

# JOURNAL OF THE BALINT SOCIETY

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Editor:  
Tom McAnea

**Cover image:** *Francisco Jose de Goya y Lucientes, Spanish, 1746–1828*  
*Self-Portrait with Dr. Arrieta, 1820*  
*Oil on canvas*  
*45 1/8 x 30 1/8 in. (114.62 x 76.52 cm) (canvas)*  
*Minneapolis Institute of Art, The Ethel Morrison Van Derlip Fund 52.14*  
*Photo: Minneapolis Institute of Art*



**Delegates at the “Balint Movement and Emotional Burnout Conference” in Yerevan, the capital of Armenia.**

## **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.

# Calendar of events 2016-2017

Information about events, contact names and the application process can be found on the website: <http://balint.co.uk/category/events/>

## Balint Weekends

9th - 11th September 2016: Oxford

18th-20th November 2016: Belfast

31st March -2nd April 2017: Whalley, Lancs

2017 Summer and late Autumn: weekends are being planned. Dates and locations to be decided.

**NB:** the normal 2017 Oxford weekend will be replaced by the International Balint Federation Congress, which is being hosted by our Society at Keble College, Oxford, 6th-10th September 2017. See the President's Report in this Journal for an introduction.

## One day events

14th October 2016: Leadership Study Day, Friends Meeting House, Manchester.

2nd December 2016: Leadership Study Day, Bristol.

3rd December 2016 (am), Bristol: Talk by Gearoid Fitzgerald: The use of the group leader's countertransference in Balint groups.

## Annual Dinner

The next Annual dinner and Study day will be on Friday 10th February 2017 at the Medical Society of London.

## Balint Memorial Lecture (every two years)

The next lecture will be on Friday 28th April 2017, delivered by Dr Pat Tate.

(Podcasts of the 2013 and 2015 lectures are available on the website: <http://balint.co.uk/our-podcasts>)

## Group leaders' peer supervision groups

These are open to anyone running a Balint group and offer an opportunity to discuss your group and related matters. To add your name to the circulation list for a regional group or for more details, contact the organiser indicated below.

Meetings take place three or four times a year.

Dates are posted on the website: <http://balint.co.uk/category/events/>

**London:** Contact David Watt ([david.watt7@nhs.net](mailto:david.watt7@nhs.net))

Meets at the Tavistock Clinic, 120 Belsize Lane, London NW3 5BA. All meetings begin at 8pm, usually a Thursday.

**Newcastle upon Tyne:** Contact Jane Dammers ([jane.dammers@newcastle.ac.uk](mailto:jane.dammers@newcastle.ac.uk))

Meetings are held from 4pm to 6pm on a Wednesday at Benfield House, Walkergate Park, Benfield Road, Newcastle NE6 4QD Tel: 0191 287 6130.

**North West:** Contact Ceri Dornan ([ceri.dornan@gmail.com](mailto:ceri.dornan@gmail.com))

Meetings are held in Manchester on a Saturday morning.

### **International meetings**

Our Society is a member of the International Balint Federation (IBF) and our members are welcome to apply to attend international meetings. It is something well worth considering, to experience the similarities and differences within the Balint family. Events can be found on the IBF website:

**[www.balintinternational.com](http://www.balintinternational.com)**

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### **The Balint Society Website: [www.balint.co.uk](http://www.balint.co.uk)**

We would encourage you to use our website as the first port of call for information about the Society and our events. We are continually adding information and resources. Suggestions for pages, content and comments on usability are welcome.

The website is being modified to allow application for events and membership to be done online. For those familiar with WordPress, we now have a large Plug-in called CiviCRM, which will, we hope, keep all our data together and allow us to be more efficient in keeping information up to date and using it more effectively for your benefit. We have expert help, but are also interested in input from members with enthusiasm for websites and WordPress, so do let us know if you would like to be involved ([contact@balint.co.uk](mailto:contact@balint.co.uk)).

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### **The Balint Society Essay Prize**

The Council of the Balint Society awards a prize of £500 each year for the best essay on the Balint Group and the clinician-patient relationship. Entry is open to all except for members of the Balint Society Council. The judges are members of the Balint Society Council and their decision is final. Entries will be considered for publication in the Journal of the Balint Society. The prizewinner will be announced at the Annual General Meeting. Essays should be based on the writer's personal experience and should not have been published previously. Length of essay is not critical. 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.

Options for submission:

- By post: 3 copies are required signed with a nom de plume and accompanied by a sealed envelope containing the writer's identity and contact details. Please type on one side of A4 paper using size 12 font and double spacing.
- By email: entries will be printed and anonymised before going to the judges. Please type using size 12 font and double spacing.

Entries must be received by 1st May 2017 and sent to:

Helen Lycett, Balint Society Administrator, 22 Kingsmead Road, London SW2 3JD or [h.lycett@icloud.com](mailto:h.lycett@icloud.com)

### **Guidance for contributors**

Please see <http://balint.co.uk/journal-of-the-balint-society/> for details of our confidentiality statement.

# Editorial

In the Mike Leigh film 'Secrets and Lies' there is a memorable and emotionally powerful scene where the character played by Timothy Spall, pleads with his wife and sister, "We're all in pain! Why can't we share our pain?" The scene is so memorable not just because of the wonderful performances, but because it conveys a universal and collective truth. We are all in pain, at least at some points in our lives. My patients frequently bring me their pain; whether it be the physical, emotional or existential. They want to share their pain.

I do what any good doctor should do-I try to listen, understand, empathise, even diagnose and suggest some means of relieving their pain. Yet, often this fails, it doesn't alleviate their suffering, and they return again, to continue to share their pain. What impact does this have on me, as their doctor?

Francisco de Goya depicts a memorable bout of illness in his painting, 'Self-portrait with Doctor Arrieta'. He is clearly suffering, probably in pain. What strikes me most about the painting is the physical intimacy between the doctor and his patient. Dr Arrieta holds Goya close as he administers his tonic, or draught, or perhaps pain-relief. Although, I often perform a brief physical examination on my patients, I rarely hold them close like this. Perhaps when visiting elderly or palliative patients at home I may hold them up in bed, or help them to sit up. Goya painted this work one year after his near-fatal illness, in honour of his physician who saved his life. This work was in contrast to his previous depictions of doctors which tended to portray them as incompetent charlatans. Art historians have commented that the relative intimacy of doctor and patient illustrates great empathy, as well as the physician and scientist being in the light as opposed to the three figures in the dark background - an allusion to the emerging Age of Enlightenment. However, as a doctor, what strikes me is the idea of boundaries. How are we affected by our patients, and how do we affect them? How close do we become, both literally and metaphorically?

This year's Journal includes three contributions from medical students in Australia and New Zealand. Each are winners of an essay competition held by the Balint Society in those two countries. I am struck how they capture vividly the emotional tension that can arise when we become 'close' to our patients. It seems remarkable to me at such an early stage in their careers, they can show (and share) deep insight into this important dynamic. The winner of the UK Balint Society essay prize describes similar insights in what is a mature and thoughtful account of their experience of being in a Balint group.

The theme continues in one of two research papers published this year. Jonathan Olds and Judy Malone describe their study which examines clinical medical students experience of a trial Balint group. Their conclusions are encouraging in that the students involved found Balint work satisfying and reiterate the importance of the doctor-patient relationship in becoming 'better doctors'. Muiris O'Sullivan, a GP trainee in Ireland, offers a similar analysis of her and colleagues' experiences of Balint work during their training.

The international reach of Balint work is reflected in Henry Jablonski's account of observing Balint groups in Annency, France. This theme continues in two accounts from Hungary and Armenia, by Ceri Dornan and David Watt. Each relates two common themes for me-the richness of the experience of sharing Balint work with colleagues across the world, and the universal themes which seem to transcend both culture and language. As another example of where boundaries become blurred, it gives me hope. I am not alone.

There is ample evidence in this year's Journal, yet again, that Balint work continues to thrive across the UK and Ireland, as well as across the world. Of course, we cannot know of all the work that goes on so please do get in touch and let us know. The website

is well established and contains lots of information about events and activities, as well as archive material from previous Journals. We are interested in hearing about your thoughts and ideas on anything related to Balint work. We are keen to share these with our interested readers, especially in anticipation of the UK hosting the conference of the International Balint Federation in 2017 when we will welcome colleagues from Balint communities across the world. A time to share our experiences, and understanding - I look forward to it.

**Tom McAnea**  
**Editor**  
**tomcmc@doctors.org.uk**

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# Should I be saying something now? Private thoughts of a Balint group leader

John Salinsky

I am sitting in a comfortable chair, one of a circle of chairs in which the others are occupied by eight congenial colleagues. They are all deeply engaged in a case discussion. But I am not saying anything. This is a Balint group and I am the leader or, if you prefer, the facilitator. My main function is to sit here, a quiet but powerful presence, radiating calm and reassurance; letting everyone know that this is a safe place where you can say anything you like and be listened to. You may admit to anything, even your stupidity, without confidentiality being breached or trust betrayed. I am the leader. This is what I do. But surely I should also speak from time to time? The group may need some guidance, some facilitation. From what I hear, they need it now because an alarm bell is ringing in my head. The intention of the Balint group is to focus on the doctor-patient relationship. We are all agreed about that. And yet, that is not what my group are doing now. They are not talking about the doctor-patient relationship. You may find that it happens in your group too. I would venture to say that most groups spend quite a lot of time this way.

So what do we talk about when we are *not* talking about the doctor-patient relationship? Well, for a start, we spend time discussing medical matters: clarifying the history, speculating about the clinical diagnosis and so on. What were those symptoms again? Have all the proper tests been done? (Yes, they have.) We need to do a certain amount of this. It's part of our training and our dread of uncertainty. Then we get on to treatment. Have you tried this treatment? Someone will say. Or that? What about physiotherapy? Well, I often find it helps.

Sometimes the presenter is actively seeking advice. And there is always someone in the group with an ace consultant to recommend. If the patient's life is devastated by fibromyalgia, someone will say, do you know Dr Ben Cartilage? He specialises in 'Medically Unexplained Rheumatology'. He's so brilliant. He will know what to do. I'll give you his email. Other people are making a note of the email too; while I squirm uncomfortably in my seat, wondering how to put a stop to this Cartilage-worship without being a wet blanket.

Another thing we do in groups is spend time agreeing about the patient's disgraceful behaviour and sympathising with the presenter's plight. This patient, it seems, just does not know how to conduct himself in a family doctor's surgery. Perhaps, we say, he or she should be firmly shown the door. Because he is clearly a liar, a scrounger, an opiate seeker, a drunk, a violator of boundaries. She won't listen to advice and she is so rude! He is too friendly, if you ask me. He is a racist and he doesn't wash. She obviously has a personality disorder of the worst kind. We should not have to put up with this sort of thing. We are not trained for it. Besides, he makes appointments and doesn't keep them. And when he does come, it's impossible to get rid of him.

## **The parallel process**

While all this sort of thing is going on, as the leader, I sometimes seem to be just sitting and listening. Obviously my calmness is helping everyone to feel secure. But shouldn't I be saying something to get them back on track? One of our legendary old-time Balint leaders (I think it might have been Tom Main) told us that all that a group leader needs to say is: What about the doctor-patient relationship? But to say it in as many different ways as possible.

We know that even if we don't allude to it in any way, that relationship is always there in 'the parallel process.' You only have to watch and you can see the drama between the two protagonists being played out between the presenter and the group. But, as a group leader, should I mention this mysterious phenomenon? And if I do, will the others want to take it up or even know what I am talking about? Supposing my intervention sinks like a stone and I don't have a co-leader to rescue it, perhaps phrase it better? Maybe I should I explain the parallel process to them. But that would be teaching, a leader-behaviour born of desperation, as we all agree. Perhaps it would be better to follow another piece of Balint wisdom and simply 'trust the group'. I don't know. You may be able to trust your group but I am not sure about mine.

### **Could Michael Balint help?**

What would Michael Balint have done? We don't get much idea of what sort of group leader he was from *The Doctor, his Patient and the Illness*. But there are still a few people around who were in those early groups with him, and by all accounts it could be an unsettling experience. Everyone agrees that he was a very good listener to a presentation but after that the discussion could be more of 'a rough and tumble' as his colleague Robert Gosling has described it.<sup>1</sup> Michael didn't go in for making people feel safe and secure. But then he said it didn't matter because, to be a GP you had to be 'as tough as old boots'. According to Michael Courtenay, who was in the *Six Minutes for the Patient* group in the 1960s, Michael B could be very directive in telling the presenter what to do next and would even include mini-lectures on points of theory from time to time.<sup>2</sup>

So I can't expect much help from him, even if here were suddenly to return to earth. Because we just don't do that sort of thing now. In fact, the Council of the Balint Society would probably say, we're sorry, Dr Balint, but if you want to start leading groups again you will have to attend a few Balint Weekends and go through the accreditation process like everyone else. (However, I must add that in his later years when he finally agreed to have student groups, he was much more gentle.)<sup>3</sup>

### **Enid Balint as group leader**

So what about Enid Balint? What would she have done to get my group back on track? Michael Courtenay also mentions in his 2004 interview with me that when the couple were leading the group together, and Michael was being a bit too abrasive, Enid would intervene 'to protect the chicks.'<sup>2</sup> I was in two groups led by Enid and got to know her quite well. She was generally calm and made us feel secure and my impression was that she was always attentive and frequently helpful. She was certainly not afraid of intervening but I find it impossible to remember the details of what she said. I do remember her saying that when she was with a group of trainee doctors she always found herself talking more. However, in addition to my inadequate memories I also have in my possession a CD of Enid leading a demonstration group in 1988. Despite being recorded on a public occasion the discussion is so intimate that I felt I was there and even laughed along with the group members a few times. So what sort of things does she say?

To my surprise I found that her style was quite different from ours today. Her voice is quiet, sometimes murmuring, as if reflecting to herself. She contributes freely and seems more like an experienced group member than a leader. Often she seems to be talking directly to the presenter, telling him what she thinks has happened to him. Then she will review the patient's narrative, speculating on the feelings but without using any psychoanalytic terminology. She sums up the crucial elements in the doctor-patient relationship in a gentle, murmuring way and this seems to resonate with everybody. Magic!



The other psychoanalyst leaders at the Tavistock, with some honourable exceptions, were not like this. They tended to remain silent for a long time and then explain at great length and with great authority what the case was all about. Michael Balint always believed that a group leader had to be a qualified analyst. But they needed to know how to lead a Balint group too. After Michael's death, when there was a shortage of analyst leaders, Enid decided that certain GPs who had been well marinated in the Balint stew, might with some supervision become Balint group leaders. The supervision was in the form of the Balint Society group leaders' workshop which continues its (not very frequent) meetings to this day. In the early workshops we presented verbatim transcripts of our groups for discussion, or should I say dissection? Not by Enid, I should add, but by each other. We were very strict with each other about sticking to the doctor-patient relationship, which was always seen as the responsibility of the leader. Nowadays, we are much more friendly and there are no transcripts: so please come along and join us.

### **Group leading today**

The present day leadership style in the UK Society seems to have evolved in this workshop. Leaders were expected to keep a low profile. We had had enough of leaders who talked too much. I think we learned a lot from Enid's approach but we were unable to replicate her style. We wanted to encourage the group members to do the work – always a major part of Michael Balint's plan. So we gave ourselves points for saying little and not teaching the group about psychoanalysis. As most of us knew very little about this subject, we sensibly did not risk trying it on. I personally owe a great deal to the leaders of my first Balint group (1974-78) Michael Courtenay and Mary Hare .

It is interesting that the same or a very similar form of group leadership was developed at the same time in Europe and the USA, possibly the result of the mutual influences encouraged by the International Balint Federation and its Congresses.

### **Different ways of saying it**

Let's get back to my current position. As I sit in my group wondering how to get the discussion back on track, I review the options that group leaders talk about among themselves. Basically I need to bring the discussion back to the patient and the doctor. (I should say that while we have been talking, I have continued to follow, with another part of my brain, the ongoing conversation in the group.)

First the patient: because, from what I am hearing, the patient as a person is being neglected. So I can ask the group to use their undoubted humanity and consider what it would be like to be in the patient's shoes. What is she thinking and feeling? Like all of us, she has been on a life journey which may have started well but has now gone disastrously wrong. How do we think this might have happened? Her father left the family home when she was eleven. Well that might have something to do with it. Then, coming back to the doctor, I might ask the group (not the doctor) how we would feel in her place. What is this patient doing to her normally composed and effective GP?

I could remind the group that if the doctor is feeling depressed, or helpless or even ill-used it is likely that the patient is feeling that way too. These could be feelings she is keen to get rid of; so she has handed them on the doctor who has passed them on the group. Now this is a psychoanalytic formulation and a very useful one. You can observe it in action everywhere. But let's not start referring to it as 'projection' or 'countertransference' and pretending to be psychotherapists which we are not. Sometimes the doctor will complain that, although he tried hard and ended up feeling terrible, he completely failed to discover the purpose of the patient's visit. Now here, if I am feeling

bold, I could say: suppose the purpose of the visit was to make the doctor feel terrible and thus be relieved of feeling quite so bad herself? She might even come back in a better mood with some empathy for the doctor so that they can make a fresh start. For this to work it is better for the doctor to be able to contain the discomfort and humiliation or whatever it is without feeling the need to retaliate or punish the patient.

