrospect, I recognise that she was suffering from hyperventilation syndrome but at the time I had not yet developed fully my views on its nature and management. So I missed a chance to show her how to regulate the dysfunctional breathing that was responsible for generating and perpetuating a lot of her physical symptoms.

My aim in treating Laura was to help her recognise that she owned her emotions and that the physical symptoms were the somatic accompaniments of these emotions. I was hoping that helping her to think and express these emotions in words could modify the intensity of their somatic components and make them a source of information about her relationship to herself and to others.

This was not an easy task with Laura. Apart from the fear that she might become overwhelmed by the intensity of her emotions and go mad, there was also a fear that her magical powers would make the wish contained in the emotion come true. One day she told me that she was trying hard not to have bad thoughts. She had the impression that she was psychic, that if she thought of something, it would happen. Her brother in law had developed leukaemia and she blamed herself for it. She remembered an argument they had in Spain long ago, when she had taken his dog for a walk that ran away and got

lost. When he told her off angrily she was annoyed and she thought: "Why don't you get lost like your dog". Now she considered herself to be the cause of her brother in law's illness and felt guilty.

THE MIDDLE

About a year and a half after I met Laura, Sally found a well- paid executive job in an advertising company and to celebrate her success she went for a trip to Spain to visit her maternal grandmother. Laura developed severe back pain about a week before Sally left and colicky abdominal pains, diarrhoea and vomiting during Sally's absence for which she made several requests for home visits.

I felt dismayed that in spite of spending so much time with her the previous year, I had made so little impact on her neediness. Her symptoms did not improve after Sally's return. She complained of severe abdominal pains for which no drug was effective. Sally was so worried about her mother's health that she made an appointment and came and see me and find out what I thought was wrong with her mother.

Laura had become afraid that she was suffering from a peptic ulcer and asked me to refer her for a barium meal. Although I knew intuitively that her symptoms were related to feeling abandoned by Sally during her trip to Spain, I felt a conflict arising in me. On the one hand I began to have doubts about my diagnosis because the symptoms were not improving. Perhaps I was 'barking up the wrong tree'? Perhaps she did have a serious medical disease that I was missing? On the other hand I felt that my authority was challenged, that it was my job to decide when physical investigations were needed. Her request implied that I was neglectful and this annoyed me.

I contained my anger by reflecting on Winnicott's view that the tendency of psychosomatic patients to consult many therapists is created by a split in their personality organisation: **that** is the main illness rather than the physical symptoms they complain of. There is little to be gained by forbidding this tendency. If the patient thinks that the doctor disapproves or expresses his anger he will not tell the doctor that he has consulted other therapists. Much more can be gained if the doctor tolerates his own anger, stays in the background and maintains a unified view of the patient's progress.

After reflection I thought that the most helpful course of action would be to ask a gastroenterologist to see her. Apart from reassuring her and me, the referral would free me from the pressure to do something about the physical symptoms in order to continue doing what I would describe as emotion coaching. In my referral letter I explained the background of Laura's symptoms and histrionic personality and asked her to rule out organic pathology. Fortunately all the investigations were normal.

Very little had changed in her behaviour or her complaints since we first met.

The main gain was that by now she considered me to be her regular doctor and she always came to see me with a double appointment, something that was beginning to contain her distress within the practice. I would listen to her symptoms and then guide her to talk about whatever upset her most. Sometimes she was angry with the neighbour but more often she talked about Sally. She would become furious if Sally came home drunk, jealous if she talked of her boyfriend, envious when she talked of her promotion, or pay rise at work, fearful when she discussed her plans of going abroad, annoyed because she spent all her money too easily without saving for the future. She used to say that their roles were reversed and Sally behaved towards her with the authority of a mother. One night she dreamt she was a cripple and was driving around in an electric wheelchair. A few weeks later she developed sudden crippling back pain (November1990). The duty doctor had to visit her at home twice in order to assess her condition and make

arrangements for domiciliary physiotherapy.

I made my first visit three days later. I found Laura in bed in a lot of pain. She greeted me with a barrage of complaints: "The stupid tablets made me dopey.... the physiotherapist was no good... her treatment was too short and ineffective". I asked whether she felt Sally was caring enough and Laura wondered whether the pain had anything to do with her daughter.

I asked how the pain started.

The day before the pain started Sally came home tipsy, giggling. Laura was furious. They had a violent row which lasted for three hours. At the height of the argument Laura slapped Sally and Sally slapped her back, breaking Laura's glasses. After this, Sally stormed out of the flat and Laura spent all night sobbing on the floor. The following morning she went out into the garden to cut some flowers to decorate her father's photograph. As she stretched her arms to cut the flowers she heard three cracks in her back and felt excruciating pain. She said that it was all Sally's fault and she wanted to scare her into not drinking. Seeing her drunk reminded her of her husband. It was not ladylike. She behaved "like a tart" and Laura was afraid that any man could take advantage of her in that state. I commented that it would be an awful shame if she tried to control Sally with her back pain, but she took no notice.

Laura said that there must be something wrong with her back and perhaps she needed an operation to put it right. I was worried about this trend towards invalidism in her. Becoming a back cripple in a wheelchair, totally dependent on Sally, was a possible outcome that I wanted to prevent by shifting her attention back to talking about her emotions. To achieve this objective I would have to continue our sessions by visiting her at home.

I visited for the second time two days later. Her pain was no better and she appeared to be in agony. Every movement caused excruciating pain and made her scream. I examined her and listened to her complaints about Sally who had left her alone for the day to go to a conference. She did however, acknowledge that Sally did everything for her. She washed her, cooked for her and if her constipation persisted she would give her an enema!

I asked about enemas in childhood. She remembered her mother bringing her children breakfast in bed: first a cup of coffee and then a deep plate of boiled chestnuts to regulate their bowels. If she did not open her bowels for three days her mother would give her an enema. When Laura was about 12 she told her mother to stop because she found it humiliating.

I visited for the third time a week later and she complained bitterly of constipation. Sally had refused to give her an enema. She had rung the duty doctor at three o'clock in the morning to ask him what to do but she did not find his advice at all helpful. We talked again about her childhood in Spain. When her mother had to go back to work in a tomato factory, after the birth of her youngest sister, one of her older sisters became the "little mother" for her.

She became the cleanest, tidiest child under the tutelage of that sister who was more fanatically clean than her own mother. She would run her fingers on surfaces that Laura had missed dusting and she would wipe her dusty finger on Laura's mouth. Her father was very much respected. He was, according to Laura, a "lovely man". When the family would sit down to dinner, Laura would complain that her mother had given more food to her brothers and sisters. Father would ask her to hush and would give her a spoonful from his own plate. She missed him very much. She did not remember her mother ever kissing her, whereas her father did.

The pain was not improving. The physiotherapist rang me to check that I was not missing a serious medical condition. I had to hold my nerve. When I visited for the fourth time three days later, Laura was in pain and full of complaints. Nobody was doing anything for her. She was angry with Sally for not devoting herself completely to her mother's care. "She could have given up her job for a few days" she said. "Is her job more important than me? She does not care for me". She was annoyed with Sally's excited chatter about her preparations for her company's Christmas party. She experienced Sally's behaviour as a stab in the back.

When I visited for the fifth time a week later she felt a lot better. She could limp around the bed without much pain and she was not complaining any more. My visit had a social character. During the visit Sally came home with her new dress for her company's Christmas party. She was cheerful and excited and she put it on to show us. I expressed my admiration for it but Laura said nothing and looked at it disapprovingly. When Sally went to the kitchen to make a cup of coffee, Laura said that she did not like the dress because it did not have any class. She went to her wardrobe and took out a black dress of her own that she had bought 15 years previously to show me how much "better class" it was than Sally's. She had lost all interest in dressing up 15 years ago, she said sadly.

THE TURNING POINT

Six weeks after the onset of her back pain (January 1991), she was able to come to the surgery again. She looked somewhat amused and she told me that **she had dreamt she had sex with the Pope!**

I asked for the details of the dream. She dreamt that she was in St. Peter's Square. The Pope came near, held his hand out to her, led her up to his chambers, sat next to her and started talking to her. He put his hand under her skirt and started fondling her. Gradually he made love to her and the whole thing was celestial, beautiful, and refined. When Sally came into her bedroom in the morning Laura felt so embarrassed. You will never believe what I have been dreaming, she told her. Sally laughed and laughed when she heard. Since then she had been dreaming of the Pope every night. They did not make love any more. He cuddled her and it felt so good. All his entourage in the dream treated her with respect as though she was a member of his family. She was worried that she was going mad. She was not even religious. She thought of writing to the Pope to ask him what he was doing in her dreams!

I told her that it was she who put him in her dreams. It was like putting a picture of the Pope in her sitting room and writing to him to ask what he was doing there. I reassured her that it was perfectly all right to have these dreams and asked her to come again in two weeks to talk more about them.

When she arrived two weeks later, she started complaining of headaches and dryness of the skin of her nose. I asked whether she was going to waste her time instead of discussing the dreams as we agreed. She looked at me craftily. "I don't want to tell you my dreams. They are saucy." Then she burst into laughter and said that a week previously she had dreamt of Patrick Swayze, the hunk who stars in the film "Dirty Dancing". He was teaching her to dance and she could do everything he taught her. Then she told me of another dream. She dreamt that she was a Jesuit and she was running through a forest. Hanging branches were whipping her face and she woke up with a feeling of suffocation, gasping for air. She often got this feeling of suffocation, she remarked.

I asked what the Jesuits would think about her dreams of having sex with the Pope.

"They would whip me, they would cut my head off", she said in alarm.

I suggested that in that case her dream expressed her guilt about all the good times

she had had in her previous dreams. She asked me what the dreams about the Pope meant and I suggested that the Pope stood for her father. She wanted her father to come and rescue her. Her back pain had started when she stretched her arms to cut some flowers to decorate his photograph. "What a good memory you have!", she marvelled. She had never accepted her father's death. She had not dreamt for 10 years, yet for the last two months she had been dreaming all the time.

She also remembered dreams of being invited by the Queen to the Palace for tea. She went to the Palace but was never given tea. When I told her that the Queen might stand for her mother she remembered how stingy her mother was, both with affection and money. Her father would not hesitate to spend money on her or to encourage her to buy an extra pair of good shoes.

Laura's improvement was clearly signalled by her ability to remember her dreams. Although I did not make a transference interpretation, I believe that the Pope dreams expressed also her wish for care and affection from me as well as from her father. Its sexualisation led to a sense of oedipal guilt expressed in her Jesuit dream. This was so strong that it could not be contained in the dream but woke her up with a sense of suffocation. I wonder whether similar unconscious emotions and fantasies underlay the hyperventilation attacks that woke her up several times at night in the past.

Laura continued to come to the surgery regularly but her physical symptoms had lost some of their urgency and now she could discuss her feelings. At the end of the year her mother became terminally ill and her brother in law's leukaemia took a turn for the worse. She had to go to Spain to be with her mother, who died within a couple of weeks of her arrival there. Laura came to see me as soon as she returned to London. She told me how amazed she was with herself for finding the strength to overcome her disgust and nurse her mother. She had to feed her, wash her and wipe her bottom. She cried a lot when she died and now she felt empty.

Two weeks after Laura's mother's death, in the middle of the evening surgery, I had an urgent request from Sally to go and visit Laura who was writhing in agony with severe abdominal pain. With a sense of exasperation, I interrupted the surgery and visited immediately. She was groaning with pain, twisting and turning in a world of her own. On examination she was tender all over. The slightest movement caused pain. I knew intuitively that the pain was related to her feelings about her mother's death. I was torn between the need to return to the practice and continue with my evening surgery and the wish to stay and soothe her in some way, but she was beyond words. I decided to give her a painkilling injection and went back to the practice.