But how does a group leader put that in a brief, non-technical intervention without it sounding like a lecture and merely puzzling the group? That is tricky. Somehow they have to experience it and then reflect on it with the help of a very useful psychoanalytic idea.

### **The doctor, the patient and the Shadow**

Now we all know that every doctor has some patients whom she always finds disturbing. And the group, if it goes on long enough, knows this too because she brings a series of patients who turn out to be very similar. The Balint research group that looked into 'doctors' defences' discovered, or rediscovered that these disturbing patients were often people who in some way resembled ourselves or people close to us.<sup>4</sup> It's as if you look into the patient's soul and it's like looking into a mirror: you see an image of yourself staring back! Surely, you think, I can't be like that? Well, not entirely. It's just partly you. A part of yourself you would rather not know about, which Carl Gustav Jung referred to as The Shadow. Awesome. Balint can really help us know ourselves better. If we want to go that far. But I don't want to probe into my group members' private lives. They need to find this sort of thing out for themselves as a result of their experiences in the group.

It helps if another group member innocently remarks, 'She's another of your single mothers' or 'your alcoholic old men'. But how can I as a group leader make that more likely to happen? Should I at least mention the possibility of a connection between the doctor's unconscious personal preoccupations and her choice of cases? We are talking, I think, about a greater knowledge of ourselves, including the lower depths where the Shadow lurks. Is this what Michael Balint meant when he said that his aim was to bring about '*a limited though considerable change in personality*'?<sup>5</sup> Robert Gosling, one of the Balints' associates at the Tavistock put it very well when he wrote of the doctors who seemed to have undergone this change:

*As they felt more accepting of themselves they found they were more open to their patients and so began to understand them better;*<sup>1</sup>

Whether everyone in my group will be able or even willing to reach such a level of self-knowledge (and self-acceptance) I don't know. I don't know if I have reached it myself.

My feeling is that the difference is not so clear cut. I think that most of us vary considerably in our degree of self-awareness from day to day and from one patient to another.

### **The group leader decides**

And now, I have to decide which of my store of insight-promoting interventions to offer to my group in order to set them back on the true path to Balint self-knowledge. To my amazement, I find that they are now talking about the doctor-patient relationship! And yet I still haven't said a word. It must be the result of something I said last week.

**Disclaimers** The group described in this article is entirely fictitious. So is Dr Ben Cartilage.

## REFERENCES

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# An Unexpected Conversation

by Arushi Jain, Monash University, Melbourne.

The BSANZ Writing Prize for Medical Students 2015

*Pseudonyms have been used in this essay to help maintain confidentiality.*

I confirmed her details; her name was Andrea Jones, she was 64 and she was a retired receptionist. Her presentation was simple enough; she had been experiencing intermittent episodes of right upper quadrant pain. These episodes were usually triggered by fatty meals and self-resolved after an hour or so. Her symptoms screamed biliary colic, and I felt confident that I would be able to present this patient's story to the consultant without any problem.

After establishing my provisional diagnosis, I moved on to ask about her comorbidities. She had the usual cocktail of hypercholesterolaemia, hypertension, type 2 diabetes mellitus and gastro-oesophageal reflux disease, coupled with depression and anxiety. All of these were reported to be well-controlled by lifestyle measures and medication prescribed by her general practitioner. She had no other medical history to report, until I asked about surgical procedures.

Ms Jones reported a tonsillectomy and adenoidectomy during childhood, and a hysterectomy 20 years ago. Then she paused and her expression became grave, I developed an awful feeling in the pit of my stomach. "I have also had many surgeries on my arms and legs and have had two surgeries on my neck."

We both knew I knew what the answer was, and I did not know if the question was appropriate, yet I still asked what the cause was. She looked me straight in the eye with a look of fresh terror, nodded her head slightly and whispered a single word.

I did not say anything; I did not know what to say. I allowed for silence – that is the only thing I could remember from the 'Breaking Bad News' tutorial we had in first year. Then I realised that I was not the one breaking the news and internally panicked. Fortunately, the silence seemed to be what Ms Jones wanted. She took it as an opportunity to tell me her story.

She had been with him since she was in her twenties; they dated, married, had children. Everything was swell until it was not. He started to hit her, she thought she could cope with it.

Ms Jones paused, and I nodded for her to continue.

The beatings became more severe, she was scared to be at home. She ended up in hospital numerous times. The first time he broke her neck, she was going to leave. She almost did until she thought of how it would tear her family apart.

Her eyes started to swell with tears, I offered her tissues. She dabbed her eyes, and I held her hand.

When it happened the second time, her eldest child insisted that it was time to leave. They did, and it was hard, but they managed. That was a decade or so ago.

The conversation came to a natural halt, Ms Jones looked more comfortable now. I am not sure if this is the right word to describe it, but one could say she looked almost relieved.

"What is it like now?" I asked. She half-smiled and told me that she had remarried. She was happier now; her new partner was kind and gentle, but she was still scared, always scared. Ms Jones let go of my hand and sat up straighter, "What else would you like to know?"

It felt unnatural to continue with the history-taking as usual, but I knew it had to be done. Ms Jones had no family history of cholelithiasis or any other gallbladder disease but did have a family history of cardiovascular disease and diabetes. There was nothing else remarkable in her history; she was a non-smoker and non-drinker, and had a healthy diet. Other than mild tenderness in the right upper quadrant there was nothing of note on examination either. I thanked Ms Jones for her time and told her that I would go and find the consultant.

“Good, you’re done. Now, when you present I want you to focus on the surgical problem at hand. I’m a surgeon, and I want to know what I can fix”, was the greeting I received when I walked into his consulting room. I know he said it in good faith, and he was wanting me to practise my presentation skills as it is an area in which he knows I need to improve. However, when I summarised the abuse Ms Jones has suffered as “complex social issues”, I felt as if I was ignoring what she had said, as if I was cheating her.

Despite this, the consultant seemed happy with the presentation, and proceeded to consent Ms Jones for an ultrasound and discussed the potential need for a cholecystectomy. She agreed to all he said, said thank you, and left to organise her scan and follow-up appointment. The consultant went back to his desk, and as if I had not just been mentally shaken, I went to call for the next patient.

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The consult with Ms Jones was the first that I had ever had in which abuse had been openly discussed. It was very confronting for me; I have lived a very sheltered life and my exposure to such issues has been very limited. It made me realise that this career will expose me to a number of social issues that I had previously only heard about on the news.

One thing that I found difficult was coming to terms with was the fact that despite not knowing me, Ms Jones instantly trusted me with such personal information. I am not even qualified, a mere student on her first year of clinical placement. Furthermore, I am less than a third of her age, young enough to be her granddaughter, and yet she still trusted me. The simple label of ‘medical student’ was enough for her for her to feel comfortable in order to tell her story. We had been told that this would happen on our first day of medical school, but the truth of the statement had not resonated for me until this consult. It made me realise the extent of the power imbalance in the doctor-patient relationship; how we can ask virtually anything and it could still be acceptable, yet the patient knows nothing about us apart from our name and position.

Another thing that I struggled with in this relationship was determining where the line lay in distinguishing appropriate from inappropriate professional behaviour. I did not know if I should have asked Ms Jones the cause of her injuries, and was not sure what the “correct” manner was to react to Ms Jones’ emotions. The whole while I was just following my gut instinct; there was no textbook or flow chart to follow. This made me uncomfortable – I did not want to say or do the wrong thing to make the situation worse.

I also did not know whether it was appropriate or not for me to hold Ms Jones’ hand. Was that considered to be breaching professional boundaries, or could that be considered to be a kind gesture? I hoped that she didn’t come from a culture that deemed it inappropriate, and hoped that the fact that she had been physically abused would not make her uncomfortable when a stranger held her hand. I was relieved when she did not react negatively when I did.

Finally, I felt uncomfortable with presenting back Ms Jones’ abuse as “complex

social issues". I felt that Ms Jones and I had formed a good relationship during the consultation, and then felt that I had betrayed this relationship when I summarised her past into those three words. However, I did recognise the consultant's point of view and understand the importance of targeting the relevant issue, particularly since this social history was not an 'active' problem.

Overall, the student-patient relationship that I had in this consultation was unlike any that I had experienced before. Despite my discomfort, I felt that the experience was a valuable one, one that I learned a lot from, and one that I will remember for a long time.

I think that I handled the situation as best as I could with the knowledge and skills that I had at the time. However, I know that this level is not good enough for me as a doctor. At medical school we learn how to break bad news, however we have never been taught how to deal with situations in which patients break bad news to us. I believe that this is something that needs to be incorporated early on into medical school curriculums. This is particularly relevant for discussions involving domestic violence as it is such a prevalent issue in our society.

I am aware that the Royal Australian College of General Practitioners has recently started a programme to educate general practitioners on how to have such conversations, and am of the firm belief that medical students should have similar training too. This could be done in the pre-clinical years so that when we are confronted with such situations in our clinical years we know how to approach them. It may even be more beneficial to us to have teaching in this area at this stage rather than breaking bad news as that is not something we will have to do as students.

The teaching could be done with simulated patients in a safe environment. Tutors and simulated patients can provide feedback regarding what we said and how we acted, and what we could do differently if presented with a similar situation in the future. The issue with this learning strategy, however, is that it is artificial and students may struggle to take it seriously. However, this training would be better than the lack of training in this area that we currently have.

We should also be made aware of the support services that are available for patients experiencing abuse. This is so that when we graduate, we will be able to refer patients so they can receive more targeted help. In a situation such as a surgeon's consulting rooms, this knowledge will be vital so that one can focus on the presenting problem but also know that the accompanying social issues are also being managed.

Currently, there is a focus on teaching medical students holistic medicine. I believe that incorporating education about domestic violence and other difficult conversations into the curriculum will help achieve this goal. It will give us confidence as students to deal with such situations, and more importantly will also have better outcomes for the patients as their problems will be addressed.

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# **One to keep and one to grow**

by Rebecca Ly, University of Otago, Dunedin

The BSANZ Writing Prize for Medical Students 2015

One of the stories that has shaped my identity and influenced my choice of medicine as a career is a story about my Cambodian grandmother. One of the things that she, along with her husband and seven children enjoyed the most was the spring season when her farm pigs gave birth. She would venture out into the poor villages and give struggling families each two piglets. However, this wasn't exactly a gift. She insisted that one piglet was theirs to keep, and required that they raise the other piglet for her to purchase once it had fully grown.

Sadly, my grandparents died in the genocidal regime that reigned when my dad was a teenager. After several years without his parents, my dad made the decision to escape the jungle that had become his home in the hopes of a better life as a refugee. In his attempt to escape, he was arrested by the Khmer Rouge and was to be executed the following day. His hopes of a life of freedom had now come to a crippling halt. At a time when it seemed as though life was at its darkest, he could not have imagined what would happen next. During the night, one of the prison guards recognised my dad. He belonged to one of the families that my grandmother shared her piglets with. To this day my dad lives because that prison guard set him free. One great act of kindness, in return for the kindness my grandmother had shown his family all those years before.

This story has had a profound impact on my life. Over the years, I've realised that the reason why I have any life at all is because of my grandmother's actions. She is the reason why I am studying medicine, as I want to carry on her legacy of kindness. I want to live my life in such a way that ensures that her death, along with others in my family, were not in vain.

As a fourth year medical student, I had this story etched on my heart. My motivation for studying medicine was inspired by compassion, but as a twenty year old who has never faced much in the way of adversity, I lacked the life experience that allows one to truly connect with another: to enter in their pain and not just acknowledge it as a formality. In the last two years of clinical medicine I have had the privilege of exploring these concepts and learning what it really means to be a doctor.

On my first hospital attachment we met a middle-aged male patient who had metastatic cancer. His reduced life expectancy was evident in his prominent bones and his skin that was a grey shade of white. And yet, despite his cachectic appearance there remained a vibrant sense of life in his eyes, his humour and his gentle smile that broke through at every ward round. It was amazing to me how although this gentleman's life was inevitably coming to an end, he had a fervent enthusiasm for life that exceeded my own. I thought about how upset I would be if I were the one dying. I wouldn't be expressing my gratitude towards the medical team every single day as this patient did. After all, it is the job of the doctor to heal the patient. If the patient is dying, the doctors are clearly failing in their duty; or so I thought.

A few months before this patient died, he shared a secret with my colleague and me. It was his wish for his body to be donated to science, and he had assigned us the task of retrieving the paperwork. As it transpired, he couldn't ask his family to help him as they disagreed with his decision. At the time I could only think of how strange this request was, and I was very curious as to why he would bequeath his body to science when those who loved him dearly were opposed to it. However, it was only after fulfilling this task

that I discovered the motivation behind his request. When we handed him the white envelope, his face beamed with absolute delight. I can close my eyes and see this moment so vividly, yet there are no words that can adequately describe it to be re-lived by another. For me, this task was an inconsequential five-minute walk to the anatomy museum. Yet, to the patient, this paperwork was of immeasurable significance. In that envelope was the assurance that his final wishes would be fulfilled; he would be able to give back to an institution that he felt had done so much for him. While he never uttered those words, it was declared by the enormity of his gesture.

After my encounter with this patient, I realised how incredibly skewed my initial view of the role of the doctor was. I had originally thought that doctors were supposed to heal the patient, to rid them of their disease. I thought that doctors did not deserve praise or thanks if their patient was dying because that meant that they had failed their patient. Over the last two years, I have come to the realisation that I could not have been more wrong. Though this patient was physically dying, he was healed. He had come to terms with the end of his life, and part of the doctor's role during this process was to ensure that he was comfortable, that his dignity was preserved as much as possible, and that he was always heard and respected. Because the doctors were successful in their endeavour, this gentleman was grateful beyond measure to the extent that he was prepared to give away a priceless gift.

As I reflect on my encounters with this gentleman, it is as though he has given me two piglets. The first piglet that I will keep for myself is the memory that I have of his delightful character and his zest for life. The other piglet that I will continue to nourish and grow is the realisation that in medicine we do not heal patients by simply diagnosing and treating them. Instead, medicine is an opportunity for us to stand beside another individual as they journey through one of the most trying times of their life. It is a platform from which we can meet others in their most vulnerable time, and in doing so, form a unique doctor-patient relationship where we can heal and alleviate suffering simply by being human; by being kind, being compassionate and being gracious. Although I cannot give this piglet back to the one who shared it with me, I will strive to be that kind doctor and human being with all those who I encounter, to honour his memory and all those who have gone before me.

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# The Approaching Storm

by Kirsty Whitmore, Griffith University, Queensland

The BSANZ Writing Prize for Medical Students 2015

In a small town in the Top End of the Territory, the wet season approaches. Being a city girl from Brisbane, I never knew of the unique seasons of the Northern Territory. Dry season (Gurrung), wet season (Gudjeuk), and knock-em-down rains (Wurreng), all with their unique animals, plants and names, were foreign to me. It didn't take long to understand why this early December weather was called the build-up (Gunumeleng). The fierce heat sucked the moisture from every surface and the humidity hung in the air, preparing for the monsoons to follow. Many afternoons were spent listening to the thunder rumbling and shaking. With anticipation, I watched the dark clouds clustering, only to see them blow past our small town. While the weather teased us with that short reprieve from the heat, we knew the storms, with time were inevitable.

I spent two weeks working at the health clinic in this town. The remarkable clinic, staffed by a handful of remote medical practitioners, nurses, Aboriginal health workers and allied health professionals served a small community. They gave bicillin injections by the dozen for rheumatic hearts, screened for melioidosis during the wet, ensured clients got to their appointments and called them with reminders about health checks.

I spent a day with Dr B, a very experienced practitioner who had worked throughout the Northern Territory. As the afternoon approached and we were beginning to close up shop, Sally a late walk-in arrived. Sally was a forty-six year old Aboriginal woman, originally from Alice Springs. She was a crisis worker, travelling out to remote communities, working with vulnerable children and families. Like many other selfless professional carers, Sally's health had suffered. A significantly obese woman, she had the typical combination of diabetes, hypertension, dyslipidaemia, sleep apnoea and developing heart failure. In February she had suffered a frightening exacerbation of illness, so short of breath she could hardly walk, with the right side of her heart unable to overcome the pressure in her pulmonary vasculature. Some intensive pharmacological intervention and a new CPAP machine kept her organs in relative synchrony, and she continued on with her life.

Today, Sally had come to see Dr B as she had been unable to keep her planned cardiology appointment. The flight home from the community she served back to Darwin had been delayed, and despite her attempts, the cardiology clinic had refused to reschedule, saying she needed a new referral. Sally's initial referral was completed eight months ago and now it seemed likely to be delayed again. As for her physical state, Sally said she was feeling the best she had in months. She had her sights set on a big lifestyle change in 2016, planning on seeing a dietician and developing an exercise plan. Despite recently taking up smoking again, her breathing felt better than ever using her CPAP machine, and she stopped taking her heart medicines months ago.