The injection did not work and at three in the morning Sally called the duty doctor who had Laura admitted as an emergency under the surgeons. In the morning Sally rang the practice to talk to me. She was crying. Her uncle had just died of leukaemia and she was very worried about her mother. She wanted to know what was wrong with her. I explained that with such a degree of physical pain it was impossible to be sure that there was nothing seriously wrong going on in her mother's tummy. We would have to wait and see.

That evening I visited Laura in hospital. She was drowsy from the analgesia and had a drip up. The surgeons suspected intestinal obstruction. I sat by her bedside and we talked for half an hour. She remembered that something similar had happened to her when her brother died and she felt so ill that she could not go to the funeral. She also remembered that her mother was complaining of abdominal pain when she was dying and Laura had to go out of the room because she could not tolerate her moans. She felt so helpless. She had heard about her brother in law's death. She had known he was poorly

but she did not expect him to die so soon.

I wondered whether some form of identification with the dead was going on, and said something like:

"You have to bear so much pain Laura". It is like becoming your mother and brother in law in one.

She groaned with pain. "What can I do about it?"

Because I was worried that the surgeons might operate prematurely before giving her the benefit of the doubt, I rang up the surgical registrar to inform him of Laura's personality and of her tendency to respond to death events with severe pain. He had noticed her capacity to dramatise and he was interested in what I had to say. He was aware of an association between acute emotional crises and paralysis of the bowel. The following day Laura's pain resolved and she was discharged from the hospital. Four days later she went back to Spain for her brother-in-law's funeral. She suffered no more pain. When she returned to London she came to see me. She was sad and subdued and complained of feeling empty and of shivering at night. She talked of her anger with her mother's helplessness. She was afraid that if she became paralysed Sally would have to do for her what Laura did for her mother and she did not want this to happen. Life was so cruel and she felt so angry with it. I asked whether it was possible for her abdominal pains to have something to do with this anger. She looked at me in silence.

A month later she came back and complained of numbness in her hands and feet and a feeling of suffocation. She felt that for the last three weeks she could not take a deep enough breath. She was also waking up at night, gasping for air. She wondered whether all these symptoms were due to anxiety because Sally had gone to a conference in Greece and with all the news about young girls being abducted and raped, she was worried.

By then I had developed a good grasp of the hyperventilation syndrome and was able to explain to her the physiological mechanism responsible for generating and perpetuating her physical symptoms. I showed her how to regulate the dysfunctional upper chest breathing by practicing diaphragmatic breathing (Zalidis 2001). When she came back three weeks later she told me that she had found the breathing exercises very helpful but she still had a lot of headaches. We discussed the money worries and how angry she can get with Sally who spends money without any thought for the future. Then she paused and said: **"sometimes I think that I make myself ill".**

I took notice of this phrase. It represented a significant change from the phrase four years earlier that **" IT"** woke her up at night.

Laura had begun to develop a capacity for reflective self- awareness and had stopped seeing herself as the passive victim of alien forces. She had begun to recognise that she owned her emotions and that her symptoms were the somatic accompaniments of these emotions. It was crucial to this change that she had formed a relationship with me in which her long standing depression, rage and denied sexuality could be acknowledged and contained rather than expressed in symptoms and fights with her daughter and neighbours.

When I looked in her medical records after this period of intensive treatment, I realised that the number of consultations had fallen from 30 a year for the first three years (1989, 1990, 1991) to 15 for the last year (1992). However, 15 was the average number of annual consultations before I adopted a psychotherapeutic approach towards her. The dramatic change was not so much in the number of consultations as in their quality. There is no longer a sense of insatiable neediness and agitated demands which made her come to the surgery as an emergency without an appointment, complaining of aches and pains and being oblivious to the disruption she caused to the doctor's work.

She still attends frequently but she always makes a double appointment one or two weeks in advance and she discusses her feelings, such as her anger with her demanding invalid brother, or her apprehension about her daughter's ambitious plans. She has been transformed from a patient whose urgent incomprehensible agitated complaints I felt exasperated about, to a person whose progress in life I follow with interest.

ENTER ALEXIS BROOK

In 1992, the year I ended the intensive phase of my patient's treatment, I met Alexis Brook at the annual Balint dinner where he was the guest speaker. He spoke of his psychosomatic eye research that he was conducting at the ophthalmological department of a general hospital in Portsmouth. After his talk I introduced myself to him and we had a discussion about psychosomatic medicine. He told me then that he wanted to conduct part of his research in a general practice setting and asked whether my partners would be interested in inviting him to our surgery. I thought that this was a once in a lifetime opportunity to collaborate with Alexis. My senior partners already knew Alexis and his contribution to General Practice and we were unanimous in our agreement. So he started coming to Well Street Surgery every two weeks to see patients with eye symptoms that we were referring to him.

WATERING EYE: WEEPING WITHOUT SADNESS.

In 2003 we published a paper in the Journal of the Balint Society, discussing a pilot study of six patients who sought help from their GP for longstanding watering eyes (Brook, A. & Zalidis, S. 2003). Their narratives revealed that all of them had experienced painful losses. Interestingly, they described their watering eyes in different ways: one said, "I am not crying; my eyes are watering". Another said: "they are not tears, I don't cry"; another said: "my eyes are weeping whilst I sleep"; two said, "they are watering eyes due to blocked tear ducts"; and the other, "I never let anything hurt me, I have never shed a tear in my life". In discussing their lives, all revealed varying degrees of preoccupation with feelings of loss: in one it was the death of a daughter; in another the death of a mother; in a third the death of a husband; in two, the death of a close relation; and in one, abandonment by her husband. In all six patients, their narratives indicated a close link between their feelings of loss and the watering eyes. The interviews suggested that, without being aware of it, they were attempting to protect themselves from experiencing the full intensity of their grief. The watering eyes it seemed, were the expression of the unresolved grieving – tears without emotional crying so to speak. Alexis's interviews with patients who say they have blocked tear ducts suggest that, without realising it, they may also be referring to blocked feelings. The expression: "blocked tear ducts" being the metaphor for blocked feelings. Discussing this with them helped to unblock the feelings.

BLOCKED TEAR DUCTS

These ideas were uppermost in my mind when Laura presented on 12 September 2001 complaining of watering eyes. The symptom annoyed her and wanted to get rid of it. She had gone to the eye hospital casualty a few times and was told how to manage her blepharitis but it had not helped. She thought that her tear ducts were blocked and asked me to refer her to an eye specialist to have them unblocked.

I agreed to do so.

However, the timing of her presentation made me wonder whether her symptom was caused by crying and so I asked whether anything had happened to upset her. She had watched on TV the twin towers of the World Trade Centre explode the day before,

and she had cried at the enormity of the disaster. She assured me however, that her eyes had been watering for at least **three** months and besides, she told me and I quote, "I am not one to cry". Having thus established denial as an important defence mechanism, she mentioned that Sally, her 32 year old daughter was **three** months pregnant and she saw no point in bringing children into the world at present.

I asked whether there might be a link between the watering eyes and her feelings about Sally's pregnancy, feelings that she might wish to block. She told me that she was afraid in case Sally's new baby suffers the same problem as the first baby that they nearly lost. In order to find out what the fear was, I invited her to come back the following week with a half hour appointment.

HER FEAR OF LOSING SALLY

On the next visit she told me that when Sally was pregnant with her first baby, she went into labour prematurely at 36/40. When Manuela was born she needed to be resuscitated. In the meantime Sally was bleeding and bleeding and she saw her becoming paler and paler, fading away in front of her very eyes. The obstetricians had left the room and the paediatrician was concentrating on the baby and there was nobody paying any attention to her daughter. So she ran out of the room in a panic to look for the doctors and she found them in a little room drinking coffee. Suddenly she went mad with anger and started screaming at them at the top of her voice, "my daughter is dying and you are sitting here drinking coffee"? She was beside herself and knocked a cup of coffee out of a doctor's hand and had to be restrained from becoming even more violent. The doctors ran to Sally and put a couple of drips up and gave her a transfusion and saved her. Laura felt that after her outburst the doctors became more attentive towards her daughter. However, she lost her voice for a few days after this shouting bout and felt embarrassed that she had lost control of herself and exploded so violently.

She knew her daughter was pregnant again before Sally knew herself. She noticed that she was more beautiful than usual and she told her so. However, she could not rejoice in Sally's pregnancy because she remembered the fear she experienced when Sally bled after the first labour and this put her off.

"This is the thing I have to block out" she said.

What do you have to block out Laura? I asked.

"If Sally dies, I will die. Sally means everything to me. Without her my life has no value".

Because I felt that her emotional explosiveness might diminish if I gave her the opportunity to talk about her feelings and help her understand them, I offered to listen to her a few times before the birth of her second grandchild.

MORE FEELINGS BLOCKED FROM CONSCIOUSNESS.

Somewhat naively, I expected that once the baby was born, Laura's health would improve. So when she told me, two months after the normal birth of her grand-son, that the rheumatologist consultant had diagnosed fibromyalgia, I was disappointed. She talked about her pains non- stop and as she talked she sighed and I noticed that her eyes were filling with tears. When I inquired whether she was sad, she denied it and said that she was the happiest person in the world. Only the pains got her down. Her inability to contemplate an emotional explanation for her distress left no room for dialogue and I began to experience a sense of helplessness. I did not know what to do to make her feel better. Because she was sighing often, I made a hypothesis that she might be hyperventilating, as she had done many times in the past and that she might benefit from

reminding her to breathe with the diaphragm.

I asked her therefore to lie on the couch in order to observe her breathing pattern. She lay down and for a few minutes we were both silent and felt calm. I was pleasantly surprised to observe that her breathing was diaphragmatic, and I told her so. I put my hand on her tummy and saw it lifting gently with every breath. We continued the consultation in this position. She, lying on the couch and me, sitting on my chair by the side of her monitoring her breathing pattern. My hypothesis was wrong, but in that position she gradually relaxed and started talking about her granddaughter Manuela. When Sally was pregnant she pretended to be pregnant too and complained about bellyaches. When Sally went into labour, Manuela gave birth too. In fact she had two babies! When Laura told her that they look too big she said that mummy's baby is big too! At this point I intuitively felt that Laura might be identifying with her granddaughter and I asked whether she too would have wished to have had two babies. She thought for a few moments and said hesitantly, "well.... if I had not lost that one..." She left her sentence unfinished. We had run out of time. I knew that we were on the verge of crossing the boundary of very painful and well- defended mental territory that I felt I did not have the mandate to cross.

The spectre of an important but denied and even disavowed grief came momentarily into view and then it was lost. Could it be that failure to grieve for this loss was at the root of her fibromyalgia? It is well known that we cannot process cognitively and symbolically emotions that are blocked from our awareness. The emotions will remain primitive and undifferentiated and when life events activate them they will be experienced at a somatosensory level as physical symptoms and their raw primitive power will threaten to get out of control, explode and disorganise us. Under these circumstances the mourning process cannot be effective and we will find it difficult to come to terms with our losses.