Her positive outlook unfortunately made it so much more difficult for Sally to receive Dr B's news. The right side of her heart was failing. Unbeknownst to her, Sally's health had deteriorated drastically since her last appointment. Excess fluid had seeped out of her capillaries and had flooded into the soft tissue of her legs. My thumb print seemed to be an indelible mark on her shin bone. I could feel her pulse racing under my fingertips. The ECG showed even the electrical wiring of her heart to be frayed, unravelling and hazardous. Dr B called the cardiology consultant: Sally needed to come into hospital.

With firm-set eyes, Sally refused. She had three weeks left of work and could not

possibly take time off to sit in hospital. If medication worked last time, then they should work this time. If she was so sick then why had she been refused another cardiology appointment? She had responsibilities! No, she would not go.

Even to my inexperienced eyes, it was clear that Sally was unwell and I could see the extreme risk of starting an unmonitored patient on diuretics without knowing how her organs would cope. Suddenly, three weeks away from a doctor, even after months of not seeing one, felt like a very long time. But Sally was adamant that she could not stop work.

While Dr B spoke to the protesting cardiology consultant on the phone attempting to create a plan to safely manage their patient, I spoke to Sally. She told me more about her work “out remote”. All of the children she worked with were at risk of neglect and family violence. “It is a whole different challenge,” she said, “when there is no one to refer to, no services to access, and nowhere to escape.” She told me about her family in Alice Springs, and that her mother had been part of the Stolen Generation. She had done “a lot of walking and searching and forgiving” about this over the years. She told me about her husband who suffered a heart attack several years ago and was now unable to work, and they struggled some weeks to pay the mortgage. She told me how she was going to get her health on track, to make all of this ‘trouble’ go away. She knew it would be hard, working in communities where fresh vegetables and fruit are luxuries and spending hours on a plane each week, but she was determined.

I could see the pieces of Sally’s life coming together to complete the picture of who she was as a person. Her overwhelming responsibility of work, family, and financial burden ranked above her health. The threat of losing her home or children suffering was so real, that by comparison, feeling as well as she was feeling, the threats to her health sounded hollow. As I answered her questions and explained what was happening inside her heart, I could see her eyes set. They wavered slightly when I told her about the risk of heart attacks, knowing what this could mean, having experienced this through her husband, but ultimately her decision was made. Despite everything that we as doctors thought was right, being fully aware of the risks, Sally had the right to decide. Before she left, while I took her bloods, I reminded her that we were only a phone call away, and told her I hoped to see her again soon.

I found my experience with Sally challenged my pre-conceived ideas about co-operation. Sally was a classic non-compliant patient. In my mind, non-compliance conjures up images of smokers who wouldn’t pay for medication but would pay the hefty taxes on cigarettes; who pull out their new cannula; who don’t take their medication; who won’t turn up to appointments and won’t take advice. Words ranging from difficult to disobedient, inconvenient to irritating spring to mind. I become an accuser; quick to judge, and ignorant of the consequences. But I could not pocket Sally into one of my narrow pigeonholes of non-compliant patients. I saw her struggles, the challenges she faced, and the tension pulling her in each direction. I felt a deep compassion for this woman who had not only sought our help but also opened up and shared the story of her life. I felt a deep shame realising that every patient I had ever flippantly labelled ‘non-compliant’ had the same richness and depth to their story had I taken the time to listen. So often, we see the doctor-patient relationship as ‘us and them’. We create an adversarial system where patients are chided into treatment, and are too ashamed to tell us when they do not follow our plan. We give narrow options and limited information and expect obedience.

Not one of Sally’s circumstances changed the fact that her heart was failing and that she needed to go to hospital. Her health was still at great risk, and she may still have a

heart attack the next day or wake up drowning in her own fluid. But the only person with the right to determine what was right for her was Sally. As she took these risks upon her own shoulders, they joined the many other responsibilities that she carried with grace and courage and determination. I admired the diligent work of Dr B as she formulated a plan to fit Sally's life and limitations. Understanding the priorities, needs and expectations of a patient not only optimises adherence to treatment, but also builds a rapport and relationships that cannot be achieved otherwise.

When I first wrote this essay, my mind drew comparisons between the weather and Sally's health. In the same way the harsh hot weather made the coming storms inevitable, so too would Sally's poor health choices lead to significant consequences. But this was not the case. Two days later Sally returned to the clinic after a weekend of chest pains. The doctor and I listened intently as she recounted the story of a man who lived in one of the remote communities where she worked. He had come into the clinic having a cardiac event, and was told by the doctor there that little that could be done for him, unless he travelled to Darwin quickly. Sally noted the concern and desperation in that doctor's voice was echoed back to her in Dr B's and mine. She said when she started to develop chest pain, she knew she couldn't do it on her own. Sally was admitted to Royal Darwin Hospital that day and remained there for five days.

My time in the Northern Territory enlightened me in ways that I did not expect. Working with Sally showed me prejudices I did not realise I carried. Challenging my perception of compliance and observing practitioners work collaboratively with patients deepened my appreciation of patient-directed care. Just one year of reflective practice at university heightened my awareness of my assumptions and how these drastically diminished my capacity to engage with patients. It is clear I have so much more to learn. Taking the time to listen to the stories of patients feels like filling the faint outlines of their diagnoses with lashing of rich colour. This is where the beauty is, and where the science of medicine becomes art.

*Names have been changed.*

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# Reflective Practice and Balint Groups Reflection

UK Essay Prize Winner by Katherine Aiken

## Introduction

I am currently a second year medical student studying at Queen's University Belfast and have recently undertaken a module entitled 'Reflective Practice and Balint Groups'. Before starting to study this student selected component, I had had no teaching on the therapeutic relationship and only few opportunities to see it in action. Now, reflecting on the semester, I feel I have learnt a lot about the importance of the 'doctor as a drug' (Balint 1957) and also practised emotional intelligence in a Balint group. I feel strongly Balint groups should be incorporated more widely into the medical curricula, as they offer a unique opportunity to gain insight into various aspects of the therapeutic relationship and learning opportunities to influence future practice.

## Background

Balint groups were initially the creation of Michael Balint, as he recognised the importance of reflecting on consultations that remained with the doctor and thought valuable lessons could be learnt through discussion with peers (The Balint Society 2012). I have found them to be the ideal way to explore some of the consultations observed in more depth. It is through the Balint groups I have developed more empathy and understanding for the patient, rather than leaping to unfounded conclusions. I have enjoyed speculating about the underlying reasons for the patient's behaviour and experiences (Wilson 2015). Balint groups aim to deal with and understand the emotional aspects of the doctor patient relationship, hence it involves reflection on past events (The Balint Society 2012).

The doctor-patient relationship encompasses how the clinician and patient interact, with the aim being to start and cause real and beneficial change in the client/patient. In an age of ever more stringent budget cuts and increasing pressure to meet targets, it is vital that health care professionals do not lose the ability to empathise with their patients or neglect spending the time required to build a relationship with them. It is by building a rapport with your patients that a foundation is laid for a relationship based on understanding, trust and a desire to address the health needs of the patient (Platt et al. 2001). Reflective practice simply put is 'thinking about or reflecting on what you do'. It has been said that reflective practice, with the aim to use it to improve and redefine subsequent practice, is one of the defining characteristics of professionalism (Schön 1983).

Emotional intelligence, defined by the Oxford English Dictionary as 'the capacity to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically' is also very important for us to consider as future clinicians, and it has been found that emotional intelligence scores were positively associated with patient trust, and these results were significant. With this background, I will now discuss a case that I observed and subsequently presented in a Balint group.

## The Unscheduled Care Team and my case

I have chosen to reflect on an interaction I observed whilst on placement with the Unscheduled Care Team. The patient was an early middle-aged male, and he attended this appointment following an assessment by a psychiatric nurse after an altercation the

previous night. The psychiatrist, the patient and myself were the only people present. Having read the patient's history before he arrived, I was a little apprehensive about what he would be like. The doctor was initially quite clinical towards the patient but over time the relationship grew less formal. The psychiatrist and patient initially built up a rapport which led to the patient being very open and honest in response to the questions he was asked.

The patient began by describing the incident that had taken place, admitting he had drunk about a quarter of a bottle of vodka and four cans of beer. He was at home, where he lives with his mother and younger brother. The patient seemed slightly hesitant and admitted that his memory of events was still somewhat hazy and he was unsure what in particular happened or provoked him but shortly after his brother arrived home he 'took a fit of rage', 'felt like somebody else' and 'just had to do harm to himself or anybody'. Following a short verbal argument, he took his brother by the throat and held him there for about 5-10 seconds. The patient said he didn't feel like he could stop himself from what he was doing, which made me initially feel quite hostile to him since I felt he was making excuses. After letting go of his brother, he tried to find a spade but was restrained by his older brother until the police and ambulance arrived.

The patient went on to describe how after about 15 minutes the rage dissipated and he was left feeling completely mortified. He can't stop thinking about what he did and what could have happened and feels very embarrassed and guilty. He described himself as someone who tends to avoid conflict and so felt it was very out of character, and later he referred to how much he values being able to think clearly and hence he really hated this perceived loss of thought processes and control of his body. He made no attempt to shift the blame and while discussing this I could see how distressed he was and so I grew in sympathy for him.

The patient had a 20-year history of depression, which was diagnosed following an overdose in 1997, although he said he knew that what he took wouldn't be fatal and he went to the GP the next day to get help. He has become alcohol dependent over the past several years, drinking half a bottle of vodka and 6 cans of cider 3-4 nights per week for the last 8 years. He's tried to stop drinking before but the longest he's gone without drinking is 4 days, then he gets the 'shakes and sweats' and feels agitated. He said by taking a drink he knows his nerves will settle. Before he was depressed he was jovial and outgoing, he blames the depression for making him more isolated and says he started to drink because it made him feel less anxious, with him describing the alcohol overall as a 'destructive force' and a major part of his life. Earlier on the day of the incident described above, the patient had actually attended his GP to talk about his drinking problem as he felt it was becoming too big an issue.

He is the third in a family of seven children and grew up in West Belfast. He described his childhood as relatively happy but secondary school was challenging. There were raids by the security services and lots of arguments at home. He had a really good relationship with his father – this was the only relationship he talked about in any detail, but he died in 1991. It seemed like his father was the only one who really supported him in pursuing his dream of being a musician and I believe once he died other family members had little patience, disapproved of him and his lifestyle, and wanted him to get a proper job.

His relationship with his mother has been more difficult but is currently the best it has ever been. He wants to move out if at all possible, since the current situation is not ideal and he finds it restrictive on what he can do. His mother and him argue regularly about his drinking but it has never turned violent. I could empathise with him in this

situation, as everyone likes to have their independence once they reach a certain age and not be made to feel like a child by their parents. It is unusual for a man of his age to still be living at home and this does perhaps reflect on his inability or unwillingness to take control of his own life and the events which occur in it.

When asked to expand a little on his current mood, he rated it as a 3/10 and said the last time he recalled feeling properly happy was in 2007. The fact that he could pinpoint so exactly the last time he felt happy really challenged me and has been something I have reflected on a lot – his mood must have been really low since. This must be very hard and restrictive for him. He sleeps very badly but has never heard voices or had any strange perceptions. He has not self-harmed or attempted suicide since 1997, although he has researched ways to commit suicide – he was very keen to point out this was purely academic. His main hobby is music and he used to be in various rock bands. He has been unemployed for a long time but is currently working on a business plan for a new venture and has been meeting with business advisors. The patient has had two long-term relationships, with the most recent one ending in 2005. He didn't elaborate but said they couldn't cope with his 'rock and roll' lifestyle.

A corroborative history was obtained by telephone conversation with his mother, during which time the patient left and smoked a cigarette. The elderly mother seemed very worried and really wants something done about the situation. She said the argument started because the younger brother was singing. It was very scary for her to watch, which I could understand as she must have had a residual fear that the patient would turn on her. She said the patient had been becoming more secluded and isolated and had lost interest in himself over the past 18 months. He spent a lot of time in his room and only left the house once or twice a week.

The patient and the doctor agreed the first priority for the patient should be to give up alcohol, and his GP is to prescribe diazepam to help with this. He was also referred to the community addictions team, although he worked unsuccessfully with them in the past, and a follow-up appointment with the psychiatrist was arranged. The patient was assured that in the meantime or in the future if he had any other bizarre episodes he could get in touch with the psychiatrist. The doctor was patient and sympathetic, yet firm when explaining that the amount of alcohol he was drinking was dangerous. He said afterwards you are always unsure whether people actually listen and will stop drinking, and this seemed to be something he understandably found frustrating. Motivational interviewing was used, where the focus is on negotiation with the patient rather than conflict, and is patient-centred (Treasure 2004). It was the patient himself who first mentioned the need to address the amount of alcohol he was drinking. This approach was found to be the best approach for people with alcohol problems, with patients subsequently participating more fully in treatment and being more motivated (Brown, Miller 1993).

Overall, the patient remained calm throughout, although he did grow uncomfortable and upset when talking about the incident the previous night. I imagine he felt quite ashamed and wanted to move on and forget what he had done, but he must have realised if he wanted help from the psychiatrist he needed to be honest. This was something that really made me respect the patient, because it is not easy for anyone to have to go over past mistakes. It led me to think he must have really trusted the doctor, in that he didn't hesitate to answer any of the questions which he was asked about the incident and other aspects of his life, some of which were quite personal.

### **Presenting to the group**

I had the opportunity to present this case in a Balint group for discussion with my peers,

which was something I found enjoyable and insightful. I felt quite nervous initially, since in presentations I have done previously I have always had my notes to hand, but once I started I appreciated the opportunity to share the case with the group and hear their thoughts on it.

An interesting point was raised about the fact that the argument started because the younger brother was singing. The patient was very musical – he sang and played keyboard. There was a suggestion he may have been provoked by jealousy towards his brother, since the fact he was singing implies he was happy and carefree. The patient has a very low mood and may have resented his brother for ‘stealing’ the music from him, since he had so little left and music was something he felt really passionate about. By the end of the Balint group, I was really considering whether this was the trigger for the fit of rage the patient experienced, which was something I had not previously considered.

There was a lot of discussion about what age his behaviour made the group think he was. I had already thought it seemed like he and his brother were still children, fighting over something inconsequential, and their mother had reached the end of her tether and wanted to hand the problem across to someone else, which was why she was so keen for the psychiatrist to intervene. Others in the group thought it was like a rebellious teenager or young adult who was fed up living in their parent’s house and wanted to escape. Someone else thought the way he was so keen to leave and have a cigarette while the psychiatrist rang his mother was suggestive of someone who didn’t want to take responsibility for their actions and was quite happy for someone else to deal with it. I wasn’t so sure about this since I did believe he was taking responsibility for his actions. His initial reaction to the referral to the community addictions team, whom he had worked with before unsuccessfully – a loud sigh, then reminding the psychiatrist he had worked with them previously before finally agreeing to give it a try - was also reminiscent of a rebellious teenager.

There was an interesting split of opinions in members of the group between feeling really sorry and frustrated for him, and feeling really sorry and frustrated for his family. This probably accurately reflects the conflicting emotions experienced by those involved in the situation.

The group had the feeling that he has distanced himself from his family and now has very poor relationships with them, which is something I agree with. Some thought his family weren’t supportive or interested any more, but from being in the consultation this wasn’t my impression, exemplified by the fact his sister came with him to the hospital immediately after the altercation and from what his mother said they seemed determined to work through the situation as a family. His younger brother also decided not to press charges.

Some interpreted this situation as a cry for help, like his previous suicide attempt, which he took knowing it would not be enough to kill him but for attention and to get noticed. I wondered if there might be an unconscious element of this, since he has had depression for a long time, it has been forgotten about and he is now left alone in his room and may want this to change.

### **A second case**

I was really struck by how good a relationship the doctor was able to build with the patient discussed above, and I think communication was vital for this. It contrasted starkly with another interaction I observed, this time at an appointment with the self-harm and personality disorders team. There was a woman in her thirties who was coming to the end of her treatment and had a review consultation. It was clear from the outset that she

didn't want to be there – she did not take her coat off or make any eye contact throughout the consultation.

The doctor started with an open question about how she was and was given a very brisk answer, of 'fine', followed by silence during which the atmosphere in the room was very tense. The doctor gently stated 'it doesn't seem like things are fine', and after some time the patient began to share a little of what was going on. It was clear she was very angry and was not willing to engage in conversation. It was certainly the most intense consultation I have ever observed, and it was amazing to watch the psychiatrist keeping her calm and even being able to make her stay for the whole length of the consultation, with the patient repeatedly stating she did not want to be there.

Unfortunately, there was not much progress made with the patient, which I'm sure was frustrating for both the patient and the psychiatrist. The difference between this consultation, where the patient seemed to arrive convinced the psychiatrist could do nothing to help her, and the other one I observed, where the patient seemed to come expecting and keen for the psychiatrist to help was something I have reflected on a lot – I imagine it must be very frustrating for clinicians when patients don't want to engage in treatment. In both situations, the psychiatrists were engaged and did all they could, but patient engagement is required for progress to be made. It has been found that patient engagement in consultations is positively correlated with many varied outcomes, including their satisfaction, their use of health care resources and services and their adherence to treatment plans (Parsons et al. 2010).