CONCLUSION

In this paper I described a number of consultations with a typical somatising patient who has a tendency to consult many specialists. Her latest complaint was watering eyes since the onset of her daughter's second pregnancy that progressed to fibromyalgia after the birth of her second grandson. She attributed the watering eyes to blocked tear ducts and denied that she had been crying. Although in the consultations she became aware of the fear of losing her daughter to an obstetric complication, the feelings about losing that other baby of hers were totally blocked from consciousness and inaccessible. Tantalisingly, I knew from reading her medical record how she had lost that baby and how she had refused in the past to acknowledge this loss. I have respected her defences and never attempted to explore these disavowed emotions but over the years I have often wondered whether, had she acknowledged and processed these feelings, her fibromyalgia might have improved. However, making sense of her functional somatic symptoms in terms of emotions enhanced my understanding of her suffering and encouraged her to consider me her personal doctor. The continuity of our relationship over twenty seven years has counteracted the fragmentation of care inherent in multiple specialist referrals.

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Professional boundaries in medical students' conversation

Balint Society Annual Essay Prize Winner

Joseph Simpson

This essay discusses my experiences as a medical student in my first year of clinical medicine taking part in a Balint Group. The group involved twelve medical students, including myself, and two group leaders who met every week to talk about our experiences with patients; to think about the new kinds of interactions we were having; and to reflect on how we felt about particular cases.

From the first session, something that caught my attention was the way in which cases were often discussed in relation to 'professional boundaries'. I felt this was strange given the very early state of our development as professionals, and I wondered whether a term like 'professional boundaries' really reflected our experiences or whether the phrase is part of a structured model to talk about relationships, a professional language that we are in the process of learning. As the phrase was used again and again, in relation to a range of different situations, I realised that we use the phrase to mean a variety of things in different settings. What I would like to do in this essay is to look at some of the meanings of the term 'professional boundaries' in different contexts.

I will describe a case I brought to the group and some of the discussion that this case raised, as well as some of the discussion around other students' experiences that seems particularly relevant. I will go on to look at some of the ways in which the concept of 'professional boundaries' is formulated in these discussions and discuss the applicability of these interpretations to my own experiences. Finally, I will conclude with a reflection on the usefulness of the concept of boundaries for myself and other medical trainees.

The case I want to discuss here involves an interaction that I felt represented one of the most successful attempts to build a relationship with a patient that I have experienced in my short exposure to clinical practice. It is one which I was initially reluctant to bring to the Balint Group, which I felt had been more focussed on situations that were distressing and disruptive.

I met Mrs. S, a 71 year-old woman, on my surgery and digestive health rotation. She had been admitted to hospital for an elective cholecystectomy and when I first saw her, she was sitting in a bay in the hospital's day treatment centre waiting to be called down for her operation. I introduced myself as a medical student attached to the surgical team and asked if I could speak to her about her symptoms, and attend the procedure. I went on to take a formal medical history of her gallstones – she had been experiencing intermittent pain for three years, culminating in an admission to hospital 5 months previously, where she was found to have developed acute pancreatitis secondary to her gallstones. Since then she had been on the waiting list for the surgery she was due to have that day.

During this conversation I focussed on covering the medical information from the case in a structured way. When I reached the social history section of the consultation however, the conversation became more personal as Mrs. S explained that she had worked as a nurse, but had taken early retirement to look after her son who had learning difficulties. I explored this further asking how her son was now and what her other four children were doing now. She told me that her son was a lot more independent now, that

he and the other children lived in the same city along with thirteen grandchildren, and that although she lived alone, her house was rarely empty.

As I was closing the conversation, saying that I would see her when she was called downstairs to the anaesthetic room, she said that although she normally found talking to strangers difficult I had made her feel comfortable. I sensed that she was feeling quite anxious about the procedure and that she would appreciate talking further so we began talking about how long she had lived in the area. She told me she had lived locally for about forty years. Since I have also lived near to the hospital for several years we spoke about the area, eventually moving on to talking about the football club which is nearby. She told me that she and her children were all huge fans of the club and I asked her if she would try to watch the match that was taking place that night on a television in the hospital. She said that she never watched the games on television since she became too nervous but that she enjoyed watching games when she went to the stadium with her son. We concluded the conversation with me promising to watch the game that night and come in to tell her about it the next day.

I saw Mrs. S again as she was being put under anaesthetic, and followed her into the operating theatre to observe the procedure which went well with no complications. I then went with her to the recovery room as the anaesthetic wore off. She recognised me as she woke up and asked how the procedure had gone and I was able to reassure her that it had been successful and that the team had no concerns.

As I was by her bedside in the recovery room she told me that she would be seeing some of her children later that evening and that they would be relieved that the procedure had gone smoothly. She said that prior to coming in to hospital she had sat down with her children and gone through her will. Her children had found this upsetting, telling her that she was being morbid since the procedure was relatively safe. I told her that I agreed with her that it was good to be able to have those difficult conversations with family members since advance planning is something that many people struggle with, and even though the risks to her in this case were fairly low, it was clearly something that concerned her.

One of the things that I remember at this point is that when one of the recovery nurses came to check her wounds, pulling the curtain round and asking me if I wanted to remain by the bedside, I declined. Even though I had been present throughout the surgery, now that Mrs. S was awake I felt that examining her wounds myself would be unnecessary and potentially embarrassing for her. When I left her, reminding her that I would be coming the next day to see how she was and to tell her about the football results, she said to me 'God bless', and I echoed this back saying 'God bless, see you tomorrow'.

Later that day, I was telling a friend who is also a medical student about Mrs S. and told him that I had promised to watch the football match that night and tell her about it the next day. He told me that he was a fan of the same club and that he and his family were season ticket holders. It transpired that none of the family was using the tickets that evening so we went to the stadium together to watch the game, which was a fantastic experience for me. Unfortunately 'our' team lost quite heavily!

The next day I went to see Mrs. S on the ward where she was in some pain and discomfort following surgery, but was still on course to be discharged home. We commiserated about the result of the football game and she thanked me for coming back to see her.

These encounters made a big impression on me. I had taken a thorough medical history, which I had successfully presented to the surgeon, and learnt a lot about Mrs. S's condition and the operation itself. At the same time I had established a good relationship

with Mrs. S and felt as if I had made a positive difference to her experience in the hospital. As previously mentioned I was unsure about bringing this case to the Balint group, since I felt that it didn't contain a lot that would interest the other students. A series of conversations in the group about professional boundaries changed my mind about this.

I think that this case relates to many of the concerns about professional boundaries that medical students have. Firstly, the encounter involved a mixture of medical and non-medical conversation touching on personal issues including not only football (which is perhaps quite trivial), but also the patient's family experiences and worries about death and dying. There was a small example of religious conversation, something that was picked up in the Balint group as being potentially problematic. There was also an emotional connection which I felt, and which perhaps was responsible for me not wanting to examine the patient's wounds myself in the recovery room.

During our discussion of these issues at the Balint group, other people in the group felt that having non-medical topics to speak about with patients was generally a good thing and helped to make consultations friendlier and smoother. Football and sport in general was seen as a particularly appropriate topic for these instances. Whilst being personal it is also quite 'safe' for medical students in that it doesn't lead to students being asked for advice about patient care or venturing opinions on sensitive matters in the way that, for example, conversations about religion might. The group facilitators were more critical about the idea of 'safe' topics, pointing out that many of us as students seemed to have such a concern about behaving appropriately that we often became worried about bringing any of our own personalities and experiences to bear on conversations with patients at all.

I felt unable to mention that I had said 'God bless', to Mrs. S to the rest of the group partly because I didn't want the other students to think I had been inappropriate but also because the other examples of religious conversation that had come up in the Balint group were a lot more dramatic. In previous weeks, one student brought a case to the group of a patient who had extensively self-harmed, including by burning his skin over a tattoo of Jesus on his leg. This patient told the student that he had done this because 'He abandoned me, so I got rid of him', and then asked directly 'He did abandon me didn't he?' The student who described this case to us felt that it would have been inappropriate for him to answer this question. Another patient discussed in the group told a student he had lost all faith in God since becoming ill and asked for the student's opinion on whether God really existed. Again the student felt that venturing an opinion would involve crossing a professional boundary.

The issue of building an emotional relationship with patients was something which came up regularly in the Balint group. One student was told several times that she was 'too nice' when she took medical histories and that this would prevent her from doing the job of a doctor efficiently. When we discussed this, several students suggested that we were all in the process of learning how to find a balance between putting patients at ease on the one hand, and obtaining all the relevant information for a medical history on the other. The development of professional boundaries was seen to be an important part of finding that balance.

I want to use the rest of this essay to examine some of the different ways in which the concept of professional boundaries appears in the preceding discussions, because I believe that in different instances the term has different emphases. I will look at some of these different emphases and explore them further.

Boundaries separate one's personal life from one's professional life, assigning appropriate behaviours to each

On the face of it, this interpretation of the meaning of professional boundaries seems logical and straightforward. As our Balint Group facilitators pointed out however, it is impossible to have a conversation with a patient or anyone else in which one's own experiences and personality do not have an influence. In my interaction with Mrs S. it was my own experiences of living near the hospital and being caught up in the local football culture that enabled us to form a relationship. Separating a personal from a professional persona in this instance would have narrowed the opportunity for such a relationship to develop.

There are clearly behaviours and relationships that are inappropriate in the clinical setting; the GMC's 2013 guidance on the issue of 'professional boundaries' refers to romantic and sexual relationships between doctors and patients or relatives of patients. The concerns here relate to issues of patient trust and the potential abuse of the power imbalance that exists between doctors and patients. Beyond these scenarios however, there is no guidance on what sort of relationship one should have with a patient – how much of yourself you bring to those relationships or how friendly you are towards patients.

Boundaries separate safe topics of discussion with patients from those that are inappropriate

None of the other students in the Balint group thought that having a conversation about football with a patient was crossing a professional boundary. On the other hand, the majority felt that religion and the intense existential questions that those who are very ill can ask were inappropriate topics of conversation, particularly for students. My interaction with Mrs S. made me realise that rather than there being a clear boundary between 'safe' and 'unsafe' topics, building trust and getting to know one another through conversations of the first sort can make patients more open to bringing up more challenging topics. I did not feel uncomfortable discussing Mrs S.'s desire to put her will in order before coming to the hospital. I felt that our relationship allowed that conversation to happen naturally. Similarly, it felt appropriate to echo her 'God bless' when leaving. Although we do not share a religious background, I felt the phrase conveyed a more caring and personal message than simply saying goodbye.

I appreciate that the examples of religious conversation brought up by other students were considerably more challenging. At the same time, I find it strange that during periods of illness and disability, when many patients are questioning their life and its meaning in a way that they may never have in the past, they are attended to by medical professionals who feel that it is not appropriate to respond to those questions. In the Balint group, myself and some of the other students felt that it should be possible to engage in these conversations without necessarily encouraging a particular perspective, but opening a space for patients to talk about their feelings related to life and death.

Boundaries serve a protective function, ensuring ones emotional wellbeing in an emotionally messy environment

My relationship with Mrs S., which involved more of an emotional engagement than most of my other interactions with patients have, left me feeling much better about my day, not only on a personal level but in terms of my professional development. It also led to me having the experience of attending a live football match for the first time. Clearly, an emotional relationship with patients will not always lead to such positive experiences. If the surgery had been unsuccessful or if any harm to the patient had occurred, I would

have been greatly emotionally affected.

It is hard to imagine however, that one's professional life would be particularly fulfilling or beneficial to one's psychological well-being if it involved a series of interactions without a significant emotional component. Ill-health and death are naturally distressing, but I cannot imagine a better way to develop the skills to make sense of them other than by forming emotional relationships with those who are ill and their relatives. Obviously there are limits to one's emotional energy, but these limits exist in life outside of the medical profession as well and part of having successful relationships in all areas of life involves recognising where those limits are. There are certainly boundaries involved here, but I'm unsure whether they are specifically 'professional'.