### **A third case**

One other consultation I observed really sticks out as I look back over the module, and it was in the liver clinic. A lady in her forties was reminded she had quite a high chance of developing cancer and would need a liver transplant at some stage, yet she had such a good relationship with the consultant that the consultation remained positive and there was a lot of laughter throughout. The doctor explained to me afterwards that by warning her and reminding her at every clinic of the likely course of her disease it will be less of a shock to her when her condition does start to deteriorate. I was really impressed by the way he handled the situation in a compassionate manner yet simultaneously not letting it overshadow the consultation, since breaking bad news to patients is something I feel very uncomfortable with and even intimidated by.

### **Conclusion**

I believe studying this module will prove invaluable to me in the course of my future studies and my career. Communication, partnership and team work is one of the four domains of 'Duties of a Doctor' and this module has honed my skills in all three of these areas (General Medical Council (Great Britain) 1995). I have been able to observe many different clinicians communicating with their patients about many different things, from telling someone they didn't have a brain tumour to making someone aware they would need a liver transplant. I have truly realised the importance of building a working partnership with your patients to ensure the best outcomes possible and working as a group for the Balint groups has been really enjoyable and a highlight of my second year of medicine. Hearing first hand from patients about their experiences, good and bad, of our healthcare system, and how many of their issues stem from poor communication and a lack of consideration of their emotions, has challenged me to ensure that in my future practice I implement the good practice I have observed and strive to learn from consultations which have not gone as well. These experiences shouldn't be confined to an



elective module, undertaken by less than 5% of my year group. I feel strongly Balint groups should be incorporate more widely into the medical curricula, as they offer a unique opportunity to gain insight into various aspects of the therapeutic relationship and learning opportunities to positively influence future practice.

I have observed many different therapeutic relationships in practice, in many different scenarios, and have come to agree that 'Even if we are unable to cure the patient of his illness, we can always give some relief, reduce suffering, and give hope and happiness to the suffering humanity' (Singh 2016).

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**‘Balint and the Body’ –  
Newcastle Balint weekend June 2016 –  
some responses to this theme  
from three participants**

Anne Tyndale, Sotiris Zalidis, Jean Daniel Gradeler

The North East organising group chose to focus attention on the body at the Newcastle weekend this year. We felt that the body can be neglected or even forgotten at times in Balint work, and chose three ways to bring this theme and the physicality of the encounter between doctor and patient into the minds of participants. We chose a short essay by Barry Lopez called ‘The Invitation’ which can be found in full on his website [www.barrylopez.com](http://www.barrylopez.com) to introduce the weekend on Friday evening. Esti Rimmer and I gave a talk on Saturday morning – the presentation including around twenty images of bodies, inspired by an exhibition at Tate Modern some years ago. Thirdly, we were delighted that Jean Pierre Bachmann and Marie Noelle Lavassiere agreed to come and co-facilitate a Balint Psycho-drama group, which brings the physical presence of the body to the foreground.

I asked three participants if they would write something about their responses to the weekend, with particular reference to these three stimuli. Anne Tyndale, Sotiris Zalidis and Jean Daniel Gradeler took up the challenge and their responses are presented below. I am very grateful to them.

**Jane Dammers July 2016**

**The Bear – a response to Barry Lopez’ essay ‘The invitation’**

I cannot attempt to summarize the beautiful essay written by Barry Lopez which Dave Morgan read to us at the opening of the June conference at Newcastle. On seeing a bear feeding on a caribou, Lopez’ inclination is to focus on the bear, to try to put the scene before him into words, to treat it as an isolated experience. In contrast, the indigenous people with whom he is travelling, gather what goes before and after, together with all their sensations aroused by the surroundings, into a continuous, to and fro experience. They are silent, words do not interrupt their total mind and body awareness. Nothing gets lost through selective observation and a wish to make sense of things. They allow the situation to unfold, they give themselves over to a dynamic event as if swimming in a stream; they have no need to impose a meaning or significance; these then emerge for them in their own time.

For me this writing brings to the fore the importance of presence rather than absence. Immediately we start focusing on a single experience all the other sensations of the moment become absent. Intellectualisation absents emotional and bodily awareness, external observation is selective. If we immerse ourselves in the stream we have to go with the flow of the water, muddy or clear, negotiate our proximity to strange creatures, absorb the beauty of reeds and flowers and learn to avoid the rapids and rocks; a lack of awareness is dangerous.

Lopez is not writing about merger. Being part of something is not giving oneself up. The other is the other and respected as such. There is no wish for something different, what is, is and we cannot control it.

As I come away from Balint groups weekends I often ask myself exactly what I have



**Discussions at the Newcastle Balint Weekend.**

learned but this question soon gets put aside as unanswerable and unnecessary. All I know is that I am different from when I arrived. In our group the discussion flowed now and then into 'bearing'; bearing unpleasantness, suffering, not knowing: the importance of continuing to be. This is what Winnicott felt was the most enabling of parent/child contributions and is perhaps our most enabling contribution to patients and each other.

Looking back at the weekend in Newcastle I am still finding myself in a kaleidoscope of experiences not yet pieced together. The journey north, finding a new meeting place, the warm welcome which helps me to tip from the bank into the stream, excitement of finding people I don't know and deepening my acquaintance with those that I do, the beach, sunshine, the sea gradually darkening in the evening light and finally returning home to political turmoil. I feel like a python after a huge meal some of which will nourish me over time and some will be discarded through the slow process of digestion.

**Anne Tyndale**

### **Balint and the Body - a response to the illustrated talk**

This year in Newcastle the Balint weekend had as its theme 'The Body'. As Balint groups have become multidisciplinary there is an awareness that although general practitioners are used to handling the physical bodies of their patients and suffer the complications that this imposes on their relationship, mental health professionals tend to view the body as a mental representation that can be elaborated through speech. I believe that Esti Rimmer, a psychotherapist, and Jane Dammers, a general practitioner, in their introduction redressed this imbalance. They emphasised the centrality of the body's physical presence in the consultation. Jane's talk was accompanied by the projection of a series of evocative photographs of natural bodies, of paintings of bodies and of sculptures of bodies. I thought that the stillness and the artistic beauty of the images shown, invited us, the delegates, to use our imagination and think of the impact of the body's physical presence on the doctor or therapist. The patient's body, its appearance, movement, smell and behaviour, constitutes a form of direct communication achieved through the emotions it arouses before the patient even starts talking.

One of the benefits of the organisers' emphasis on the body was also their concern

for the well-being of the bodies of the delegates. The conference took place in a light and spacious building that maintained a comfortable temperature. In the small group discussions we were encouraged to stand and stretch at the appropriate interval half way through the session in order to relieve the muscle tension from sitting too long and reflecting on the painful emotions in the doctor-patient relationship. On Saturday the fish bowl was sacrificed in order to give the delegates more time to relax and enjoy the fine summer afternoon and evening in Tynemouth. After a long walk on the beach with our colleagues we had dinner at a quaint seaside restaurant listening and dancing to lovely music played by a local band. By the end of the weekend I felt nourished both physically and emotionally.



Relaxing listening to music at Newcastle.

**Sotiris Zalidis**

### **Balint Psycho-drama Group – a participant’s experience**

My first participation in a Newcastle Balint weekend took place in June 2014. At that time I was a little bit anxious, having to present the French Balint Society’s proposal for the 19th International Congress which was held in Metz in September 2015. Even if these were not the best conditions to enjoy a Balint weekend, I keep good memories of it. When I saw the timetable for the Balint events in the UK, I took the opportunity to ask Jane if I could come and join the Balint Society in Newcastle. Luckily for me she said ‘Yes, you would be most welcome!’

I must say that I was greeted in a very kindly and very friendly way. The organising team managed to create a very clear and secure atmosphere. We all felt the same in the Balint Psycho-drama group. It allowed us to work in total confidence with the leaders and the other members of the group. This was very important as it was, for most of us, our first experience of this approach.

At the beginning, wondering what I would be asked to do didn’t make me feel totally confident and comfortable. I knew that it would be something different from the ‘classical’ Balint group work and that I would have to do something with my body. I had only once been to a Balint conference in Belgium and participated in two sessions of a Balint Psycho-drama group. This time I had signed up to four sessions! I knew that I would have to speak, to think, to act. All things which are quite different from the ones I’m used to in a classical Balint group. I now realise that it forced me to leave my security zone, and that I felt much more exposed than in a classical Balint work.

First the rules were explained including each leader’s role, and what we could do to

work on the cases - the dubbing and the soliloquy. The different techniques the leaders could use were also explained. Once the frame was clearly set, came the traditional 'who's got at case?'

The first thing I could say about this experience is that it was very intense. As a presenter of a case I found it quite difficult to have many jobs at a time. I was a storyteller while presenting my case, and the next minute a film director choosing my actors. I am quite sure there is a lot to think about in the way the presenter chooses the participants to enact the scenes!. Just after that I was the script writer telling everybody on stage where they were, where they had to stand or sit, what they had to do and say. And at last I had to be an actor myself, in my own movie! Not only playing my own role but also changing roles to make the other participants/actors understand how I wanted them to act. It was really tiring for the body and the mind. On top of that, I had to share both stage and work with the leader in a very strange and intense way: the leader spoke a lot more than the leaders usually do during classical Balint sessions. It was as if he was also in charge of making the film with me. He could make suggestions, direct the actors, cut the scenes to make the actors rest and so on - quite a strange and unusual partnership.

I experienced different feelings during the sessions. As a participant it's not really comfortable to sit, knowing that the presenter may invite you to be part of his/her case. As a presenter, having to stand in front of all the participants and having to choose the actors is not comfortable either. We usually don't have this stress in a classical Balint group as we know that we won't have to play something in front of the others. It's also quite disturbing to have someone like the leader to direct you, to ask questions, and to organise the session in a very active way. At the beginning it could be perceived as a bit pushy or intrusive, especially when you are used to having a very quiet leader in a classical Balint group. There are a lot more interactions between the leader and the presenter in a Balint Psycho-drama. Reflecting now on this I don't remember exactly if I was physically touched by the leader during the session in order to place me where he wanted me to be. But I think that it could have happened. Funny to realise that the memories I have from the session cannot be as precise as I would like it to be: at least in my memories I was directed by the leader in this way - that it is as if I had been physically touched.

I also experienced a very strange feeling while I was re-enacting the case: I was asked to tell the participants what the patient had told me during the consultation. At first it was a total blank: I couldn't remember the patient's words. The very moment I put myself in the patient's shoes and sat on the chair to play his role, the words came out of my mouth easily. A very strange feeling to experience! During a different part of this session I was asked by the leader to explain what the patient had done. I was surprised by my reaction: I didn't try to explain or to describe it in words - I immediately acted it. I felt I had to use my body instead of words. It was obvious for me that showing in a very precise way by my gestures how the patient had acted would be much more enriching to the participants than a thousand words. At another moment I felt very reluctant to follow the leader's directions. At the moment I couldn't explain why, I just felt it in my guts. I apologised to the leader because I didn't want him to think that I wanted to disturb the work. I think that confidence was very important at this stage: he trusted me, followed my idea and we played the scene I wanted. At the end it appeared to be very useful for my understanding of the case.

It is also a very strange feeling to see how people swap places and play your role. Even if they are very attentive to what you have said or to the way you have acted, they don't repeat word for word and don't act in exactly the same way. There is an interpretation you cannot avoid. In my mind that has to be considered as part of the case.

As a presenter or as a participant it is very interesting and instructive to pay attention to all these elements. It is something that struck me while I was observing the participants in a previous session. So I felt obliged to observe the mimics, the actions, the gestures in addition to listening to the words. It was something very unusual for me, and I think that this added to the intensity of the work. I had this feeling that I needed to jump physically and mentally into the case work, that I couldn't stay on the side of the road. I think that it may be more tiring than a classical Balint group where you can more easily do a mental pushback, stay quiet with your own thoughts.

I am sure that the way we worked may have appeared a lot more disturbing to my British colleagues who are used to have a definite time to work on the case - usually 45 minutes. Many know that they will work on the facts first, then on the feelings while the presenter will be pushed back. It is something very formal and common in my experience of international Balint work. The French way is far less structured as we don't systematically use the pushback. We sometimes let all the participants and the presenter work on the case together in the same circle. So I was not disturbed by the method of free association of the thoughts we used during this weekend, as it is the way most of the groups work in France.

The main idea to have in mind is to notice that at the end of each group I always had the peaceful feeling of a well accomplished work. No matter the means we used it was always following the ground rules of Balint work. I think that once the rules have been explained to the group we all grabbed the method we were offered. A lot of us were used to classical Balint work but we were all very keen to try the Balint Psycho-drama. At each session a presenter had exposed themselves and their problems to others, in total confidence, and we had very seriously worked on it. Each time we had tried to understand the patient-doctor relationship, the doctor's problems and how we could help him/her understand what was going on. As a presenter the group work helped me to understand the relationship I have with my patients, what my role is, the way I can help them. And it worked. The Monday after this weekend, I saw the patient I had presented during the Psycho-drama group at my practice. It was clearer and quieter in my mind than what it was before my presentation. I didn't see him in the same way.

Another proof that we can still say : 'Balint group? Yes it works !'

**Jean Daniel Gradelier**



**A long walk on the beach at the Balint Newcastle Weekend.**

# The Implementation and Evaluation of a Trial Balint Group for Clinical medical Students

Jonathan Olds & Judy Malone

## 1 - Introduction

With the advent of the National Health Service (1948), GPs were removed entirely from inpatient care, resulting in their perceived loss of status and purpose. Under the influence of the Hungarian Psychoanalytical society, Michael Balint established seminars with general practitioners (GPs) in the early 1930's, exploring the psychodynamics of the relationship between patients and primary care physicians. Described as "*Training-cum-research*", the formation of "Balint Groups"; to study the doctor-patient relationship, provided a new sense of confidence and mission. As such, groups were adopted worldwide and the International Balint Society was established<sup>1</sup>.

The International Balint society describes the Balint method as "regular case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research."<sup>2</sup> The work of the original group of GPs, in Britain, under the leadership of Balint, led to the recognition of a number of features of the doctor-patient relationship; including the apostolic function of the doctor, the "doctor as drug" and the "conspiracy of anonymity and silence"<sup>1</sup>.

Traditional Balint groups consist of up to ten GPs, meeting on a weekly basis for a period of 90 minutes, with a trained group leader. The participants are offered the opportunity to reflect upon their work through patient case reports and group discussions, with the aim of enhancing members' self-knowledge and appreciation of transference and counter transference phenomena within a safe psychoanalytical environment<sup>1</sup>. Pinder *et al* declare that a main aim of Balint group work is to offer an opportunity to refine the initial emotional experiences with the aid of facilitated reflection<sup>3</sup>. Within Balint sessions, group members reveal inner experiences, feelings and their self-reflection to other members of the group. Discussions about feelings can make one more aware of their impact, thus enabling them to be analysed and understood. Balint recognises that emotions and feelings in clinical work can benefit patients, but only if they are tolerated, understood, and controlled by the doctor<sup>1</sup>. Recent work by Monrouxe suggests that understanding the process through which we develop our identities has profound implications for medical education<sup>4</sup>. Furthermore, Clandinin *et al* explored the efficacy of the parallel chart process – a narrative reflective process strategy, with American doctors in terms of the doctor-patient relationship<sup>5</sup>. Ten themes were identified, including the importance of taking time to engage in a collaborative narrative reflective practice process over time with colleagues. The study concluded that the reflective process employed has potential to foster the development of clinical skills.

In addition to competency in knowledge and skills, medical schools aim to teach elements of professionalism effectively<sup>6,7,8</sup>. Cruess *et al* suggest that teaching a cognitive foundation for professionalism is inadequate and that promoting professionalism may include support for self-awareness, maintaining a healthy balance between personal and professional roles, as well as exploring and resolving interpersonal conflicts in professional relationships<sup>9</sup>. Furthermore, recent work by Martimianakis *et al* concludes that a focus on individual characteristics and behaviours alone is insufficient as a basis on which to build further understanding of professionalism and represents a "shaky foundation for the development of educational programmes and tools"<sup>10</sup>. The question as to how best to promote emotional intelligence as part of medical curricula remains

unanswered. Do we therefore need to teach and learn these important skills in a different way? Torppa *et al* identify that the Balint method may be applied to support, and even facilitate these processes<sup>11</sup>; potentially through the provision of a safe space in which to express ourselves, and discuss and reflect on our work or practice.

Traditional styles of Balint groups have been modified in order to meet the specific participant needs. As reported by Salinky<sup>12</sup>, junior doctors have used Balint groups to discuss issues such as difficulties in relating clinical hospital training with the human aspects of general practice. Söllner *et al* report that students may present doctor-patient encounters and problems arising during their studies, rather than their own experiences with patients<sup>13</sup>. Key learning aspects for medical student Balint groups have been to gain further appreciation of the doctor-patient relationship<sup>14</sup>, supporting professional development, to help the process of conflict resolution and to validate identity<sup>15</sup>. Research by Kjeldman *et al.* evaluated experiences of doctors participating in Balint groups and compared them with those of non-participants. The study concluded that those who had participated had better satisfaction and a higher sense of control at work than those who did not participate<sup>16</sup>.

To our knowledge, only one qualitative study on student Balint groups has been published<sup>11</sup>. Torppa *et al* studied<sup>15</sup> student Balint sessions, composed of nine female medical students and grounded theory-based approach was employed, with thematic content analysis of field notes. Five triggers for case narrations were identified; originating from three distinct contexts. The study concluded that the context of case in student Balint groups was wider than in traditional Balint groups. Our study aims to build on Torppa's work by implementing a trial Balint group for male and female third year undergraduate clinical medical students studying at a UK university, identifying the key themes of discussion, as well as the triggers that prompted the discussion themes. Furthermore, we aim to ascertain the perceived benefits to medical students in attending, in terms of personal and professional gains.

## **2 – Methods**

### *2.1 - Organisation of the Balint Groups*

All third-year clinical medical students undertaking a clinical attachment at a Bristol (UK) hospital were invited, via email, to attend six Balint group sessions, of one hour's duration for a period of six consecutive weeks in 2011, led and facilitated by a psychoanalytic psychotherapist, with experience of running Balint groups. Students committed to attend in order to establish an authentic Balint experience and to generate feedback of the students' experiences.

Upon being granted ethical approval by the Faculty of Medical Education at the University of Bristol (UK), eleven students consented to participate.

### *2.2 - Materials*

Participant observations from all six student Balint sessions were based on the written notes of the participant transcripts made during and after each session by the group facilitator (group leader). Upon completion of the final Balint group session, the participants were asked to complete an anonymous multiple-choice, as well as written-response questionnaire to assess their experience of their attendance. The main author did not meet any of the participants, nor attend any of the Balint groups, in order to respect confidentiality of the participants and to avoid introducing personal bias.



### 2.3 - Data Analysis

A grounded theory-based approach<sup>17</sup> was employed to identify emerging issues and themes from the facilitator's transcripts. The iterative aspect of the approach, however, was not employed. Upon completion of the final Balint session, the authors systematically and critically appraised the transcripts, repeatedly returning to them and coded discussion issues from the data. The individual codes were subsequently discussed within shared reflecting sessions between the authors and the facilitator. During these sessions, ambiguities in coding were discussed and resolved. Contents of each category were subsequently analysed and thus organised into themes.

## 3 – Results

### 3.1 - General

Table 1 details the attendance for each Balint group session. There were various reasons for non-attendance, as illustrated in Table 2. During sessions consisting of only one participant and the facilitator, the participant was offered the option of attending and engaging in Balint work with the facilitator, which on each occasion, the participant accepted. Within the six sessions, nineteen cases were identified as being put forward for discussion, with an average of three cases normally being discussed during each session.

### 3.2 – Triggers and Themes of Group Discussions

The dynamic model of case discussion 'Trigger and Theme' analysis, first published by Torppa *et al.*<sup>11</sup>, was employed in order to evaluate the contexts of, and triggers for case discussion and has been used as the template for presenting the results of this study.

The analysis of group discussion from the facilitator notes identified three categories of perspectives on cases and group discussions (Figure 1):

- 1 - The cases derived from different contexts of students' lives.
- 2 - Different conflicting incidents from students' experiences triggered presentations of the cases.
- 3 - The cases produced various themes in group discussions irrespective of the context of the case or triggering event.

#### 3.2.1 – Contexts of Cases

Two contexts for cases were identified, most usually a "patient encounter" during the participants' clinical placement. Eleven cases were identified as belonging to this group. Traditional Balint groups accept only patient cases; however, due to the nature of the medical student experience, including anxiety-provoking situations encountered with academic mentors for example, it was felt necessary to accept other contexts. Eight cases originated from the context of "profession". This typically comprised unprofessional behaviour or attitudes of other medical professionals within the hospital (Table 3).

#### 3.2.2 – Triggering Incidents for the Cases Presented

The triggers for presenting cases were related to ethical questions, values, feelings, or difficulties within life as a medical student. The most common triggering factors were "*witnessing lack of professionalism & respect for patients/carers*", and "*initial patient impression*". The first trigger was related to experiences in which a student witnessed rude, humiliating or unprofessional behaviour of professionals towards patients/carers or students. The second emerged from dialogue relating to how patients initially presented themselves to medical students and left initial impressions such as "coping

well”, “resolved to the situation and amenable to students practicing clerking”, “angry” and “uncooperative”. “*Medical student role confusion*” was a key trigger within the Balint sessions, and involved students describing feelings of disempowerment at not having a clearly defined role within the hospital setting. This aspect will be discussed in more detail as this trigger appeared to evoke the most feelings, from the dialogue within the medical student cohort. “Value conflict” was a trigger in which the student experienced inner conflict between his/her willingness to help and the limitations set by the system. “*Upsetting patient encounters*” emerged from experiences that evoked empathy and sadness within the students, as well as feelings of unease, fear or disgust. It should be noted that such evoked feelings were as a direct result of the patient themselves, and not the scenario in which the patient was seen. The trigger of “*Non-concordance*” arose from student experience of patients who declined physical examination and/or history-taking; whilst the “*Unwillingness of medical professionals to engage in teaching role*” emerged from scenarios where medical students were not provided with an educational experience by a medical professional - for example a student approached a consultant and had asked to observe the ward round. The consultant angrily dismissed the student, without explanation.

### 3.2.3 – *Main Themes in Group Discussions*

The themes discussed in groups with the aid of cases may be allocated to six categories. Each topic was typically discussed in association with several cases. The number of cases refers to the information in Table 3.

#### 3.2.3.1 – *Medical students’ Lack of Role*

Medical students’ feelings of lacking a role within the hospital setting were identified as being discussed in association with four cases. This particular theme was discussed with passion, as the students felt disempowered to react to situations and requests by medical staff. Furthermore, such feelings of disempowerment resulted in the experience of certain behaviours by medical staff that the students deemed unprofessional, but felt unable to challenge due to their perceived lack of potency.

*Case example 1: A female medical student was left unattended with a male patient who suffered with gynaecomastia. The male doctor who was running the clinic asked the student to examine the gentleman and said that he would return. The student and patient were left unattended for a prolonged period of time.*

This was an uncomfortable and embarrassing situation for the medical student, who felt unable to challenge the doctor either before or after the encounter with the patient, as she felt unclear as to what her role as medical student should be. The student felt obliged to sacrifice her professional comfort in order to achieve a clinically useful experience, without the perceived ability to challenge this. On numerous occasions, it was noted that student participants would discuss feelings of “being in the way”, or “being just a student”, which seemed to have arisen from feeling unwelcomed and feeling “untitled” within the hospital environment.

#### 3.2.3.2 - *Respect of Patients*

Respect of patients was identified as a theme discussed within the context of five cases. All cases were based on examples of an exhibited lack of respect. Interestingly, when discussing witnessing such encounters, the students advanced the discussion and would discuss how their perceived lack of role within the hospital setting provided a sense of lack of potency to challenge such behaviours, although the desire to do so was there.

*Case example 2: A student asked a senior doctor on a ward whether they knew of a 'good' patient to clerk for the purpose of practicing history-taking and physical examination skills. The doctor told the student to go to see "this annoying patient".*

The student reported that not only did the encounter leave her feeling rejected; the doctor's remark left her feeling negative. This furthermore initiated discussion of negative role models in terms of the wish not to lose respect for patients and talk about people in such a manner.

### *3.2.3.3 - Negative Role Models*

Negative role models were identified as a theme discussed in association with six cases. Medical teachers' or doctors' unprofessional behaviour evoked particularly strong emotions among the students. They were seen as negative role models, to which the students did not wish to aspire, in terms of being a doctor.

*Case example 3: A student asked a consultant, prior to starting a ward round if he could observe. The consultant appeared outraged and responded "I am a consultant, what do you think you're doing?"*

The case not only provoked embarrassment within the student, but also feelings of concern. The group were very supportive of the student in terms of affirming this particular consultant as a negative role model, and therefore persuaded the student not to invest emotionally or professionally in the experience.

We believe, however, that it is important to note that this style of group discussion, especially over a short period of time, naturally facilitates the consideration of negative role models, instead of discussing the numerous positive role models that students expect and do indeed encounter within the hospital setting.

### *3.2.3.4 - Feelings Related to Patients*

Feelings related to patients were identified as themes of six case discussions, and were explored in terms of professional distancing versus empathy. The student participants all spoke of their realisation of their own emotions related to patient encounters. Interestingly, the student participants spoke of being surprised at their emotional responses to patient encounters and at times feeling "silly". Exploratory work was facilitated in terms of emotional awareness, but within the context of professionalism - an advanced concept for medical students, which was embraced with maturity and insight by the group.

*Case example 4: A student approached an "unhappy elderly male patient" who refused to allow her to practice a physical examination on him.*

In this case, the facilitator prompted discussion regarding being courteous and respectful to the patient, as well as how to deal with the situation where a patient declines a student encounter. The discussion developed into how this encounter had emotionally affected the student, and made her feel sad in the acute phase, and then surprised and silly upon reflection of the episode. Central Balint concepts of transference and counter-transference were introduced by the group facilitator as crucial bases of the doctor-patient relationship.

### *3.2.3.5 - Constructing Professional Identity*

Constructing professional identity was identified as a theme discussed in association with five cases. Interestingly, all cases discussed were based on negative role models and the students' will to non-identify with such attitudes and behaviours as doctors. Conversations regarding constructing professional identity were not, however, exclusively

driven by such exposure. Issues of dealing with emotions and lack of student role also fed into discussions of professional identity construct.

*Case example 5: A student was asked, by a junior doctor, to request a nurse to organise a radiograph and blood tests for a patient.*

The student described feeling neither empowered nor authorised to assume this role, which prompted discussion regarding when this would change - “at what point does the student have the potency to request action by nursing staff?” The student discussed feelings of embarrassment regarding taking authority and directing people. The facilitator prompted discussion relating to “how we might want to do it as a doctor”.

### *3.2.3.6 - Making Assumptions and Judgements about Patients*

Making assumptions and judgements about patients was identified as arising from seven case discussions. Judgements made regarding how patients become ill were discussed at length. As well as considering the students' inner conflicts regarding NHS utilitarianism and “revolving-door” patients, the issue of self-harming patients prompted many of the discussions. An interesting observation of the group involved one student having particularly strong feelings in favour of potent, disempowering control of such behaviour. The group challenged this in a sensitive manner, which led to the dilution of the student's tone, which even became “pro-patient” upon completion of the case discussion.

*Case example 6: A student encountered a patient who was on dialysis, with concomitant multiple-organ failure. The patient was also severely visually impaired. Despite his condition, the patient was jovial, highly amenable to students and very “matter-of-fact” about his health status.*

The facilitator prompted the discussion as to the importance of looking beyond one's own first impressions - a key Balint practice. Consideration as to whether the patient was genuinely happy with their situation or whether it was a defence/coping mechanism led on to discussions regarding grief and denial, making assumptions, acceptance, and the importance of these issues.

### *3.3 – Trial Student Balint Group Evaluation*

Of the eleven student Balint group participants, ten responded to the evaluation questionnaire. Table 4 illustrates the cohort desire to continue attending Balint groups either as a medical student, or once qualified. Of the ten students, two would wish to continue at a lower frequency, for example once monthly. Students were less definite in their response to the question of whether they would wish to continue Balint sessions upon completion of medical school. Issues such as perceived time-constraints and medical discipline choice were provided as reasons for the uncertainty.

Table 5 outlines the student perspectives in terms of their outcomes from attending the Balint group, including aspects of the Balint sessions that the participants felt challenging. The results are discussed within section 4.

## **4 – Discussion**

Building on the work of Torppa *et al*<sup>11</sup>, this study not only evaluates the themes of Balint discussion, but also the student experience from attending Balint groups. The triggers and themes of case discussions compare well to those described by Torppa *et al*<sup>11</sup>. A particularly interesting outcome, and an objective for future work would be to compare the triggers and themes of third-year medical student Balint groups with those of earlier and later years of medical education, and even foundation-year doctors.

Interestingly, the dominant discussion theme from the group “*Making assumptions*

*and judgements about patients*” was not elicited in Torppa’s study, and it is therefore important to consider the impact of the facilitator’s experience when analysing the group work. The hypothesis that the group facilitator’s specialism and interests influence the group discussion themes remains to be studied. The theme of “*making assumptions and judgements about patients*” also facilitated discussions regarding transference and counter-transference; which were noted to have been discussed with maturity, insight and emotional intelligence.

The theme of students feeling they lack a validated role within the hospital setting was discussed with passion within the group, and this theme also provided a basis for the themes of negative role models, constructing professional identity and respect of patients. By challenging the perceived lack of medical student role, and furthermore working to validate the medical student role within the clinical setting, perhaps greater professional satisfaction may be adopted and better learning outcomes achieved. Recent work by Dornan *et al*<sup>18</sup> concludes that “to reach their ultimate goal of helping patients, medical students must develop two qualities. One is practical competence; the other is a state of mind that includes confidence, motivation and a sense of professional identity. These two qualities reinforce one another”.

We believe in acknowledging the limitations of this study. The recruiting strategy of invitation via email is likely to attract students particularly motivated to reflect upon their feelings. Whilst this is inevitable to the workings of all Balint groups, we feel this should be acknowledged. We further acknowledge this study recruited a small sample size with low attendance in some sessions. Further research would be warranted in order to ascertain as to whether this is a measure of interest among ‘hard-pressed’ medical students, who may find themselves prioritising clinical exposure and other aspects of student life over attendance of a reflective Balint group. As the concept of Balint methodology is ill-understood amongst undergraduate medical students, a lack of interest should also be considered. Whilst existing UK medical curricula promote the concept of reflective learning and practice, perhaps a greater awareness of the methods to facilitate such concepts would improve recruitment and attendance at Balint group sessions.

Owing to the nature of the clinical placements and student timetabling, only six Balint groups could be facilitated. Longer-term groups would enable more in-depth study focusing on how situations were resolved within the Balint group and how the skills gained were put into practice. Furthermore, we feel it would be interesting in the longer term for the group to be followed up to see if there was any objective benefit in participating; i.e. on future mental health or ability to cope with the stresses of a medical career, as well as how they approach their own doctor-patient relationships.

It is important to acknowledge that this transcript represents a limited “slice” through the clinical student experience, and that whilst negative experiences were predominant in discussion, this may be attributed to the fact that the Balint group ran for a limited period of six weeks. Balint group members will often report that the ‘real’ work of the group is enabled by building trust and openness through consistent membership over time. It is indeed common for longer-running Balint groups to create a safe-space to air negative experiences and to reflect on these, but according to the Balint methodology, longer-term groups facilitate problem-solving and the chance to air techniques that work well, as well as highly positive encounters<sup>1</sup>. Of the ten responding students, nine feel that they would wish to continue Balint sessions throughout their undergraduate medical career. Table 5 illustrates that four of the ten responding students felt intimidated to share thoughts or feelings within the sessions. If the groups were to have continued, consistent membership over time may have enhanced trust and openness

within the sessions and a follow-up questionnaire may have reflected this with a lower proportion reporting intimidation. It is important to acknowledge, therefore, the differences between what may be discovered in six sessions versus an established Balint group.

Thought has been given to the potential costs involved if Balint groups were to be implemented for all University clinical medical students. If one considers not only the benefits in terms of supporting medical students and enhancing their training, but also the preventative benefits in potentially identifying students who may be experiencing problems whilst active on the course; to the extent of identifying those who may even be unsafe as doctors; the benefits may be viewed as outweighing costs of implementation. A detailed cost analysis would provide further information regarding such hypotheses. As well as being beneficial to student health, and possibly reducing the burden on existing student support and health services, such a scheme may also prove useful in selecting students for careers in psychiatry. We recognise logistical difficulties in implementing such a scheme, facilitated appropriately within an already full-time student clinical timetable. With this in mind, it is important to state that Balint groups require members to prioritise attendance, or groups do not work, or die out. To be successful, the Balint groups would need to be accepted, owned and implemented by the medical school as an important training activity; in order to reinforce elements of competency, knowledge, skills and professionalism through reflective practice and understanding of the doctor-patient relationship. As well as the recently published core-skills required by the General Medical Council (GMC) in order to be deemed as competent to practice as a foundation doctor<sup>19</sup>, professional capacity needs to be recognised as including not only practical skills, but also all that Balint can provide; including its potential to recognise those unsafe to or not suited to become doctors.

The implementation of the trial medical student Balint group has been a highly satisfying experience, providing not only insight into potential modifications to the teaching/learning environment of clinical medicine, but also providing students the opportunity, space and skills to self-reflect, gain confidence in group dynamics and understand their role as medical students. As well as providing apparent catharsis, the Balint process aims to promote mental and professional well-being to the group participants. All responding students expressed that attendance of the Balint groups increased their ability to share experiences and opinions professionally with peers. Six students stated that the groups increased their ability to reflect; with five students feeling greater affirmation in their role as medical students within the hospital setting. Furthermore, the process has affirmed the participants' responsibility in creating healthy doctor-patient relationships, in order to ultimately become better doctors.

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### **Declaration of interests**

Both Dr J. Olds and Dr J. Malone have an interest in Psychoanalytical psychotherapy, medical education and supporting doctors.

Dr J. Malone runs Balint groups for GPs, psychiatrists and mental health workers both privately and within her work for Avon and Wiltshire Mental Health Partnership trust.

Dr J. Olds is an undergraduate medical student at the University of Bristol. Neither Dr J. Olds nor Dr J. Malone have financial associations with any party who may have interest in this work; nor have done over the previous 36 months. No external funds were received in order to fund this project and the study was approved by the University of Bristol Faculty of Medicine and Dentistry Committee for Ethics (FCE) in May, 2011.