The question that I began this essay with was whether or not the term 'professional boundaries' is applicable to the experiences that we have as medical students developing a professional identity. The term relies on a particular definition of what being part of 'the profession' entails. This includes engaging in certain topics of conversation and not in others, and limiting the degree of emotional engagement with patients, but I believe that this formulation of a doctor's role is open to contestation. It is a conception of medical practice as specialised and technical rather than diverse and unpredictable. Again, this is not to say that there are no limits to the extent to which one can engage with patients, especially those who are suffering greatly. But it seems to me that those limits belong to us as people rather than to the medical profession as an institution, 'personal boundaries' rather than 'professional boundaries'.

I think that insofar as the term suggests a separation of one's personal and professional life, it reflects an imagined division rather than the reality of the relationships we develop, which often involve bringing our own experiences, personalities, and values to bear on conversations. The fact that I along with many medical students worry about doing this is one of the main realisations that I have had as part of the Balint group. Perhaps being able to think about the way in which we form relationships with patients, without using the framework of 'professional boundaries' could allow us to feel freer to develop a personal style of practice?

Psychiatry Trainee-led Balint Group Scheme for Medical Students: Avon and Wiltshire Mental Health Partnership NHS Trust

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We have developed a sustainable, affordable Balint group scheme run by Psychiatry Trainees at all levels of training. The scheme provides groups for University of Bristol medical students in their first clinical year. Our scheme is novel in terms of the involvement of trainees, the provision of Balint groups within medicine and surgery placements and the scale. The scheme is housed in and supported by the Department of Medical Education; we have found this helpful in promoting our stance of generic 'Balint for all.' The scheme is supported by the University of Bristol Undergraduate leads and endorsed by our School of Psychiatry which recognises and supports trainee participation. We have worked hard to develop good relationships with key individuals and groups involved. This has been and continues to be a significant factor in increasing acceptance and recognition of the scheme and working towards anchoring and embedding the scheme in Medicine and Surgery, the University, the Deanery and the Trust.

We have worked together to develop a vision for the scheme and to generate ideas. Ami has worked to actively coordinate the scheme with direction and support from Judy. The scheme started following on from focus groups held in 2012 where students expressed interest in peer-group reflective discussion to think about the impact of their clinical experiences. 3 group leaders ran 6 pilot groups later that year for students on their psychiatry placement with good uptake and feedback. The scheme expanded in 2013 with 24 groups run by 6 leaders, again with good uptake and feedback.

Though the scheme started in psychiatry, the transition to medicine and surgery has been our long-term aim. In this academic year the scheme expanded further offering Balint groups to all 246 students in their first clinical year on their medical and surgical placements. There is usually one trainee leader per group of around 7 students offering up to 9 one-hour group sessions over the student placement. Trainee leaders have had between 40 and 120 hours experience in Balint groups as part of their psychiatry training. They attend fortnightly group supervision with Judy, with peer supervision in intervening weeks.

Students identified the common themes for groups as including the doctor-patient relationship; the impact of illness on patient, families, clinician and teams; the medical student role; developing professional identity and effective communication. Students appreciated the groups and talked about the usefulness of a space for reflection; increased understanding of the patient, doctor and student experience and the helpfulness of a facilitated peer-environment to explore their experiences. The main challenges to participating from the student perspective include uncertainty about the endeavour and practical barriers such as demands of the placement.

Trainees observed student gains through engagement in the groups; their enjoyment in participation; peer learning on many levels; changes in attitude towards patients with complex presentations and questions around doctors' responsibilities. They

have noticed that characteristic cases included patients with medically unexplained symptoms; chronic illness and urgent, critical and tragic presentations. Students have been able to think about ranging feelings typically of sadness, hopelessness, helplessness and frustration in themselves and the patient, clinician and team. Challenges for trainees as group leaders have included managing group dynamics, coping with struggling or obstructive students and managing their own time. All trainees who have been involved in the scheme recommend participating and have valued their experience. Specific gains include learning about Balint group leadership skills; peer-learning in group supervision as well as opportunities for training, research, presentation and publication. Ami and Judy will be presenting a paper about the scheme written with colleagues at the IBF International Congress in Metz this year.

Supervision has been important to support the psychiatry trainee leaders with little experience of running groups. Supervision groups are run like Balint groups with 2 group leaders presenting their groups and cases, then sitting back as group members reflect and discuss. Supervision is active on occasion where trainees have brought specific questions and issues typically around Balint leader stance and intervention, group dynamics, attendance issues and concerns about challenging students. The Balint Society has been supportive of the scheme; Jane Dammers and Judy ran two successful training sessions for trainees and further sessions are planned. We are promoting Balint society membership, activities and leadership training to trainees and informing medical students about the Society.

The scheme links with the Royal College of Psychiatry recruitment strategy and based on this alignment Ami and Eva Stigaard-Laird were successful in being awarded funding from Health Education England to develop the scheme. The funding will allow further training opportunities, sharing of the scheme model with other regions and expansion to provide Balint groups for Foundation doctors in the acute hospital setting.

Qualitative Analysis of Medical Student Balint Groups during a Psychiatry Placement

Dr Tom Stockmann MA (Oxon), MRCPsych

Abstract

Aims
This study involved medical student Balint groups held during a psychiatry placement. The aims were twofold: a qualitative analysis of the discussion content of the groups, and an exploration of the participating students' experiences.

Background
Fourth year medical students who undertake a 5 week psychiatry placement are invited to attend a weekly Balint group during this time.

Methods
There were two strands – analysis of group discussions and student feedback. Notes were made by the leader immediately after the sessions, and thematic content analysis of these notes was performed.

Results
The trigger for all case presentations was the recall of a strong emotional reaction in the student, primarily concerning either themselves, a patient, or staff members. Subsequent discussions tended to involve common overarching themes. In addition, the groups lead to self-reported improvements in student communication skills, person-centred attitudes, and reflective practice.

Conclusions
Medical students describe significant emotional reactions to experiences during a psychiatry placement. The Balint groups may support medical students' professional and personal growth.

Aims
Balint groups are a method of teaching about the role of emotions in illness and the doctor–patient relationship, and are used in some UK medical schools to improve student communication skills1. There is limited research on Balint groups for UK medical students, particularly those attended during a clinical psychiatry rotation.

This study involved medical student Balint groups held during a psychiatry placement. The aims were twofold: a qualitative analysis of the discussion content of the groups, and an exploration of the participating students' experiences.

Background
The proposed need for medical student Balint groups

Medical students are likely to be exposed to novel and challenging interpersonal encounters, and other situations, as they undertake clinical placements, including in psychiatry. These will result in significant emotional responses, variously perceived as positive or negative. Some have argued that students unfortunately find themselves in an environment of 'professional alexithymia'2, which prevents them from helpfully

recognising, processing and regulating these emotions. It can be hypothesised that attempts to manage these emotions using maladaptive coping mechanisms, perhaps modelled from practising clinicians, such as distancing and detachment from the patient1, are linked to findings of a decline in students' empathy, communication skills and patient-centred attitudes as they progress through medical school3.

Balint groups, as well as offering a safe space for students to discuss their feelings, have been shown to improve medical students' knowledge of the emotional aspects of the student/doctor-patient relationship. Medical students have reported that participation in Balint group meetings increased their confidence, improved their communication skills, encouraged whole-patient medicine and reflection, provided support and increased their enjoyment of their work1.

Methods

The Balint groups are introduced during the placement induction. All 12 medical students within each cohort are invited to attend a weekly one hour Balint group for the first four weeks of their five week placements. The group is not described as compulsory. There were minor fluctuations in the number of attendees between groups, with a minimum of 10 and average of 11 in any one group.

The groups were led by the author. The students are invited to discuss experiences with patients that have stayed in their mind for an emotional reason. A volunteer presents a case, and the group reflects on this. Excessive questioning of the presenter is discouraged in favour of the group relying on its own resources. The main focus is on the emotional aspects of the patient-student relationship, although the group may pursue other avenues of shared interest. Usually, two cases are discussed in a single meeting.

There were two strands to the research: analysis of the content of group discussions, and feedback from students.

The content analysis was based on 12 separate Balint groups, involving 3 separate student groups, each of which participated in four sessions. Notes were made by the leader immediately after each sessions, and thematic content analysis of these notes was performed.

Individual student feedback was collected from two groups. Structured feedback forms were distributed to students after the final session. These forms asked the students to rate to what extent they agreed with the following statements, on a scale of 0 ('not at all'), to 9 ('very much so'): 1. The groups increased my confidence; 2. The groups improved my communication skills; 3. The groups encouraged me to consider the whole patient; 4. The groups encouraged me to reflect; 5. The groups provided me with support; 6. The groups increased my enjoyment of my placement.

Results

Group discussions

The trigger for all case presentations was the recall of a strong emotional reaction in the student. This primarily concerned themselves, a patient and/or family, or staff members. Figure A shows the contexts of these experiences, with box size an indication of the relative frequency within which each context appeared. Subsequent discussions tended to involve common overarching themes.

Contexts

The majority of students' presentations involved discussing emotionally salient encounters with patients. Students' descriptions broadly separated into positive and

negative feelings towards patients, plus general feelings of hopelessness about a situation they had encountered or heard about. The latter tended to revolve around patients for whom years of mental health service input had achieved seemingly little, and often involved discussions about the effects on family members/carers.

Positive feelings about patients within students were often, but not always, described with an emphasis on the student themselves, and often linked to identifying with the patient. Identification was most common with patients of similar age and socioeconomic background, although there were also discussions about patients confounding student expectations and the effect of stigma.

Descriptions of negative feelings towards patients were more common than positive feelings. Most commonly, students felt angry towards the patient. This occasionally appeared to be related to student uncertainty and anxiety around the interview. Students often questioned whether the patient was ill, and expressed frustration that the mental health service was supporting someone possibly undeserving.

Some contexts to student presentations clearly involved both feelings about themselves and patients. A fear that commonly emerged was that of making the patient worse when speaking to them. Students worried about upsetting the patient, and so tended to avoid allowing emotions to enter the dialogue. There reasoning was sometimes for fear of driving the patient to a repeated suicide attempt. In one group, there was the belief, held by around half of the students, that a patient starting to cry meant that the interview was a failure.

Identification with a patient could be both positive and negative; linked to a good rapport and ability to empathise, but also a source of worry about being vulnerable to the same illness, although this could also lead to positive discussions about stigma.

With contexts to powerful affective responses primarily concerning the self, there is an overlap with feelings primarily concerning patients, but I have separated the below contexts on the basis that the emphasis was placed on the self by the presenting student.

There were common anxieties about the role of a medical student within the clinical mental health setting. Students frequently found themselves conflicted over their roles as a professional and as a fellow human being. Individuals described feeling urges, in response to emotions, which went against their ideas of professional behaviour. Examples included wanting to hug the patient, to cry in front of them; stifling laughter at a patient's utterances, and 'judging' a patient's lifestyle.

Another example was student concern that their own mental health may be at risk. This related to a variety of factors, such as a fear of being overwhelmed by unexpected powerful emotions, the triggering of memories of personal or family/friends' mental illness, and the realisation, via identification with a patient, that they could also develop similar difficulties.

Emotionally significant encounters with other staff members were less commonly mentioned. Those that were presented involved negative feelings towards clinicians, rooted in the student finding themselves unsure about the clinician's course of action regarding the patient – including both perceived excessive and insufficient intervention.

Resulting discussions

It was interesting to see that the wide variety of presentations in different groups tended to lead to a narrower range of discussions with common, overarching themes, which were discussed in more depth.

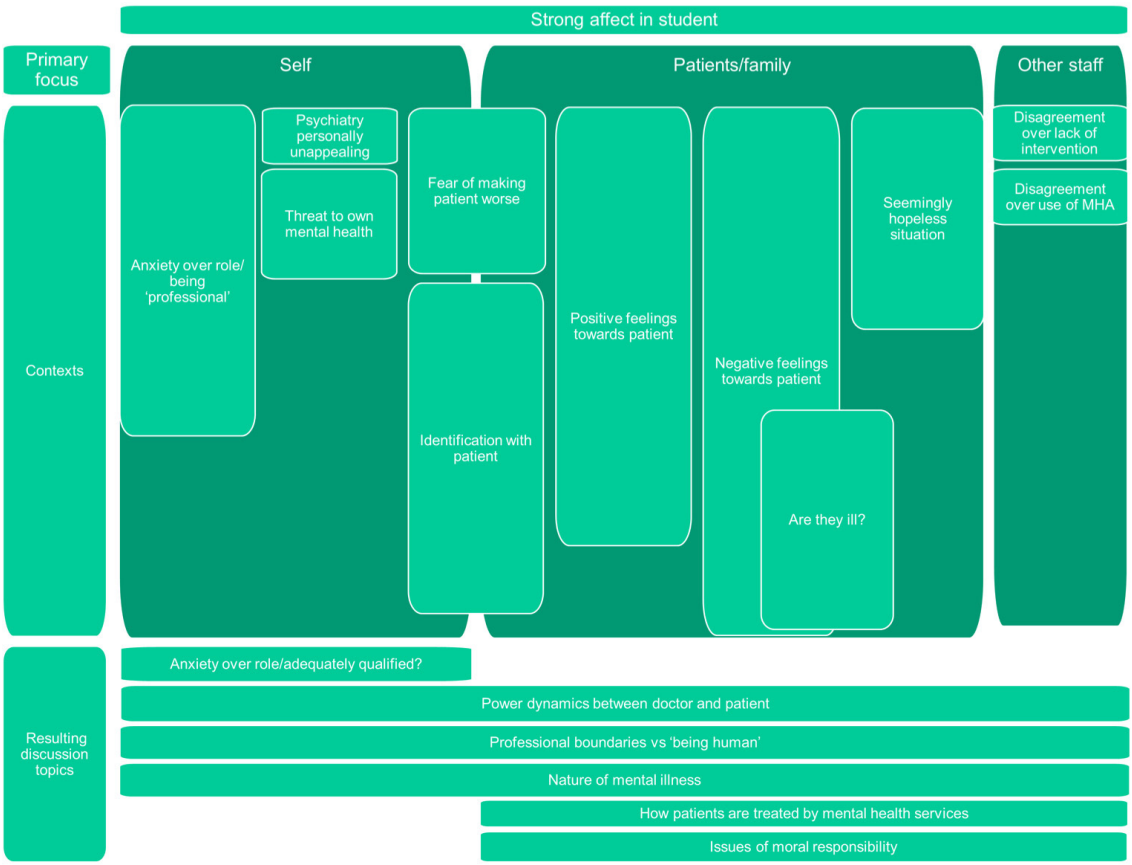
Discussions around medical students' role anxieties tended to follow presentations about feelings concerning the self, for example dilemmas about professional behaviour

and making the patient worse.

Most discussions were relevant to a large number of the presentation contexts, for example, discussions around the conflict between 'being professional' and 'being human', the power dynamics between clinicians and patients and families, and the nature of mental illness. The latter topic was reached through a variety of paths, such as a recognition of the clear influence of psychological and social factors on patients' difficulties, identification with patients and the realisation of universal vulnerability to mental ill-health, and also debates about the boundaries of behaviour inconsistent with societal norms and a diagnosis of a psychiatric condition. The latter point tended to lead the group to go on to think about issues of moral philosophy, and also consider how patients are treated by both society and mental health services – a point also clearly linked to the nature of mental illness.

The in depth discussions are clearly not discrete, and there was a natural flow between the topics.

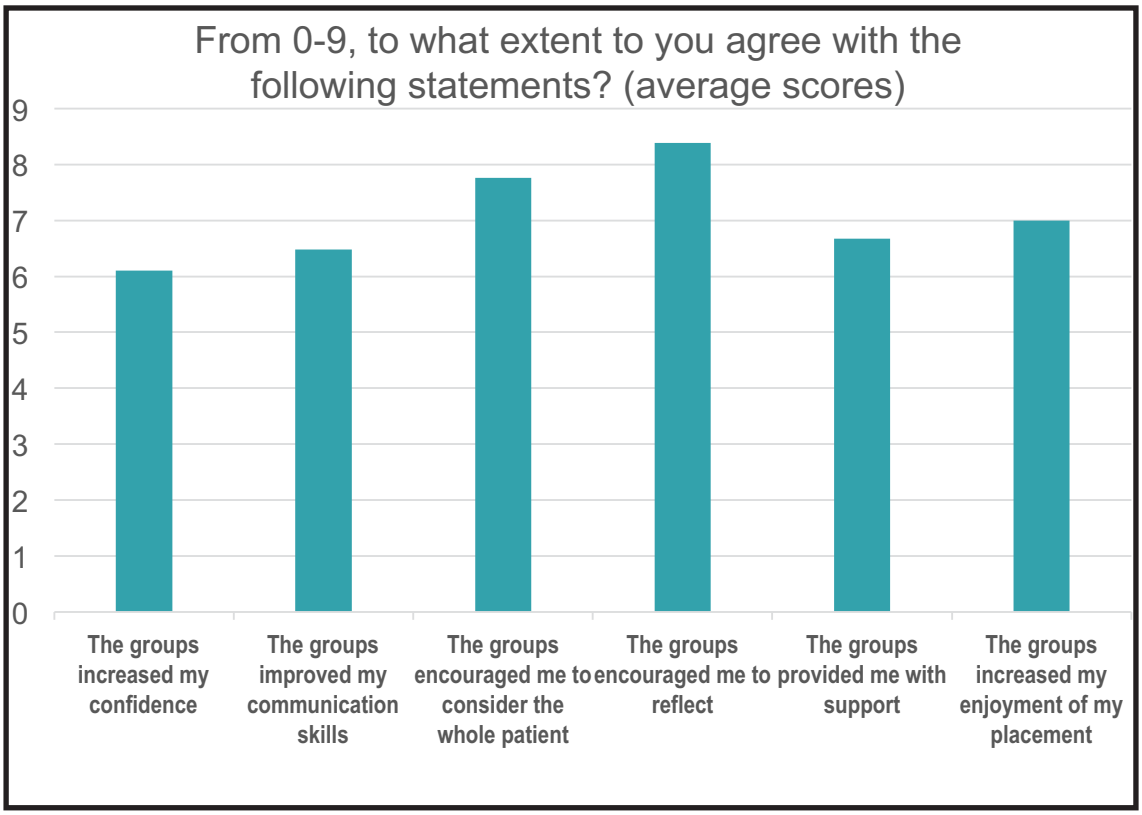
Figure A: Visual representation of Balint group discussion content



Student Feedback

Results were obtained from all 21 students who attended the two surveyed groups (11 in one group, 10 in the other group). The average scores are displayed graphically in Figure B. These results show strong student agreement that the Balint groups led to the defined positive outcomes, with all average scores over 6 out of 9. There was particular agreement with the statements 'The groups encouraged me to consider the whole patient' (7.8), and 'The groups encouraged me to reflect' (8.4).

Figure B: Subjective effects of Balint groups on students



Discussion

Medical students describe significant emotional reactions to experiences during a psychiatry placement. The Balint groups were felt to provide students with support for these experiences, for their professional and personal growth, and their improvement of skills important in psychiatry and other medical specialities.

This study has a number of limitations. In order to fit into the medical school timetable, each cohort was able to attend a maximum of only four groups. In addition, this study involves small numbers of students. An improved study design, perhaps to build on the findings here, would involve recording and transcribing a number of sessions, and carrying out a more rigorous thematic analysis. Despite these limitations, these findings are of interest given there appears to be little other current research on Balint groups for students undertaking a psychiatry placement. As such, they appear to warrant further study.

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What are Balint groups?

Personal reflections of the Balint weekend at Whalley Abbey

Fiona Sweeney BSc Hons

As a recent psychology graduate entering my first full-time job within mental health services, I was apprehensive about the challenges ahead. Reflective practice is something which has always been emphasised throughout my degree, yet I was somewhat bemused when this took a back seat within the NHS service and the crisis team I work within. Crisis work, within its own right is demanding. The team receives numerous referrals, varying in terms of presentations. I believe I have an advantage in only coming into the team recently. However, members of staff who have worked within the NHS and mental health services for some time, I feel become somewhat blunted in affect. I do not believe that this is a reflection of their personality per se. However, I do feel that this can have, and has proven to have detrimental effects upon the emotions and thoughts of the service users that are in the midst of experiencing a crisis.

This being said, within the service that I work for there are limited opportunities for guided reflection, and with the continuous pressures placed upon staff members this is somewhat overlooked. I had never heard of Balint groups through my work place, however was fortunate enough to have a father who is a GP and has been a member of Balint groups for over twenty years.

I attended my first Balint weekend on the 20th of March 2015 at Whalley Abbey. I had my reservations about attending, and was not expecting to obtain much from the weekend. I was apprehensive about being faced with flurries of esteemed professionals, to whom I did not feel adequate to be around, or have the professional knowledge that they have. However, I was immediately made to feel welcome by all who were attending that weekend. For all that attended, I am sure they will agree with me when I say it was a very intense weekend. Both roles within the group, whether one is presenting, or listening, requires deep thought. It was a fantastic opportunity to explore the pertinent parts of the presentation for each member, and to also listen to others' perspectives. I found it refreshing to hear and explore so many alternative ideas, yet each with the identical goal of exploring the doctor-patient relationship. It was also refreshing to take a step back and identify both personal and professional blind spots that continuously influence the work professionals undertake with patients, yet seem somewhat unconscious to ourselves at that time.

The major overarching theme the weekend highlighted to me was exposure. Presenting a case, I found, was extremely exposing. You are expressing emotions that you have not necessarily had a chance to express before to colleagues, and emotions which cause conflict within you as a caring professional. I suppose, this highlights how professionals are largely governed by 'political correctness', and that although this is vital to uphold good standards, it can sometime cause ignorance of the feelings to which professionals face when working with numerous patients. After all, whether a doctor or a patient we are all humans, and at some point the doctor also experiences the role of a patient.

Nonetheless, it resonated with me that the exposure I was personally feeling, is one which patients face when coming into secondary mental health services. Service users through assessments and the support they receive, whether that be in an inpatient setting or community, are exposed. Their history is written down for numerous people to see, they relive painful experiences ultimately for another individual to form some

formulations about, or as many professionals will not admit, to be judged upon. Patients are on the whole expected to expose themselves to professionals they may never have encountered before, and when guarded may be assumed to be 'difficult' or 'hiding something.' By attending the Balint weekend this is something which I am now very much aware of, and I feel has enhanced my skills as a clinician.

Attending this weekend exceeded my expectations. Sometimes reflection often gets lost in the midst of paperwork and ever growing demands, however I came away feeling humbled and refreshed, ready to take a more reflective attitude back into work.

I wanted to end this by saying a huge thank you to the group leaders, and all that attended the weekend at Whalley Abbey. Balint work is now something I will continue, and it is something I will encourage others, regardless of experience, to partake in.

From the Whalley Abbey Weekend.