### **Contribution of authors**

Both Dr J. Olds and Dr J. Malone were involved with the concept and design of the study; as well as the analysis and interpretation of data. Dr J. Olds drafted the article, with intellectual input and revision from Dr J. Malone. Both authors approved the final version for publication.

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# **Where teaching meets therapy: an exploration of the experiences of General Practice trainees participating in Balint group discussions**

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## **INTRODUCTION**

The primary purpose of a Balint group is to 'examine the relationship between the doctor and the patient, to look at the feelings generated in the doctor as possibly being part of the patient's world and then use this to help the patient'. (Balint 1964). Typically, a group of doctors meet and discuss patient encounters in the presence of a leader trained in the method. Clinical details are avoided and attention is given to the story of the encounter and the emotions it arouses in the participants, with the goal of facilitating new ways of understanding the physician– patient relationship (Kjeldmand 2008).

A typical group has between 6 and 10 members, with 1 or 2 leaders (usually a psychologist). The success of the group is contingent upon the active participation of each member, both as presenters and discussants, but it should be noted that “free association” (Balint 1957) is desirable, and the participant should report “as freely as possible” (Balint 1964); active participation is desired but is not coerced. The technique is widely used in General Practice training in Ireland and the UK (Kjeldmand 2004, 2008). Though it appears to enhance psychological medicine skills (Das 2003), active participation (as presenter or discussant) is variable within groups (Moreau 1972, Nease 2007).

## **Rationale**

The Balint technique is widely employed by general practitioners and though there is some evidence to suggest that it may not be universally popular (Smith et al 2007), it has, broadly, been a successful endeavour in General Practice (Lustig et al 2006, Kjeldmand et al 2004). The Balint technique has also been adopted as a form of professional supervision and as a pedagogic instrument. This has evolved incrementally, and literature defending its use as such is paucе. Most of the extant literature concerns the identification of commonly discussed themes (Torppa et al 2008), the prevalence of its use, its apparent benefits (Nielsen et al 2008, Margalit 2005, Lelorain et al 2013), and practical aspects of its execution. The experience of the Balint facilitator (or “leader”) has also been examined (Johnson et al 2004, Kjendmand 2010). Unfortunately, there is little evidence examining the experience of the group participants, particularly where Balint is used as an undergraduate or postgraduate educational tool and ceases to be a truly voluntary enterprise. Many trainees will abandon the Balint group after completion of training (Johnson et al 2003). The reasons for this are not known, but it further highlights the need for a robust examination of the personal experiences of participants in this particular setting.



### **The use of Balint groups in General Practice**

The Balint technique is widely used in General Practice in the UK and Ireland (Kjeldmand et al 2004, Johnson et al 2001). As a form of professional support and development, Balint groups appear to be unique, as they focus on understanding the dynamic of the consultation rather than offering solutions to problems that may arise (Lustig et al 2006). Balint participants are more patient-centred (Kjeldmand et al 2006), appear more resistant to burnout and compassion fatigue (Nilesen et al 2009, Lelorain et al 2013), and appear to “thrive” more in their careers through better control of their work situation and improved self-reported emotional and psychological intelligence (Kjeldmand et al 2004). In all, Balint groups appear to be a “gentle efficient method to train physicians, but with limitations” (Kjeldmand et al 2010). Balint groups also serve as a means to aid professional transition (Shorer et al 2011), and serve in part as a tool for examining the psychological processes at play in the consultation (Brock et al 1999, Granek et al 1996), including examining and modifying the physician narrative (Rabin et al 1999).

So, Balint appears to be of benefit when employed by qualified GPs and family practitioners. There is some disquiet, however. Participation in Balint groups appears to wane with time (Johnson et al 2001), and Balint leaders frequently deviate (Merestein et al) from the original model as described at Tavistock (Balint et al 1964). Group membership is also frequently dynamic rather than static (Edgcumbe 2010). Indeed, a move towards a post-Balint model incorporating more clinical supervision has been proposed (Launer et al 2007). And while the themes discussed at groups are known, along with some of the outcomes, the individual experiences of group participants have not been examined. In addition, the foregoing cited research relates specifically to qualified general practitioners and family physicians; the body of evidence relating to GP trainees is much less. Finally, qualified GPs participate in Balint groups voluntarily. The situation in the setting of undergraduate and postgraduate training is, as we will see, quite different.

### **The use of Balint groups in other medical and psychiatric residencies**

Balint has been adopted by psychiatry as a means of examining the patient-doctor relationship but also as a pedagogic instrument. In the UK and Ireland, psychotherapy training is mandatory (Royal College of Psychiatry 2010) and Balint is frequently used as an introduction (Fitzgerald et al 2003). A very limited examination of the experience of psychiatry trainees undergoing such mandatory training is reason to give pause. Trainees had “an over whelming anxiety to have a patient ready” and described “increasing desperation in those whose unofficial ‘turn’ was coming up” (Das et al 2003). In general, the use of Balint groups in psychiatry training seems to be worthwhile and rewarding, with the caveat that outcome measures are often qualitative and do not examine specific trainee experiences (Graham et al 2009).

Balint has also found its way into oncology residencies and appears to reduce burnout in that particular cohort (Bar-Sela et al 2012), with commonly identified themes including challenges in communication with patients, patients’ relatives and other physicians (Salander et al 2014). Balint has also been used in obstetrics and gynaecology; a study by Adams et al claims that “six months of (mandatory) Balint training was successful in providing resident education in professionalism”, again illustrating how very far from Michael Balint’s original model we now are and how elastic the term “Balint group” has become (Adams et al 2006).

### **Balint in postgraduate GP training**

The extant literature focuses predominantly on outcomes, that is, whether trainees

seemed to benefit or not (Scheingold et al 1980, Keith et al 1993). Data concerning rates of Balint use in US and UK residency programs are also described (Brock et al 1990); interestingly, the use of Balint groups attenuates significantly after physicians graduate from residency, though the reasons for this trend are not identified (Johnson et al 2003). Indeed, Salinsky (though a proponent) observes that “junior doctors have not signed up to do Balint .... they have had Balint thrust upon them by enthusiastic course organisers” (Salinsky et al 2006). And though most course directors seem to agree that Balint is a good idea, no one seems to have asked the trainees.

## **Conclusion**

The individual experience of the postgraduate GP trainee Balint group participant has not been examined. This constitutes a deficit in the literature and has significant implications. By using the Balint approach in our training programs, we subject our trainees not just to (what has become) a pedagogic method but also to a form of psychotherapy. A doctor would not, one hopes, prescribe a treatment and not ask the patient for informed consent or, if the patient has already taken the treatment, how it made them feel. Were there any side effects? Do you feel any better? Our colleagues in psychiatry strike a cautionary note (Das et al 2003) and we in postgraduate GP education would do well to more fully explore the experience of our trainees.

## **METHODOLOGY**

### **Research setting and aims**

The study was conducted within a single General Practice training programme in the northwest of Ireland. The study aimed to:

1. Explore the individual experience of the general practice trainee participant in Balint groups
2. Examine the educational benefits of Balint group discussions as identified by general practice trainees
3. Examine general practice trainees' views on future participation in Balint groups

### **Research design**

The research was framed within the interpretivist paradigm and a Husserlian phenomenological approach was employed (Burrell 1979). Semi structured “inter-views” (Kvale 1996) were employed. The interview guide approach was used to provide reliable and comparable data. The target number of interviews was six. The research design was feasible within the time and resource constraints of the researcher and the sample population. Data collection continued in an iterative fashion until theoretical saturation was achieved.

### **Issues associated with use of methods**

#### ***Ethical issues***

The ethical implications of the research were examined using a four-layer model after Seedhouse et al (Seedhouse 2008). Informed consent was obtained from all study participants. The local hospital committee granted research and ethical approval.

The study was, to a degree, insider research. From the consequential perspective, it was performed for the beneficial outcome of a particular group but also for the personal benefit of the researcher. As qualitative data was obtained, and the methodology included interview methods, there existed the potential for deductive identification. The researcher

employed reflexivity throughout data collection and analysis, self-critiquing and self-appraising as the process evolved.

### **Logistical issues**

The study sample (six trainees on a postgraduate GP training scheme in the northwest of Ireland) was proximal to the researcher and informed consent was obtained for all interviews. Access was granted following negotiation with the scheme directorship. No financial or other inducement was offered. A schedule of interviews at mutually convenient times for the subjects and researchers was arranged. Recording equipment was purchased and tested. Data were stored on an encrypted hard drive, which was in turn stored in a locked filing cabinet in a secure location. The first author performed data transcription and analysis, and received supervisory academic support.

### **Validity and reliability issues**

The methodology was valid as a means towards examination of the research question. After Cresswell, the qualitative paradigm is defined as “an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting” (Cresswell et al 2009). The research examined a human problem requiring an exploration of the detailed views of the subjects. Thus, the paradigm is valid and the “phenomenon of interest unfold(ed) naturally” (Patton 2001). The results of the study, however, should be considered within the interpretivist paradigm only.

Semi-structured interviews were used as the single mode of data collection. Qualitative or mixed methods were not felt appropriate, as qualitative methodology would have failed to generate sufficiently rich data to identify and examine complex phenomena.

### **Piloting**

Two pilot interviews were carried out. The first interview was of an informal conversational nature. Marked instability was encountered, with both researcher and subject straying “off topic” and exceeding the allotted time of one hour; the technique was consequently rejected. In the second interview a semi-structured interview approach was utilised, and, though less flexible, resulted in a much greater proportion of “usable” data. As the resources and time of the researcher were limited, this approach was felt to be preferable as a compromise between adequate data generation and more pragmatic constraints.

### **Data analysis**

Data were transcribed by the author from audio recordings of interviews. Six- phase thematic analysis after the model described by Braun and Clarke (Braun et al 2006) was then carried out *viz*

Phase	Result
1	Familiarisation with data during transcription
2	Start code generation
3	Search for themes
4	Reviewing themes
5	Defining and naming themes
6	Producing report

Note that the process was recursive, with movement between phases permitted as necessary. The Braun and Clarke model was selected for its ease of use, coherence and consistency.

TAMSAalyzer software was employed as a workspace for data interpretation.

## **RESULTS AND ANALYSIS**

### **Preamble**

Six (6) general practice trainees were interviewed. All subjects had participated in Balint groups as a part of postgraduate education and training. Each trainee was a member of a Balint group comprised of GP trainee peers, with a static membership, meeting at least monthly. The groups were facilitated either by a psychologist or general practitioner. Each subject had also participated in psychiatry-run Balint groups during the psychiatry component of their training. The groups in this latter case were non-peer based, contained members with varying levels of professional experience, and were facilitated by a consultant psychiatrist. Subjects were recruited from each of the four years of general practice training.

### **The personal experience of trainees in Balint groups**

#### ***Group factors***

Interviewees reported a generally positive experience in the Balint group. An adherence to the Balint structural framework was viewed as an important determinant of a positive experience. Interviewees cited informality and a lack of structure as a barrier to active participation, and to learning. The Balint structure allowed the more reticent members of the group to speak out more readily; conversely, loss of structure permitted the emergence of so called “louder voices”. “Veering off” off was cited as the most common problem in the functioning of the group, that is to say a situation in which the group loses focus on the presented case and discusses instead extraneous issues; these were often clinical or personal matters, which one interviewee described as

*“... less psychologically challenging ... sitting around for an hour and chatting is a lot easier and a lot less mentally intrusive than considering what one has done and objectively thinking about decisions and hard choices” (Int 4)*

The change from a structured into an unstructured group sometimes occurred with the tacit agreement of the participants and facilitators viz

*“I think it can get diverted and I think that’s what can be frustrating about Balint, that you can go off on stories that aren’t related to the issue ... it needs to be very well structured and well supervised” (Int 6)*

Time was viewed as an important contributing factor to how groups functioned. In general, the interviewee experience improved with the passage of time as peers became more comfortable with each other and with the Balint structure.

*“I probably didn’t say anything in year one, probably halfway through year two started talking out loud ... whereas now that I know them a lot better I’m more comfortable” (Int 2)*

On the other hand, the perceived need for Balint waned over time as the group members improved in their coping strategies and developed as clinicians. Variable membership of the group was also an important factor in the trainee experience; in general, having at least one other peer in the group was viewed positively. A mixture of more junior and more senior members was also viewed with favour, even if this variability of group membership caused psychological discomfort. The usefulness of groups with

invariable or minimally variable membership waned with time due to a lack of new voices or views. All interviewees expressed discomfort at the idea of not having a peer in their Balint group.

The issue of rota systems for case presentation was also explored. Some interviewees expressed discomfort with a rota system, citing psychological stress before and during viz

*“I would have been nervous for the whole morning and not settled until I’d done the Balint.” (Int 1)*

Interviewees also commented that rotas can lead to the presentation of so-called “bad cases”, or cases that yielded little in terms of group discussion and predisposed to “veering off”. This was most commonly seen in circumstances where a trainee was scheduled to present a case but had not encountered a scenario they considered sufficiently complex to warrant group discussion. In all, a greater degree of flexibility in the scheduling of case presentations was viewed as desirable.

### **Peer factors**

Having one’s peer group also be one’s Balint group (and vice versa) was generally viewed as a very supportive and positive contributing factor to the trainee experience. Most subjects cited trust as a key factor to their participation viz

*“There’s a big element of trust in Balint ... you have to be able to trust the facilitator and trust everyone else at the table” (Int 4)*

This peer group / Balint group duality made participants more likely to contribute to the group and led to the development of a support network both in and out of the Balint setting. Cases or issues discussed in Balint groups were often discussed by members prior to and outside of the Balint group:

*“We tend to Balint a lot amongst each other as a group anyhow, even outside the training scheme” (Int 3)*

*“A lot of our Balint stuff would have been discussed outside the Balint group” (Int 5)*

However, this peer / Balint group interplay had a few unintended consequences. Balint group discussions occasionally changed how interviewees viewed their peers, sometimes with consequences for social dynamics outside the Balint group. Disagreement or dissent within the group was limited by peer / Balint duality; sometimes this also led to perceived false reassurance of peers or withholding of criticism by peers for reasons of personal loyalty viz

*“You’re never going to give your full opinion, especially if the other person is wrong ... you can over sympathize or empathize, or give false support to somebody ... you shouldn’t be praised for not performing to the best of your ability or to the standard required” (Int 6)*

Indeed, one subject reported a more favourable personal and educational experience where the other group members were effectively “strangers” (Int 4).

In addition, participants were observed by interviewees to use the Balint group as a means of debriefing after a stressful event, particularly where formal debriefing had been unavailable or inadequate.

### **Facilitator factors**

Interviewees viewed as crucial the ability of the facilitator to maintain a coherent group structure; poor maintenance of structure and loss of objectivity by the facilitator were viewed as problematic. Most viewed the role of the facilitator to be an educational one

and some suggested that general practice trainees should train as facilitators or act as co-facilitators on a rotating basis.

### ***Personal factors***

Some interviewees described feeling judged or expressed a fear of being judged by other participants. Participation in Balint sometimes caused anxiety and a sense of vulnerability, particularly where the group was not comprised of peers, and where a rota for presentation was in place. Interviewees cited the presentation of cases where they had “done something wrong” (Int 5) as the most likely to provoke such anxiety, partially for fear of personal reputational damage.

Interviewees also described a decline in the personal need for Balint groups over time, usually attributed to advancing experience, coping skills and resilience. Balint was viewed as a support group as well as a means towards understanding the patient-doctor relationship, and interviewees described an improvement in their understanding of self with Balint group participation. Though none of the interviewees felt coerced to participate, some appeared uncertain as to whether they could opt in or opt out of the process, whether it constituted a mandatory part of training, and whether explicitly stated consent to participate was necessary.

### **Educational experience of trainees**

#### ***Perceived benefit***

Peer learning was cited as the most important educational component of Balint groups. Interviewees used Balint as a means of comparing themselves to peers in several domains, including clinical skills, communication skills, and in managing consultations.

*“It tells you where you are amongst your peers” (Int 3)*

All interviewees reported an improvement in reflexivity and in their understanding of the patient experience, the physician experience, the doctor-patient interaction, and the experience of other health professionals, including nurses. A greater understanding of empathy and the interplay of clinical and emotional aspects of the consultation were also described viz

*“I think you understand a lot more about human dynamics ... it gives you a whole new empathy” (Int 5)*

*“It did make me think more about why I did certain things ... it made me consider what I had done and what implications the decisions I had made carried” (Int 6)*

The perceived determinants of education benefit included how well-structured the group was, whether the group contained friends and peers, the availability of “good” cases, and variable membership, that is, the involvement of persons with multiple grades of seniority or levels of experience viz

*“... we would benefit from having people in the group that had been there and been out the other side ... who could say “this is what we went through as well but this is how we found things and this is how it applied differently to us” as opposed to “we’re all going through this at the same time” (Int 4)*

Some limitations were encountered, mostly attributable to the duality of the peer and Balint group- most interviewees described “holding fire” in the dissection of a case out of personal loyalty to the presenter, sometimes with attendant false reassurance. The tendency towards unstructured groups and loss of learning opportunities was also described in this context.

### ***Knowledge of and perception of the Balint model***

Most interviewees viewed Balint, not unfavourably, as lying at the intersection of education and therapy. No trainees had knowledge of Balint groups prior to the commencement of GP training, and though some had benefitted from limited formal instruction in the model, most were unsure if they had sufficiently understood it viz

*“We know f--k all about Balint ... and there’s probably quite a lot to know about it” (Int 1)*

*“No one is a born Balinter ... an educational session would be good” (Int 5)*

### **Views on future participation**

Several conditions of, and barriers to, participation in Balint groups subsequent to the completion of training were described. Adherence to group structure was again cited as an important factor, as was peer participation. In fact, some subjects viewed Balint participation after graduation as a means towards social networking and support in the absence of a readily available peer group. Barriers to participation included practical considerations (time and distance limitations), fear of judgment and reputational damage, and the competitive nature of general practice after completion of training viz

*“Among established GPs, there’s a lot of watching each other’s turf ... I’d imagine it’s a lot less lovey-dovey than in GP training, where we’re not really competing against each other in any form” (Int 1)*

*“I could see the benefits of doing it but I suppose I’d need to get to know the group a little bit more before I’d be very comfortable” (Int 4)*

## **DISCUSSION**

The Balint group represents a unique learning environment; trainees described significant educational benefit from participation. This was predominantly a social phenomenon – trainees learned most by comparing their experiences, and each other. Empathy was enhanced and the experience of both the patient and doctor more fully explored and understood. The effectiveness of the Balint group was dependent on a number of factors, not least the presence of peers, which contributed significantly to the psychological ease of the trainee participant.

What the trainees actually experienced in-group was at odds with the classical description of the Balint process. The groups were malleable; clinical discussion sat alongside analysis of the patient-doctor interaction; objective dissection of a case sat alongside psychological support and debriefing. As Torrpa asserts (Torrpa, 2008), the Balint group can be a flexible entity, and trainees can guide its evolution to fit their needs. However, too much flexibility can be detrimental, as evidenced by the assertion of most of the subjects that loss of structure in the group and veering off towards unrelated subjects can make Balint a less rewarding personal and educational experience. The role of the facilitator is key here.

The observed duality of the group as both peer and Balint group is perhaps the most intriguing aspect of the study and lends to the examined collective both its greatest strengths and greatest weaknesses. Trainee peers in the Balint group, as they moved forward together, developed a profound sense of trust that allowed them to exchange closely held intimacies; herein lay the “good” cases, from which fruitful discussion might flow. The Balint group appeared to actually contribute to the social development of the peer group, and vice versa, with subjects engaging in informal “Balinting” outside the structured environment. The Balint group was also a surrogate support group for many

members, where difficult cases and experiences could be discussed in confidence and where debriefing could take place. In relation to participation in Balint groups after completion of training, most subjects expressed a desire that at least some of the proposed group be friends and peers, and cited this as a key determinant of future engagement.

Such intimacy has its downsides. The peer dynamic led in many cases to an unwelcome informality, a loss of group structure, a loosening of boundaries, and the phenomenon of “veering off”. Here, the usual precepts of social dynamics supervened, leading to the emergence of “louder voices” at the expense of more reticent members of the group. Additionally, participation in Balint groups, particularly in the rotating role of the presenter was not without psychological stress; the “overwhelming anxiety” identified by Das (Das2003) is well exposed here.

In summary, the trainee Balint group represents a unique social and learning entity, lying not only at the intersection of education and therapy, but also at the crossroads of socialisation and peer support. Though structure is key to an effective learning and personal experience, limited flexibility of the group structure is required to facilitate so many interweaving strands; it is clear that the development of a distinct model of the Balint group geared towards the unique needs of the trainee community is required; *ar scáth a chéile a mharamid*<sup>1</sup>.

### **Boundaries and limitations**

Selective sampling was employed as a practical necessity, shaped as it was “by the time the researcher has available to him ... and any restrictions placed upon his observations by his hosts” (Schatzman 1973). Time and resources in this case were limited. A purposive convenience sample of six GP trainees proximal to the author was selected.

The study was limited by several factors. The sample population, though valid, was limited to a single GP training scheme in the northwest of Ireland. Thus, the study was somewhat limited ethnologically. The study is descriptive only and does not provide for the generation of an explanatory theory. Finally, the author was a novice in qualitative research, although reflexivity was maintained.

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## President's Report 2016

It's an exciting time for Balint in the UK. Balint groups are being started in many medical schools for medical students and in hospitals for FY doctors, and in September 2017 we will host the International Balint Federation Congress in Oxford.

The medical student work is based on an initiative by the RCPsych, with the Balint Society as an advisory voice. We are providing a lot of leadership training and supervision for the new leaders, recruited from the ranks of junior psychiatrists, who experience Balint groups as a compulsory part of their core training. This is making the society focus on leadership training, mostly amongst psychiatrists and therapists. Leadership groups are part of all four annual Balint weekends, and there are also at least 8 training days round the country, spaced through the year. Unfortunately there are very few GPs seeking leadership training, or seeking Balint groups as participants. The weekends are made up of about half and half GPs and non-GPs, and the society membership is similar in proportion.

How will we encourage GPs into Balint work? Can an organisation be very influential, or just be present when the time is right? In psychiatry there were social changes pushing for increased psychological awareness, as opposed to medication, which favoured change over the last 10-15 years, and there were some prominent voices for Balint work in their college. What of the RCGP? This year's annual conference rejected a presentation of Balint work as had been done this year at Wonca in Istanbul, and in 2014 at the RCPsych International Conference in Birmingham. However, there will be a couple of Balint related sessions dealing with Balint work in care homes, and using Balint work to think about the end of one's career. Will the combination of more young doctors experiencing Balint at medical school, and in their junior training, and the probable lengthening of GP training, prove a potent mixture over the next few years, if we keep up our profile? I think the volume of work being done in the society, as described in the Regional Reports, are good evidence of the current strength and increased prominence of our work.

On the international scene this year, many of us went to the 2015 IBF congress in Metz, France. Ceri Dornan and I in October presented at Wonca in Istanbul. I have been to Austria and Germany to national meetings, and will go to Armenia in July, and, along with many others, to the International leaders meeting to be held in September in Warsaw the weekend after our Oxford weekend (9-11 September). Ceri has also been to Hungary this June and re-established links with the Hungarian Society.

Our IBF congress, September 6-10, 2017, is entitled "Balint Theory and Practice: Exploring Diversity". We last had an IBF Congress here in 1998. We will have papers, workshops, and groups thinking about diversity in terms of race, religion, gender, and sexuality, but also the differences in Balint work with different professionals at different stages of their training in the groups, and in different countries and continents. We hope to be able to bring all these things together, expanding and enriching Balint work worldwide.

**D Watt**

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# Annual Reports from around the regions in England and Wales

## London and the South East

### **Weekends and leaders training days**

The year started as usual at Corpus Christi College with the Oxford Balint Weekend, from 2nd to 4th October, with the theme “Reflection in Action”. Ceri Dornan gave the keynote address. Eighty one people attended, including thirty Icelandic GP trainees, who come every two years as part of their training programme. The next London event was the Balint Study Day and Dinner on February 5th at the Medical Society of London, organised largely by Dr Jane Dammers. There were fifty people on the study day, and also fifty for dinner in the evening, when the after dinner speech was given by Professor George Freeman. The next day we held the third Supervision Study day at the Swiss Cottage Hotel for accredited leaders who are offering supervision to those on the accreditation pathway. Another leaders’ study day in London on June 10th 2016 was well attended, led by David Watt and Helen Sheldon.

### **GP Balint groups**

Three ordinary GP Balint groups continue in London and one in Brighton. There is also a special ongoing group at the PHP (Physician Health Partnership), led by Andrew Elder and Anne Tyndale. There are groups operating in several GP Vocational Training Schemes (VTS), and three operating within large general practice partnerships. The Society has also delivered taster sessions to various GP VTS schemes in South London and to some Trainer groups.

### **Medical Student and Foundation year groups**

There is a blossoming growth area in groups for medical students, with projects starting at Barts and London Hospitals (Amy Jabreel and Tom Stockman), Kings (Barbara Wood and Eamonn Marshall) and in North West London (Anne Patterson), as well as the long-standing groups at UCL. Training leaders for some of these schemes has been supported by the energetic Bristol group who have developed medical student Balint groups in Bristol, and the Balint Society. These are part of the Royal College of Psychiatrists initiative to increase psychodynamic work for medical students - Helen Sheldon, Ceri Dornan, Ami Kothari and Judy Malone are members of the RCPsych working party on this.

Foundation Year groups continue at Newham University Hospital run by Paul Julian and David Watt, and there is also a new start for this at UCL, led by Amy Jabreel and Helen Sheldon.

### **Peer supervision group**

Indirectly supporting all the work in London and the south east there continues to be the Balint Group Leaders Workshop which meets three times a year at the Tavistock Institute, co-ordinated by David Watt. It usually has 8-12 attendees who work hard on a presented group, to help the presenter, and further understand group leadership issues. It is advertised in the Journal and on the website and anyone can email David Watt to join the mailing list

**Dr David Watt, [david.watt@nhs.net](mailto:david.watt@nhs.net)**

# North West

## Leadership

A good network of people interested in Balint work and particularly in group leadership is building up in the NW of England. There is also a growing cohort in Liverpool, which is encouraging. Helen Sheldon and Ceri Dornan have run a half day leadership workshop in Liverpool, liaising with Simon Graham, a Medical Psychotherapist there. Helen and Ceri also ran a one day leadership workshop in Manchester in April, attracting a number of new people who hope to, or already run a variety of groups - for medical students, CMHT, ward staff in psychiatry, GPs and psychiatry trainees. A second leadership workshop is now being planned for October 2016.

Caroline Palmer co-leads a psychiatry trainee group with Phil Brown, Medical Psychotherapist, in Preston; and similar groups are run in Blackpool by Swapna Kongara and in Blackburn by Alison Summers and Guz Singh .

Those who are currently leading a group meet for peer supervision two or three times per year.

## Balint groups in the community

Two GP groups continue in South Manchester, while Caroline Palmer & Laura Fisk are holding two taster sessions in Nelson, Lancashire in the early summer, with the hope of forming and launching an on-going group for clinicians in practice from September.

Ceri Dornan and Mark Evans, Medical Psychotherapist ran a taster Balint group in a large GP practice, though there has been no follow-up so far.

If you are interested in joining or starting a group in the north west of England, please contact Ceri Dornan, [ceri.dornan@gmail.com](mailto:ceri.dornan@gmail.com), Caroline Palmer, [cazpalmer54@hotmail.com](mailto:cazpalmer54@hotmail.com) or Sally Wraight, [philsal.wraight@btopenworld.com](mailto:philsal.wraight@btopenworld.com)

## Vocational Training Schemes

Simon Henshall, a Manchester GP currently training as a Balint leader, has introduced some Balint sessions into the Salford VTS scheme. Esme Towse, a psychotherapist, is involved in Macclesfield, part of the Liverpool VTS, although the number of sessions has been reduced.

## Medical students

There is some Balint activity in the medical schools at Manchester, Liverpool and Lancaster, with the intention to increase this, following outreach from the RCPsych working party, which aims to encourage all UK medical schools to introduce psychotherapy schemes including Balint groups. Sally Wraight and Phil Brown are involved in some of this work.

## The Spring Balint Weekend Workshop

This year following Boxing Day flooding at our perennially preferred venue Whalley Abbey, we were very lucky to re-book our weekend at short notice at another comfortable characterful venue, The Oaks Hotel in Burnley, built by a tea merchant and known locally as Taypot Hall. There were over thirty of us who had travelled from far and wide, including Glasgow, North Wales, Brighton, London, Cambridge, Sheffield and even from India just for this Balint weekend! We had a great mix of GPs, consultants, counsellors, psychotherapists, analysts, a mental health midwife and four medical students, who

agreed that we all benefitted from the cross-fertilisation of ideas and rich mix of working cultures. The numbers attending and their stated preferences allowed us to meet in three groups, one of which was a leadership group. We enjoyed some free time on the Saturday afternoon, when people were able to relax in the hotel spa, visit Towneley Hall, the local stately home, or go off for a walk in the hills and moors near Haworth. The plenary was positive in its feedback, and all agreed that it had been a stimulating and yet refreshing weekend.

Next year, floods being in abeyance we hope we will meet once again at Whalley Abbey, 31st March to April 2nd 2017 and have booked the Abbey again for Spring 2018 too.

**Dr Caroline Palmer cazpalmer54@hotmail.com**

## **North East and Yorkshire**

### **Balint Weekends and Leaders training days**

We held our first Balint weekend in Leeds in November 2015, offering ordinary Balint groups and two leaders' workshops. It was well attended by more than fifty people and Weetwood Hall proved to be a good venue, we enjoyed dinner in the lovely Jacobean dining room on Saturday evening. Alex Pavlovic was responsible for much of the administration and did a fantastic job along with colleagues from Leeds and Sheffield, and supported by those from Newcastle. It was encouraging to see a lot of local people, with lots of new faces and considerable diversity. Esti Rimmer and Dave Morgan gave a joint presentation on Friday evening, and John Salinsky showed a film 'Partie de Campagne' directed by Jean Renoir on the Saturday afternoon provoking a lively discussion. We experimented by having two goldfish bowls as large numbers can create difficulties with hearing and participation.

Most of our experienced leaders are now accredited and we have not run any leaders' training days this year in the region. There are a number of new people training to be leaders. We continue to provide supervision and supervision groups to those interested in becoming accredited. One new development has been Skype supervision with a leader in training in Karachi in Pakistan and an ongoing supervisory link with a trained leader in Athens who is helping some other colleagues to begin to think about training. Also, there is an ongoing group in Dublin for the Irish College of Psychiatrists which is generating potential leaders with a consistent experience of Balint in Ireland which may influence psychiatric training throughout the country. If you would like supervision with your group contact Gearoid Fitzgerald in Leeds gearoid.fitzgerald@nhs.net or Jane Dammers in Newcastle jane.dammers@ncl.ac.uk

See the website for dates of the north east peer supervision group.

This year the Balint weekend will be held in Newcastle in June with the theme 'Balint and the Body' – an area we feel is often overlooked in our work. We have booked a conference venue and asked participants to make their own arrangements re accommodation, in an effort to keep down costs. It will be interesting to have feedback on this model.

### **Balint groups in the community**

Four groups continue to thrive in the north east, mainly involving GPs, but also consultant psychiatrists, a gastroenterologist, counsellors and a CPN working with people with

disabilities. We would like to start a new group for newly-qualified GPs. It has been harder to make contact with GPs in the Leeds area but we are keen to try to develop these links and establish some GP groups.

There are foundation and core trainees groups in Leeds, Bradford and in south west Yorkshire. In Leeds there is an ongoing SpR group with members from all psychiatric sub-specialities and one in south-west Yorkshire for SpRs in forensic psychiatry. Lucy Buckley and Richard Duggins continue to run the Balint group for Psychiatry trainees in the NE region, and Lucy and Chris Brogan have started a weekly group for foundation doctors during their psychiatry rotation. This is part of a pilot project for a year – we hope it will continue.

In South Yorkshire there is a group for clinical psychology trainees with one trained leader and one leader in training. This group has to fit in with the DClinPsy timetable and is relatively short-term. Sadly, the Balint component of the clinical psychology course in Newcastle has been scrapped. Esti Rimmer, Christina Blackwell and others were involved in these groups for many years, and have written about them and the good feedback they received. It is a huge loss.

### **Links with other organisations**

We were again asked to deliver Balint groups on two separate days for trainers at the north east annual educators' conference. The focus was on the trainer-trainee relationship using the Balint method to explore this. Most participants were enthusiastic about this approach, though there are always some sceptics.

The North East Sessional GPs asked us to present Balint at one of their monthly educational groups. After a brief introduction we ran a Balint group, with some people observing. One of the doctors brought a very moving case and there was plenty for the group to get into. Our local groups have proved popular with sessional GPs – those who do locum and out of hours work. They often face very difficult and emotional situations and may never see the patient again. A Balint group can provide a space in which to process some of their experiences.

In Leeds and Bradford we are now running groups for medical students on their psychiatric placement. This allows new group leaders to work with a more experienced group leader and work towards accreditation. There is regular supervision built in. It follows the successful Bristol model and we were grateful for their generosity in sharing their expertise with us. Technically it is quite difficult to run a short-term group and I think it will be interesting to hear how this develops. James Johnston, one of the group leaders, is leading this development for the RCPSych.

We approached Newcastle Medical School about introducing Balint in to the curriculum. We have yet to find a protagonist within the medical school and our approach was met with politeness but not a deal of enthusiasm. Newcastle has a satellite medical school in Malaysia and we were told whatever we proposed would need to be exactly replicable in Malaysia – quite a challenge. There may be an opportunity for a small pilot project.