Book Review:

Sex Versus Survival: The Life and Ideas of Sabina Spielrein Author: Dr Henry Jablonski

John Launer, Duckworth/Overlook, London 2014

To be overshadowed by men who take all the credit – that is a fate that the Russian-Jewish psychoanalyst Sabina Spielrein shared with many other exceptionally talented and capable women. Wilkins´ theft, and Watson and Crick's disregard of Rosalind Franklin's ground-breaking discovery of DNA structure, is one example. Another is the downplaying by Otto Hahn, and the denial by the Swedish Nobel Committee, of research on the nuclear fission process by Lise Meitner (who had taken refuge in Sweden from the Nazis during the war), for which Hahn *alone* was awarded the Prize in 1944 – of all years!

In the case of Spielrein, the image is further obscured and distorted. Stalinism and Nazism destroyed her and her European context, in the East as in the West. Facilitated by these double holocausts, an extensive mythologizing of her deep love of CG Jung has been given free rein, ranging between renditions like DM Thomas' novel "The White Hotel", which has generally been perceived to refer to Jung and Spielrein, and the recently produced film "A Dangerous Method". Various more or less tendentious and peculiar dramatisations and documentaries, dramas and movies have for some decades cemented this “out-of-joint” image of Sabina Spielrein. Even as a story about a passion, the Spielrein-Jung affair has suffered distortions, as the Jungian movement with its sectarian features has had a vested interest to veil what morally and medically/ethically hardly can be described as anything but a gross exploitation by Jung of Spielrein - both emotionally and intellectually.

25 years ago in the basement of the Rousseau Institute in Geneva a box of letters, diaries, scientific texts and essays by Sabina Spielrein was discovered. She had left them behind when she moved to Moscow in 1923, not suspecting that she would never return. Since then, a few Russian and German researchers have made significant further discoveries, as well as the Swedish professor of Slavic languages Magnus Ljunggren, who found traces of Sabina Spielrein in the Stalinist abyss.

John Launer, a London-based GP, family psychotherapist, medical educator and author, has done extensive research on documents in several languages for his biography of Sabina Spielrein, *"Sex Versus Survival: The Life and Ideas of Sabina Spielrein"* (Duckworth/Overlook, London 2014) in his attempt “to set the time right”. The 57 years of Spielrein’s fascinating and impressive life and achievements emerge in his book. Launer is indeed well suited for the task of bringing Sabina Spielrein to life. He has his professional roots in the Tavistock Clinic, an important psychotherapeutic institution where, among other things, the understanding and theorising of the psychology of institutions and organizations and the analysis of the psycho-history of institutions have been developed. He is also very familiar with the history of psychological ideas and general contemporary history, and has a central European family background.

This – one hesitates to use the word *privileged* - position allows him vividly and with great sensitivity to portray the family background of Spielrein, the circumstances of her mental suffering and deterioration, her time as a patient at the Burghölzli (the mental

hospital in Zurich), her medical, psychoanalytical and educational career, and her collaboration with many of the iconic personalities of the early 20th century: Sigmund Freud in Vienna, Bleuler and Jung in Zürich, Karl Abraham and Max Eitingon in Berlin, Piaget and Claparède in Geneva , and Alexander Luria and Lev Vygotsky in Moscow.

Through Launer we get to know Sabina, as the eldest daughter of a very wealthy family where education is central. Her mother Eva, born Lublinskaya, the daughter of a greatly respected and (for his times) wisely broadminded rabbi, is one of the first women to study at a Russian university. Sabina has three brothers, who all make brilliant academic careers, and a much loved sister ten years younger, who dies when Sabina is 16 years old. This personal tragedy accelerated the mental sufferings of an already troubled Sabina - emotional outbursts, severe psychosomatic pains and compulsive symptoms - which did not prevent her from pursuing her studies. Her family tried to find qualified psychiatric care. After a couple of unsatisfactory attempts, Sabina Spielrein at age 19 ended up by being registered as an in-patient at the Burghölzli psychiatric hospital. It was headed by Professor Eugene Bleuler, an important figure in the modernisation of psychiatry. By reading and interpreting the medical records and comparing them with the correspondence and the diary entries, Launer very convincingly provides the reader with the picture of a teenager in crisis, a precocious and an exceptionally versatile and gifted person seeking her place in life. Launer´s re-examination also brings to light the importance of Bleuler. He did not shun from the dramatic expressions of her symptoms and seems to have understood them as expressions of her despair and as a reaction to severe abuse within Spielrein´s family. He took active measures to secure the frame of her treatment at the Burghölzli. The role of C G Jung is given adequate proportions. He examined her on admission, took her story and documented it well. In the following few months they had sporadic conversations - which Jung later claimed had been an analysis.

Spielrein´s speedy recovery is fascinating. In a few months, she transformed from a very dramatic and at times bizarre acting-out patient into a medical student. At the Burghölzli she met with Russian medical students who soon became her fellow students and friends.

Launer portrays and analyzes Sabina's great love for Jung in a clear and empathic way. She sees his weaknesses and severe shortcomings, but her love persists. Launer allows us to follow the lengthy emotional liberation process as it emerges in her diary notes, and her correspondence with Jung and Freud. It is a universal existential situation to be taken very seriously - as relevant today as in those days. Spielrein's psychoanalytic paper on "Destruction as a cause of coming into being" may, among other things, be seen as the result of her inner work to free herself from this strong and unequal bond, which carried an inner significance that she bravely, analytically, and very much alone, had to struggle with in order to come to terms with what had happened. She had sent her "Destruction" paper to Jung, awaiting his comments before publication. He did not respond for half a year and meanwhile used her concepts and thoughts - without specifying the source - in his own more psychotically coloured psychological vision. Indeed, Meitner and Franklin had a fellow sister in Spielrein ...

During the same period, both Freud and Jung tried to make her a pawn in their conflict, while Sabina Spielrein was trying to convince both of them that their psychological ideas and also those of Adler, were complementary on a broader common ground. She also, without success, tried to assert her own view: that sexuality also should be understood in a biological and Darwinian context. These are thoughts that much later and gradually have gained influence among Freudian-oriented psychoanalysts.

Freud refers to Spielrein in his paper on the death instinct and human

destructiveness, written in the wake of the end of WW1. But he is just using the term. It is stripped of its original meaning and he admits that Spielrein´s concept is obscure to him (which seems like a polite way of disqualifying it). In contrast, it seems to me that he borrowed the entire idea about destruction from Spielrein for his essay "Der Untergang des Ödipuskomplexes" (1924), the destruction (Aufhebung rather than Verdrängung) of the Oedipus complex when leaving childhood. It is a contradictory essay in terms of Freud´s own psychological conceptualisation but makes better sense with the ideas of Spielrein in mind.

Spielrein became the first to write a psychoanalytic medical dissertation paper. In 1911 she demonstrated the special nature of language and communication in psychotic patients - half a century ahead of Frieda Fromm-Reichman, RD Laing and D Cooper. This was to be the first of a series of important essays on language and language development. It is generally thought that Hermine Hug-Hellmuth was the first child analyst. Launer claims it was Spielrein. She wrote a number of studies and lectures on child therapy and children's mental development. Anna Freud and Melanie Klein were in the 1920 audience.

Launer usually begins his chapters with a quote from Spielrein's diaries, letters or papers. I find them often breathtaking in their maturity and insight. She comes across as both astutely independent and empathetic - two important characteristics of a true psychoanalyst.

During her two years in Moscow 1923-25 before ending her odyssey in her home town of Rostov-on-Don, she works at the first state psychoanalytic institute, which also houses a children´s home. Launer portrays the increasingly totalitarian and terror/narrow-minded post-revolutionary political conditions, and how these limit Spielrein as a professional. Spielrein emerges as a psychoanalyst and educator of great integrity who did not lend herself to Marxist-Leninist competitive rhetoric. In consequence her views and competence became politically irrelevant in the late 1920s. Nevertheless she dared to challenge an important representative of Soviet pedology – the official psychological and educational method and gospel – for imposing measures and methods on children that were far too directive and manipulative. In the same vein she had criticized Melanie Klein and Hermine Hug-Hellmuth for disrespectfully invading children mentally with their analytic techniques. She publicly defended psychoanalysis as late as 1929 long after it had fallen into disfavour in the Soviet Union. Leading Soviet psychoanalysts had already defected abroad. Her three brothers were to be murdered by Stalin in the 30s.

Spielrein was probably better off in Rostov than in Moscow to escape the same fate. The day Spielrein's family correspondence becomes public, we will have a more complete image of her Soviet period in life, one that Launer treats with sensitivity and insight with the few fragments available.

One such piece was offered by Spielrein´s step-daughter, Nina Snetkova. She recalled a memory from the 30s of a windowless room in the converted stables where Spielrein now lived. In that room there was only one large sofa. This was previously interpreted by a psychoanalyst - evidently lacking any cultural competence - as Spielrein´s wish to create a womb-like environment. Launer draws a different conclusion: in addition to her work in Soviet pedology and psychiatry, Spielrein had the courage to pursue psychoanalysis clandestinely during the Stalin era.

While writing this review I often find myself thinking about Sabina Spielrein in a contemporary and personal context. I think these fantasies reflect her imaginative intelligence, her erudition and her capacity for love as she emerges through her own writings and Launer´s narrative. As a contributor to psychoanalytical thinking she was

genuinely soul-searching and openminded and the way she addressed central issues still have relevance. In her private life, though social conditions were different, any gifted emancipated 21st century woman should easily be able to link her own existential issues to the dilemmas that Spielrein was struggling with. In these respects she is of course not unique among our psychoanalytical predecessors. But far from all – even among those who like Spielrein have made important theoretical contributions – would be looked upon with as few reservations as a professional asset in a contemporary psychoanalytical context.

Henry Jablonski
Psychiatrist, Psychoanalyst in private practice , Balint group leader.
Chairman of the Division of Medical Psychology within The Swedish Society of Medicine and former President of the International Balint Federation

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Some attendees at the Whalley Abbey Weekend Workshop.

Obituary:
Professor Benyamin Maoz

Benyamin Maoz was born 1929 in Kassel in Germany, under the name of Mosbacher. He emigrated to Palestine in 1937 and lived at first in Haifa, with his parents. Two years after the end of the Second World War he went back to Europe to study medicine at the University of Amsterdam and returned to the new state of Israel after marrying his wife Elly. At first he was a family physician on a Kibbutz in the Galilee, thereafter completing his residency and specialisation in Psychiatry at Tel Aviv University and at the Geha Hospital in Petach Tikva. His growing interest in the psychosocial, cultural and anthropological aspects of physical disease led him to being awarded a PhD from the University of Leiden. His research study was related to the perception of menopause among various cultural groups in Israel including a group of women who survived the concentration camps. It was from this joint research project that Aharon Antonovsky developed his innovative concept of Salutogenesis.

In the 1970's Benyamin was appointed head of the outpatient clinic at the Geha Hospital. From 1979-1995 he was the Head of the Department of Psychiatry at the Soroka University Medical Centre in Beersheba from where he acquired a Professorship in the Centre for Health Sciences at the Ben Gurion University of the Negev. During this period Benyamin was also the Director of the Psychotherapy School of the Ben Gurion University. In 2009, he received an Honorary Award from the Israeli Psychiatric Association for his outstanding contribution to the profession.

Throughout his career Benyamin passionately advanced liaison between family practitioners and mental health professionals. He was also one of the pioneer figures in organising Balint groups in Israel, the founder of the Israeli Balint Society and soon became the "father figure" and mentor to many professionals and Family Physicians in Balint activity. In both Israel and abroad he actively led groups and supervised leaders and became a role model and inspiration for generations of family doctors and other health professionals in the leadership of Balint groups.

Benyamin was very well known internationally, where he attended conferences and participated in service training programs for Balint Leaders and for many years served as the Vice President of the International Balint Federation.

Benyamin was a very creative man with a broad perspective, a man steeped in knowledge of various disciplines - medicine, history, philosophy, music, Judaism, anthropology and literature. He was the personification of a liberal humanist with very staunch beliefs about life and justice. He was an inspiration to so many of us: a doctor, a psychotherapist, a teacher and a pioneer in the integration of psychiatry and primary care, and in Balint activity.

We will always remember his gracious smile, his original comments, and his ability to explain complicated concepts in a clear and focussed way. Even on his last day, he still lectured to his doctor, friends visiting him at his bedside, as he struggled with hematological cancer. But for us, he will always be remembered for his loyal and uncompromising friendship.

Benyamin passed away at the age of 84 in August 2014, leaving behind his devoted wife Elly, three daughters and 10 grandchildren.

May his soul rest in peace…

In deep friendship,

Andre Matalon and Stanley Rabin, Israel Balint Society.

President's Report 2015

After 22 years as Secretary and 3 years of being Vice-President, I now find myself President of a quite different Society. It is now a dynamic multi-professional Society, rather than an organisation of GPs, carefully nurturing a rather small Balint movement in the UK. The change has largely come about because of the integration of case-based discussion groups (very often Balint groups) into the core training of psychiatrists, prescribed by the Royal College of Psychiatry. Psychiatrists, psychotherapists and medical psychotherapists are now leading Balint groups all over the British Isles. The Society has become a resource for them to learn about leadership, hone their skills, and often become officially accredited as Balint Group Leaders by our Society. To do this we have increased our weekend meetings, now all including group leadership workshops, and our leadership study days, all over the country. We also formed a formal multi-professional accreditation committee to deal with and advise on applications. All this has led to an increase in our membership, and a great increase in administrative work for the Honorary officers of the Society, particularly the Secretary, Dr Ceri Dornan and the Treasurer, Dr Ann Evans. We have produced a development plan, which you have all been sent by email. In line with this we are reassessing our needs for administrative support and also, just as importantly, how we use the latest IT available to perform administrative tasks. We need to be ready for the future, and for the needs of future officers.

Considering the origins of the Society in General Practice we are not succeeding in drawing in GPs to groups and group leadership in the way we would wish. We are still a long way from embedding Balint groups in the training of GPs, despite efforts to liaise with the RCGP, such as inviting the Chair, Dr Maureen Baker, to speak at our Annual Dinner. Anyone that can help in that dialogue would be most gratefully appreciated. Some new groups have been formed in London, Brighton, Lancashire and the North East but we still are often unable to suggest a local group if someone enquires. Publicising our work in the world of General Practice remains a priority and we will be presenting Balint work at the European Wonca conference in Istanbul in October, and have committed to holding the 2017 International Balint Congress in Oxford (last held in the UK in 1998) from 6th to 10th September.

We will continue to work closely with the RCPsych, in particular, running Balint groups with them at their own conferences, and working with them to promote Balint groups for medical students-a priority under their current president, Sir Simon Wessely.

A final very positive note is the burgeoning of Balint work in the Republic of Ireland. This has been spearheaded by Dr Glenda Mock in Belfast, initiating Balint weekends shared between Northern Ireland and the Republic, and by the enthusiasm of Dr Jane Dammers and Dr Géaroid Fitzgerald. We need to continually try to use the energy we generate at meetings to further the aims of the Society. The impending Metz IBF Congress in September should be a great catalyst for us all.

David Watt 13/6/15

Regional Reports of Balint Activities

The following are reports from around the country of some of the work the Society is involved in, including new developments, Balint groups, leadership training, Balint weekends and links with other organisations. There is also a contact for each region.

If you are involved in a body of Balint work in a region not represented here, and would like to link more closely with the Balint society, then please get in touch.

Scotland

Balint leader training

Dr Esti Rimmer co-ordinated our first Balint Leaders training day in Scotland in May 2015 on behalf of the Balint Society Leadership group. We are very grateful to Dr Emma Lewington and the Department of Psychotherapy at the Royal Edinburgh Hospital who hosted and supported the day which was attended by more than twenty people. There was an interesting mix of psychiatrists, psychotherapists, clinical psychologists, group analysts, a retired GP and two church Ministers. People came from all over Scotland as well as from the North East of England and Cumbria. There was a sense of wanting to develop Balint work and to join together. The day was facilitated by Esti Rimmer, Gearoid Fitzgerald, Jane Dammers and Sharon Warden.

Esti, who is also the Chair of The Scottish Association of Psychoanalytic Psychotherapy, will be the link person for anyone who would like more information about Balint Leadership training in Scotland.

Dr Esti Rimmer Clinical psychologist and psychotherapist
st_rimmer@yahoo.co.uk

North East of England – Leeds and Newcastle upon Tyne

Balint groups

In Leeds, Bradford and South West Yorkshire - Wakefield, Halifax and Huddersfield, there are Balint groups for foundation year doctors, core trainees in psychiatry and general practice, and for specialist registrars, all within the NHS. As yet there are no groups running for qualified GPs. In Newcastle we continue to run four Balint groups, two for GPs and two that are mixed with GPs, counsellors, psychiatrists and others. We are looking to start a new group with 'first five' newly qualified GPs. Lucy Buckley, who co-leads a Balint group for psychiatry trainees with Richard Duggins, has been asked to start a group for Foundation doctors during a four month psychiatry rotation. Balint groups continue for all trainees in Clinical Psychology.

In both regions the groups are run by accredited Balint leaders. We are always keen to develop new leaders with opportunities for them to co-lead alongside experienced leaders and have supervision.

Leadership training and supervision
We ran another leadership training day in Newcastle when we tried out an observed supervision with the leaders, after they had run a Balint group. This was interesting as it gave very different insights into the leaders' thoughts and feelings about the group than we get when we simply 'debrief' after a group at a leaders workshop. At the same time it is quite exposing for the leaders. We are interested in developing ideas relating to supervision and tried this out again at the London training day and the Sligo weekend. The day was facilitated by Gearoid Fitzgerald, Jane Dammers and Christina Blackwell.

There are Balint leaders supervision groups in Newcastle and Leeds which meet every 2 – 3 months, the dates are on the society website.

Balint weekends
We had a very successful weekend in Newcastle in June 2014 linked with the international IBF. The next NE weekends will be at Weetwood Hall, Leeds November 11 – 13th 2015 and then in Newcastle in June 2016.

We again ran two days for GP trainers and educators at their annual conference to give them some experience of Balint and introduce them to the Balint framework. We have not yet been successful in re-introducing consistent Balint work to the Northumberland vocational training scheme, nor in the medical school.

Dr Gearoid Fitzgerald Consultant Psychiatrist and Psychoanalyst
gearoid.fitzgerald@nhs.net Leeds
Dr Jane Dammers GP jane.dammers@ncl.ac.uk Newcastle upon Tyne

North West England

New developments
There is a growing network of people interested in Balint work in the North West of England, which began with a group of leaders getting together to discuss their groups. Clinicians came from Liverpool, Wirral, North Wales, Cumbria, Lancashire, West Yorkshire, Derbyshire and Manchester. There is representation from Psychiatry, Psychotherapy, Psychology and General Practice. A second meeting introduced more new people and as a result there will be a Leadership Training Meeting in Liverpool, arranged with Dr Simon Graham, Consultant Medical Psychotherapist there, for a group of his colleagues. There is also a wish to continue a peer supervision group for the wider area, probably meeting three times per year.

Balint work is not part of GP training in many North West schemes. Liverpool has some. Simon Henshall, a GP member of a Balint group for several years, now training towards Leadership Accreditation, has become a GP Educator in the Salford and Trafford training scheme. He is gradually bringing Balint work to the ST2 and ST3 doctors, which is a welcome development. With Ceri Dornan, he co-leads a Balint group for some First 5 GPs in Tameside. The group is small but enthusiastic, so we hope to continue in the autumn. Links with medical schools continue in Lancaster and we hope that the RCPsych initiative to promote Psychotherapy Schemes, including Balint work, will start to grow across the region.

Whalley Abbey Weekend 2015
This year in March, we had a larger number of people descending on the conference centre at Whalley Abbey, which allowed us to run two leadership groups, and one 'normal' Balint case discussion group. We had a great diversity of people attending, including two medical students from Keele, a mental health support worker, and a psychoanalyst, as well as GPs, psychiatrists, psychotherapists and clinical psychologists. People came from all over England and Wales, as well as from Sweden and even New Zealand. Each day we enjoyed a communal experience of some kind, including a fishbowl on the Saturday, but the bulk of our time was spent in our small groups, which created enough of a sense of safety to allow genuine interaction, and more challenging interpretations and responses to develop. Everyone said that they appreciated the weekend, which afforded time for reflection, and exploration of the patient/practitioner relationship. As always, the peaceful, comfortable and contemplative environs of Whalley Abbey proved conducive to the Balint process, and all approved of the proposal to hold the North West weekend workshop there again, on March 11-13th 2016 and March 30th to April 1st in 2017.

Drs Ceri Dornan ceri.dornan@gmail.com ,
Caroline Palmer and Sally Wraight GPs

North Wales

Balint Groups
The 'NEW' Balint group has now been running for over a year, co-led by Linda Mary Edwards, Group Analyst, and myself. We meet monthly and initially we had three GPs and a Psychiatrist attending, but two group members decided not to continue, and we now have a new group member who is a Clinical Psychologist. Although the group is small, the quality of the Balint work is high and group members have reported that they wish the group to continue. We are planning to advertise the group across the border in Cheshire and Shropshire and also within other professional networks in the locality with the aim of attracting new members.

Linda Mary and I also co-lead a termly Balint group for the Dyffryn Clwyd VTS and this is going from strength to strength. At our last meeting we had a group of ten, which is very encouraging.

Dr Ann Evans GP evansann@live.co.uk

Midlands

New Balint groups
The past year has seen some new green shoots emerging in new Balint groups. Following our study day in April 2014 a group has started in Central Birmingham, attended by GPs. It is led by Dr Sylvia Chudley, an experienced (ex) GP Course Organiser and NLP trainer, who has Balint experience and is thinking about accreditation. Attendees are GPs. Another group has started in Burton on Trent/ Derby facilitated by Dr Bitty Muller an accredited leader who co-leads with a family therapist, Professor Chris Ward. The initial target group is recent GP trainees and local young practitioners. A third group has been established in Telford, lead by Dr Shake Seigel with co-leadership from Tammy Rathoff

and Diana Webb. The membership are GPs, Psychiatrists and Psychotherapists.

Leadership
A second study day to pursue leadership interest is intended for some time in 2015 -date to be confirmed.

Dr Shake Seigel GP shake.seigel@btinternet.com

London and South East

London continues to have much stable, long established Balint work and some new shoots are arriving we hope.

Events
In September the Oxford weekend was the largest, without the Icelandic GP trainees, for many years, with seventy two people attending spread between the GP, psychiatry and psychotherapy professions. The Annual Dinner and London Leadership Study day in February at the Medical Society of London, was well attended. We ran three groups - one for newer leaders, one leadership training group, and one peer leadership supervision group. Dr Maureen Baker, Chair of the Council of the RCGP, spoke at the dinner about what a difficult place general practice is in at the moment - hoping, perhaps naively, that things could only get better! Any commitment to Balint work from the College was unfortunately not in evidence. Reaching out to other bodies, Dr Gearoid Fitzgerald gave a talk to the Applied Section meeting of the British Psychoanalytical Society in February on the usefulness of Balint groups in and of themselves, as an experience of using psychoanalytic concepts without theoretical overload. The Society will also participate with the RCPsych in running Balint groups at their International Congress in Birmingham at the end of June. This is the brainchild of Dr James Johnston and the sessions 'Balint - From Cradle to Grave' will consist of groups for juniors, intermediates and consultants. This is a welcome collaboration between our two organisations and potentially a strengthening of future collegiality.

Training
Helen Sheldon and I ran a London Leadership Study day, a new event, in June at the Swiss Cottage hotel. There were seven psychiatrists and a clinical psychologist. In addition to having the space to think about and discuss the challenges and rewards of developing and leading Balint groups for doctors in training, we held two Balint group sessions which provided an opportunity for four of the study day participants to lead in pairs. The distinctions between a more freestyle and a structured model were vividly demonstrated during the day and gave rise to a lively discussion about the impact of different types of leadership on the group process. We concluded the day with an interesting discussion about the tensions which arise in a psychiatry training setting between promoting a space for open reflection, evaluation of trainees' competencies and how to manage adherence to the principle of confidentiality when concerns about safeguarding arise.

In March, Mary Burd and I concluded our work with Dr Suni Perera and her team in Brent and Harrow. They have produced a Toolkit called 'Developing people for health and healthcare - The Brent and Harrow CEPN Narratives in Care home education'

demonstrating a way of providing continuing education and support for care workers in residential homes. The programme is underpinned by Balint group work with the carers, led by junior leaders who are supported with ongoing training and supervision. We hope to hear more of this in the future.

Balint groups and Leaders workshop

Balint groups continue in London in Wembley, led by John Salinsky and Tessa Dresser, and in South east London, led by Paul Julian and Eamonn Mitchell. I have just started an ordinary GP group in East London co- leading with Joan Fogel. Andrew Elder runs at least three groups, including a group for the Physicians Health Partnership, and a group of private GPs in central London. There is also a group in Brighton, run by Anne Tyndale and Fiona Barnard. In addition there are many longstanding VTS Balint groups in London and student Balint groups at UCH, and we believe some new student groups at Kings College.

The Tavistock Balint Group Leaders Workshop continues to meet three times a year - the dates are published in the journal and on the website. If you are would like to be on the mailing list please contact me.

On 30th June, the Brent and Harrow Care Home CEPN project was awarded 1st place in the HENWL awards for 'Innovation in inter-professional learning in Primary Care/Community Care' and runner up in the category "Most innovative approach to teaching and learning - Excellence in Education & Training". The legacy of this for the project is: -

Skills for Care has chosen to highlight the work as a case study (see attached) and their July newsletter will be sent out nationally to over 10,000 social care and education leads introducing them to the project toolkit on the Skills for Care Website.

The toolkit http://nwl.hee.nhs.uk/files/2015/06/BH-Care-Home-Toolkit-WEB_12a.pdf is a free resource available to support others developing their own inter - professional care home education programmes. We do hope HEE, CCGS and partner organisations will be encouraged to support multi-professional care home education, ideally making it part of their mainstream training activity.

In July there is a launch event for managers and social care development and education leads in NWL.

Bids by other organisations (ALIGN and the Brent and Harrow EOL Education Project) have been submitted to HENWL for resources take forward components of the work done so far and deliver training to care home staff.

It is hoped to maintain a care home managers Balint group for this year and two Balint groups will continue for inter professional learning at St Luke's Hospice.

Dr David Watt david.watt7@nhs.net

Bristol

Department of Medical Education, Avon and Wiltshire Mental Health Partnership NHS Trust

Balint provision for GP trainees, Foundation doctors and Psychiatry Core trainees

There are numerous Balint groups that run across Avon and Wiltshire Mental Health Partnership Trust. Dr Thanos Tsapas, Consultant Psychiatrist in Psychotherapy, the Trust-wide Psychotherapy tutor, has led an initiative to map Balint group provision across the Trust, compiling a comprehensive summary document as a basis for further development and progress.

There are seven Balint groups for trainees - in Salisbury, Swindon, Bath, Weston and Bristol. Groups run either weekly or fortnightly and are led by a variety of clinicians including Medical Psychotherapists, Consultant Psychiatrists, Clinical Psychologists, Speciality doctors, and Psychiatry Advanced trainees. All core trainees in psychiatry in the Trust are expected to participate in a group in accordance with the School of Psychiatry's Strategy for Psychotherapy training, based on the Royal College of Psychiatrists' guidance. Core trainees are also expected to complete Work Place Based Assessments with their group leaders in order to reflect on their experience and learning over a period of time. GP trainees and Foundation doctors are invited to participate and do so at some sites in Bristol and Weston. The groups tend to be of mixed membership with some long term participants and others who stay for shorter periods of time. Dr Tsapas is working with Balint group leaders and postgraduate tutors at some of the sites to ensure that obstacles to attendance are removed and that Balint groups continue to be available to trainees in the long term.

Psychiatry Trainee-led Balint group scheme for Medical Students

This scheme was started in 2012 by Dr Ami Kothari and Dr Judy Malone, supported by Dr John Potokar, Undergraduate Lead for Psychiatry, University of Bristol.

Over the last 3 years the scheme has expanded from offering groups to students on Psychiatry rotation to students in Medicine and Surgery. In the current academic year, Balint groups were offered to all 246 medical students in their first clinical year for the first time. Twelve Psychiatry trainees, from CT1-ST6 grade, led sixteen groups which repeated twice over the year. Trainees had access to regular supervision with Dr Judy Malone, psychoanalytic psychotherapist. The scheme gives psychiatry trainees the opportunity to develop their group leadership skills, enhancing their overall training experience.

A steering group has been set up to guide the project which is housed in the Medical Education Department. We are grateful for the support of Dr Steve Arnott, Director of Medical Education and for support from the Balint Society. The School of Psychiatry, Severn Deanery, endorses the scheme and supports trainee involvement. We are developing good relationships with the University and the undergraduate academies. Trainees have taken posters to conferences winning prizes on five occasions. Drs Ami Kothari, Judy Malone, Laura Bennet, Eva Stigaard-Laird and Ross Spackman have a paper accepted for presentation at the IBF International Congress in Metz this year.

Future Developments

After a competitive interview process, the scheme was awarded funding from Health

Education England. Planned developments include delivering Balint groups for Foundation doctors in the acute setting; a pilot is currently underway. We will continue to develop Balint leadership training in our region with a training programme for Psychiatry trainees, and a Balint Leadership training day, planned for December 2015 in conjunction with the Balint Society.

Other Balint activity in Bristol – GP Balint groups

Judy Malone continues to lead a longstanding Balint group for more experienced GPs in Bristol and has been co-leading a new group over the last year with Ami Kothari for GPs at the end of their training or less than 10 years qualified.

Dr Ami Kothari Clinical Teaching Fellow & AWP Trainee Lead for Balint Groups, ami.kothari@nhs.net

Dr Judy Malone Psychoanalytic Psychotherapist and Psychotherapy tutor, AWP NHS Trust jude_malone@orange.net

Dr Thanos Tsapas Consultant Psychiatrist in Psychotherapy & Psychotherapy Tutor AWP NHS Trust

Dr Steve Arnott Director of Medical Education, AWP NHS Trust

Ireland

Balint in Belfast 2014

The second Belfast Balint weekend was held in November 2014 at the Holiday Inn, Belfast. Once again it was organised by Glenda Mock, Marie King and Christine Christie. There were fifty two delegates attending from different professions: General Practice, Psychiatry, Psychotherapy, Nursing, Psychology, Palliative Care and Oncology. People had come from all over Great Britain, Ireland and even Iceland!

The Balint Society UK President Dr David Watt opened the meeting with a thought-provoking look at the background to this work. Throughout the weekend delegates participated in four 90 minute sessions in either a Leaders workshop or a Balint group. Interest in the Leaders workshop was sufficient to run two separate groups. Additionally all delegates experienced a 90 minute fishbowl, either through observation or active participation.

Once again, Belfast exceeded expectations weather wise: it was bright and sunny! Dinner on Saturday night was held in the Robinson and Cleaver restaurant, and overlooked the City Hall. Unexpectedly, our meal coincided with the Christmas tree lights switch on at the City Hall. This was a delightful bonus. Following the meal, some delegates set off on an intrepid exploration of the local night life. As always, the leaders and the delegates made the whole experience enjoyable and instructive. We are looking forward to welcoming old friends and new to Belfast in November 2016.

Dr Glenda Mock GP glenda.mock@doctors.org.uk

Sligo 2015

Clive Garland and Patsy Brady co-ordinated the second very successful Balint weekend in Sligo in June 2015. Fifty-five participants attended from a diverse range of disciplines and engaged in the usual ordinary, and leader training workshops through the weekend. There was a really positive attitude to the work which was helped by having asked all participants to bring their own favourite poem with them, a number of which were read

out over the weekend. Two other features were also notable — a workshop to examine the factors which are at the essence of Balint Groups, what gets in the way of their succeeding and how to promote this type of thinking with a wider audience. This was also interesting in the light of the Quality Improvement Division of the Irish Health Executive sending a representative to get a first hand experience of the Balint way of working. It was fitting that poetry and the arts played a part in the weekend. It is W.B. Yeats 150th birthday this year and, as mentioned above, most participants brought poetry to the event. We also arranged to have Niall Henry, of the locally based Blue Raincoat Theatre Group, address the large group and he gave a fantastic talk on aspects of innovation, sensing, creativity and magic which drew parallels between that art form and Balint.

The weather was not brilliant but some of us enjoyed walks to Rosses Point, up Knocknarea and Ben Bulben and across the causeway at low tide to Coney Island. A good time was had in the town, with local music and singing, after a lovely dinner in the hotel on Saturday night.

Developments

The Balint method continues to gain slow and steady purchase in the country. GPs are setting up groups around the country. The GP training schemes are beginning to adapt the model and provide groups in some schemes. There are plans afoot to bring pressure to bear to get all involved in the activity! Patsy and Clive are in liaison with the Department of Health and are assisting in looking at a proposal to set up some pilot multi disciplinary groups in general hospitals nationwide. If the pilots are successful this method will be rolled out nationally, so watch this space!

The Irish College of Psychiatrists decided that all junior doctors should have a year long Balint group with no assessment built in. They have made huge efforts to offer consultants an opportunity to train in the Balint method; Dr Gearoid Fitzgerald, member of the Balint Society council, is involved in delivering this training. This is continuing in Autumn 2015 and it is hoped that some will some become accredited leaders in the coming 18 months. There has been continued support at the highest levels of the College. We hope this very important support for Balint groups will link in with other developments in Ireland as they are the first College of Psychiatry to give the Balint method such official support.

A discussion was held at the meeting and a group has been formed to examine a way forward for setting up an association/society or an affiliate of Balint UK. So, there is a lot going on!

Patsy Brady Psychotherapist and Assistant Programme Director with the Sligo GP training scheme padraigob@me.com
Clive Garland Psychotherapist & Group Analyst clivegarland@icloud.com
Dr Gearoid Fitzgerald Consultant Psychiatrist and Psychoanalyst gearoid.fitzgerald@nhs.net

The Balint Society Essay Prize 2016

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 2016 and sent to: Ceri Dornan,
10 Raynham Avenue,
Manchester,
M20 6BW.

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.

All contributors should be mindful of confidentiality when writing about patients, please contact the Journal Editor for guidance when submitting your article.