**Dr Jane Dammers [jane.dammers@ncl.ac.uk](mailto:jane.dammers@ncl.ac.uk)  
and Dr Gearoid Fitzgerald [gearoid.fitzgerald@nhs.net](mailto:gearoid.fitzgerald@nhs.net)**

# Bristol

## **Psychiatry Trainee led Balint group scheme for Medical Students and Foundation doctors**

This scheme, which started in 2012 by Dr Ami Kothari and Dr Judy Malone, is now in its fourth year. The scheme has grown and expanded over this time. All 3rd year medical students at Bristol University had the opportunity to participate in groups once again this year. Sixteen Psychiatry trainees, from CT1-ST6 grades, led sixteen groups, which repeated twice over the year. Trainees have access to regular supervision with Dr Judy Malone. We are pleased to welcome Dr Melanie Woolgar as an additional supervisor from April this year. Drs Eva Stigaard-Laird and Clare Trevelyan have joined the senior management team and run additional peer supervision.

In 2015, 3 pilot Balint groups for Foundation doctors were run by trainees as an extension to the medical student scheme. This year, Dr Eva Stigaard-Laird is leading the expansion to the pilot, with 6 groups being run with the support of our local Foundation School. The scheme was presented at the International Balint Congress 2015, and will be presented at the International Association for Medical Education (AMEE) this year. We have joined the RCPsych Medical student Psychotherapy scheme working group who are looking to increase Psychotherapy and Balint experience for medical students in the UK. We are also part of an Australian working group with similar aims to increase Balint group provision for medical students in Australia and New Zealand.

We have been awarded funding from Health Education England and RCPsych. We have used the funding to share our model and link with interested psychiatry trainees across the UK. We have linked with the Balint Society to run training events for trainees in Birmingham and London who are in the process of setting up schemes similar to ours.

## **Leadership training**

Trainees involved in our medical student scheme attend biannual leadership training co-run by Dr Judy Malone and Dr Jane Dammers. The trainees leading the scheme additionally receive supervision from Dr Jane Dammers. The scheme continues to give psychiatry trainees the opportunity to develop their group leadership skills, with some working towards and achieving leadership accreditation through the Balint Society. The first Bristol Balint leadership study day was held in December 2015, in conjunction with the Balint Society and Medical Education AWP. The event was well attended and we are holding a further study day on Friday 2nd December 2016 along with a morning presentation by Dr Gearoid Fitzgerald on Saturday 3rd December - see website for further details.

## **Groups**

There are numerous Balint groups that continue to run across Avon and Wiltshire Mental Health Partnership Trust. Judy Malone continues to lead a longstanding Balint group for more experienced GPs in Bristol. There seems to be interest in and around Bristol for further groups to develop.

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# Midlands

## Leadership

There has been an increase in interest across the region about accreditation for Balint Group Leadership. The second Birmingham workshop on Leadership training was held in late April in the historic Foxglove suite at the Edgbaston Golf Club. This was once the residence of Dr William Withering, discoverer of Digoxin from foxgloves. The workshop was facilitated by Esti Rimmer, Bitty Muller, Gilly Cooper and myself, Shake Seigel. It was well attended and we now have a number of applicants on the pathway to accreditation in the region. There are clear signs of growing interest in Balint in the region.

## Groups

A number of groups are running in the Midlands.

1. The Telford group is now well into its second year and well supported. This mixed group of GPs, Palliative Care consultants and psychiatrists meets monthly. Facilitation is by Shake Seigel, assisted by Diana Webb and Tammy Ratoff. The venue is Shawburch Medical Centre and meets monthly. This group could possibly accept new members.
2. The longstanding Burton-Lichfield- Tamworth group still meets monthly after 33 years. Facilitation is done in rotation by members in private homes.
3. Two Birmingham groups continue to meet regularly. One in Central Birmingham being facilitated by Sylvia Chudley, and another in the south of Birmingham facilitated on a rotating basis by members.
4. Sandwell Hospital has started a new group, facilitated by Diana Webb. This group consists of mixed hospital specialities.
5. Palliative Care Group: trainees and new consultants have continued to meet as a group in private homes.
6. A new group has just begun in Nottingham and is being facilitated by Bertram Karrasch. This group is open to new members.
7. A "skype" group of former GP trainees from the region still exists. This is a creative alternative for young GPs who have chosen to stay in touch by skype, following a short series of introductory groups run by Bitty Muller and Shake Seigel. Geographically they are now scattered across England.
8. Birmingham University Medical School has introduced groups during psychiatry attachments and community health. These are being facilitated by Isabelle Akinojo and Helen Campbell.

A couple of new groups are about to begin in Birmingham. If you are interested in either of these groups please contact Shake Seigel, [shake.seigel@btinternet.com](mailto:shake.seigel@btinternet.com)

- A. Mixed speciality group being offered by Sylvia Chudley and Debbie Williams.
- B. Another mixed group, but mainly drawing from the West Midlands Institute of Psychotherapy (WMIp) membership, will begin in July initially meeting at the Friends Meeting House in Edgbaston and facilitated by Shake Seigel.

## Peer Supervision

With the increase in numbers of people applying for accreditation as leaders, the seed of

an intention to form a peer supervision group has been planted. With luck a peer supervision group will start up within the year in Birmingham. Watch this space!  
Dr Shake Seigel shake.seigel@btinternet.com

**Dr Shake Seigel GP shake.seigel@btinternet.com**

## **Wales**

The monthly Wrexham Balint group restarted in May with GP Dr Ann Evans as leader. The group has comprised GPs so far but we are hoping that a Community Psychiatrist and a Counselling Psychologist will soon be joining the group. The termly Dyffryn Clwyd GP Vocational Training Scheme Balint group continues, co-led by Linda Mary Edwards, Group Analyst and GP Dr Ann Evans. The latest group was well attended and excellent cases presented.

Some colleagues from south wales who are interested in leadership training attended a leadership day in Bristol and we hope there will be an ongoing connection with the Bristol group.

For further details please email Dr Ann Evans [evansann@live.co.uk](mailto:evansann@live.co.uk)

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# Balint across borders: a weekend conference in Hungary June 2016

Ceri Dornan, Retired GP, Balint Group Leader

My husband plays bassoon in the European Doctors' Orchestra (EDO) and I was looking forward to hearing the next concert in Budapest. Then, through a Hungarian contact in the orchestra I found myself not only with an invitation to the annual Hungarian Balint Weekend but also to speak. This meant I could extend my visit to ten days; all very exciting. It then began to sink in that I was going to Michael Balint's own country AND speaking to Hungarian Balint enthusiasts.



Fortunately I have been to several International Balint Federation conferences and know that there is more that binds people from Balint Societies in different countries than divides them. As a correspondence developed with Katalin Dobó, a GP, conference organiser and now President of the Hungarian Society, I could already feel a sense of connection and warmth, which was realised on reaching the conference venue in Erd, on the outskirts of Budapest.

The conference was held in the calm and restful environment of the Regina Mundi Abbey, an order of Cistercian nuns who survived the Communist years by functioning in secret from within the community, until the ban on religious orders was lifted. The Abbey has guest rooms and catering by the sisters, using their home-grown produce. Those of you who have attended the Spring Balint weekends at Whalley Abbey in Lancashire would appreciate the setting.

The Magyarországi Bálint Mihály Pszichoszomatikus Társaság, or Hungarian Michael Balint Society for Psychosomatics, was founded in 1990, although a Psychosomatic workgroup using Balint group methods had been functioning since 1960. The name reminds us of the importance that the Balints placed on consideration of the mind and the body. At that time it was not possible to use the name Balint in the title for political reasons. The current membership is multidisciplinary within health professions and interested in the application of the Balint



method in other professions, such as teaching. It is an outward looking organisation, with interest in how the Balint theory and method fits with other methods of case analysis. Our Societies share the challenge of encouraging busy and overworked professionals to allow themselves time to think about their work, but in the UK we do not have the additional pressure of an economic situation in which such professionals are poorly paid and have little to

spare for membership subscriptions or conference fees.

About forty people attended, mainly Hungarian, with some Hungarian speaking Balintees from Romania. English speakers were very attentive to my needs for translation and a future psychology student, Balazs, had been delegated the task of being my ears. Though recognizing few words, it was easy to feel included in the spirit of the occasion and enjoy the rhythm of the language.

The conference format was very familiar, with large and small groups, a couple of talks and social time, though we were worked hard. The large groups, which we call a fishbowl, followed a model of the outer group being able to comment on the case and the inner group's work, part way through the case. There wasn't time to talk about this compared with the UK model, where the outer group is silent until the end of the case, then discussion is about the process rather than the case. I wonder if the latter is more helpful to those new to Balint in growing to understand the Balint model? For future debate I think.



One small group was English speaking, both for my benefit and to allow others to practise, with future international meetings in mind. Out of four groups, I co-led two, with a young psychiatrist, Kinga. It felt just like home, in terms of cases presented, leadership and the nature of the discussion. Kinga thought my leadership style was a little different, in inviting speculation about specific aspects, but this may be more to do with my style rather than UK specific.

Sunday morning was devoted to two group demonstrations. The first, which I joined as a member, was a Balint group combining talking and art. We began with a period of meditation, to help us to access a 'feeling mode'. A case was then presented and clarifying questions allowed. Rather than start with discussion, we were asked to use paints to express our feelings in reaction to the story, and to cover the whole of a blank canvas on the table in the middle of the group. We then could describe our feelings, in particular to what was on the canvas, so reacting to what others had contributed. The next phase was to glue materials chosen from trays in response to the discussion. A final phase of discussion took place with the presenter back in the group. The presenter reported that she had come to realise that she, as well as the patient, was stuck in the emotion of the case, which involved a mother whose son had disappeared; maybe a suicide, or an escape from a difficult situation. She planned to show a photograph of the finished work to her patient. New to the method, we were quite restrained and respectful of other participants' creative space. There was more similarity of emotion than difference and I wondered what a canvas would look like where a case evoked very different emotions. However, as a way of accessing our emotional responses it was powerful. Palma has a GP group which uses this method and she is hoping to achieve recognition of the model.

The second demonstration group was led by Andor Harrach, the former president of the Society, using something called Integrative Casuistry. A casuistic, or case-based approach combines theoretical principles with factors of the individual case and has been promoted as a more holistic development of evidence based medicine. In this group setting, a case was discussed under specified headings, which included medical, social, therapeutic aspects as well as the more familiar relational aspects of Balint. For a description of the method I refer you to the English section of the Hungarian Society

website (<http://www.balinttarsasag.hu/english/>). The discussion was fast moving, so hard to translate in detail, but group members seemed to be struggling to use the method as written rather than a Balint method. It was the end of an intense weekend, but a reminder of the value of looking at other approaches to understand the position of one's own.

This is a Society wanting to grow and move forward with a broad vision. The commitment and passion was palpable. There were a good number of young members there. It was a stimulating and collegial weekend. From what I have learned about Hungarian persistence in the face of adversity, during visits to museums in Budapest going through the country's history, I think this Society will thrive. They expressed much gratitude for me attending, but I would say that I came away with more than I took there, especially in human terms. I would strongly encourage you to attend Balint events in other countries, in the knowledge that Balint work transcends language differences.

My thanks go to those who attended the weekend for their kindness, patience and friendship and especially to Kati, for the invitation.

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## **A Week in Armenia, July 2015**

I landed at Yerevan international airport at 3:30am on Tuesday morning, a little tired, though I had had dinner in Vienna airport with friends during the stop over. I was very pleased to find 2 young students there to meet me and put me in a taxi to my hotel (literally we were put up in the boutique hotel "Myhotel").

Why was I there I was still thinking? Anzhela Avagimyan had approached me after the February London study day and asked me if I would come to a conference she was running called "Balint Movement and Emotional Burnout" in Yerevan, the capital of Armenia. I had decided to go as long as I would not have to pay a conference fee, but before I knew it, Anzhela's email said they would be paying everything, including my airfare! Further e-mails after I accepted indicated I would need to present a report (needed in advance for translation into Russian), run one large demonstration group, and lead an ongoing small group. I understood that several German Balinters were going, including Gunther Bergmann and Guido Flatten, and my old friend Vladimir Vinokur from St Petersburg. I imagined I was to set the scene of current Balint work in the UK and perhaps highlight, in practice, the differences Anzhela had seen at our London study day. Armenia, though independent, leans heavily towards the Russian Federation, and Balint work there has been largely influenced by the German Balint society who have worked hard with the Russians. Anzhela, though she lives in Moscow, is Armenian and has brought Balint to Armenia. She has started a Balint group experience and leadership training in the education of psychologists at Yerevan State University. No medical doctors are currently involved.

I had Tuesday to myself, spent at a local swimming pool in the 35 degree heat, reading and mulling over what I was going to say in my prepared report, whether to read or adapt it. Wednesday proved the start of the legendary Armenian hospitality. Most of the foreign attendees were taken on a tour of Yerevan, including the Matenadaran-the collection of ancient manuscripts, and the Blue Mosque, the only one left in Yerevan, recently restored by the Iranian state. The next sight was the Armenian Genocide Memorial, a moving modern construction, allowed by the Soviet regime. We all laid roses at the eternal flame. We then were offered lunch, mostly salads, fresh vegetables and roast meat, on the way to Echmiadzin. This is a city close by, which is the home of Armenian Christianity, with a cathedral and several other churches. In the evening the invited

leaders went with Anzhela to a party given by one of her friends. It was a child's birthday party on a rather grand scale with music and dancing. Eventually we got to bed...

The conference started in earnest on Thursday morning with a report or paper session. There were actually 25 Germans present but the conference languages (in which the conference book was printed) were Russian and English for the paper sessions, with excellent interpreters for Russian/English. In the small groups there was also a German/Russian translator. Three papers were about burnout theory and prevention from Gunther Bergmann, Galina Makarova and Aysa Berberyan. The final one was by Guido Flatten and was a report of his large research project on questionnaires delivered immediately after Balint group participation with some interesting conclusions, soon to be published, hopefully in our journal and elsewhere. Groups seemed to have more effect on younger doctors, on somatic doctors and on women. Also there appeared to be no difference between compulsory and voluntary group participation. We were then whisked away by bus to Lake Sevan, a very large natural lake at 1900 metres, about 50k from Yerevan. We got onto a pontoon and they started to serve lunch. To everyone's amazement the pontoon then set off across the lake. After lunch we landed below a monastery and had about an hour to visit it. Then we returned to the boat which had been changed into the stage for a demonstration group, with 2 circles and numerous microphones. It was led by Professor Vinokur and co-leader was Anzhela. A young Armenian psychologist presented a depressed woman who wanted a very active therapist which irritated him a lot. The group talked almost exclusively about their feelings in what seemed to me a rather abstract way. The presenter was allowed back in for about 5 minutes in the middle and then excluded again till the very end. The group worked well despite the slow process of translation of everything into English as it was said. This left room for thought and worked well throughout the weekend, though it meant one could only possibly have one case per 90 minute session.

Friday began with the first small group session, after which we all piled onto coaches for another excursion, first to a small monastery near the foot of mount Ararat by the Turkish border, then to a marvellous sculpted monastery in the mountains, surrounded by cliffs. Justly are the Armenians proud of their religious heritage! After a BBQ in the open air, in a mountain pass by a rushing stream, we got back on the bus to go to an apricot orchard where I was to deliver my report and lead a large group. As we got off the bus, the weather seemed to be set for a major storm, with clouds and rising winds. Not perturbed, the team set up benches in a large group formation and a sound system powered by a small portable generator-never mind the mountain river rapids- just next to us. In case we got rained out, Anzhela asked me to postpone my talk and just do the group, which we did. I co-led with Anzhela and the style was English with presenter out for about one third of the time, and back in for the later discussion. The use of roving microphones plus translation was new to me but as a leader gave a good deal of time to think, not to intervene, but also to try to show a more down to earth kind of Balint group. The case, from another Armenian psychologist, was rather like that on the first big group. The therapist was being drawn into the relationship between his patient and his live in girlfriend in an over active way. There were some profound bursts of emotion from various members of the group.

My small group went on over Friday, Saturday and Sunday with 5 meetings. The members were one psychologist from Russia, 3 Armenian psychologists, one psychologist from Kazakhstan and 4 German doctors (therapists, occupational health doctor and GP). They chose to have an ordinary Balint group, rather than a leadership type group. Even though run in a way different to that which all the participants were used to, they found

it helpful and of great interest. There was a safe space for some very dramatic cases: anorexic twins working in a “ministry” in Berlin, a woman of Armenian birth but living for many years in Belgium and suffering from bipolar illness seeking skype psychotherapy with an Armenian psychologist in Yerevan, a government lawyer in Germany whose ex-military husband committed suicide by hanging himself 2 hours after talking to her on the phone, a psychology student in Kazakhstan who admitted to paying someone to write an important paper, and then complaining that her mark was not high enough, and a very successful gay professor in Germany suffering from anxiety symptoms after getting his new department with 42 members of staff.



In the last two sessions the 3 Armenians sat out as observers to give them this experience which they found very useful for their leader training.

Saturday morning was small groups, followed by a couple more reports, including mine about what we are doing in the UK, and the necessity of different ways of running a Balint group for different participants. In the evening was the “conference dinner”. It was held at a huge restaurant complex on the edge of Yerevan and, with a floor show, dancing, singing, eating, and was a great success.

We were back at work in small groups on Sunday with finishing speeches about 13:00. Finally, we then went on our last excursion, to the monastery of Geghard, a mystical grouping of churches, partly hewn into the rock of high mountain cliffs. Lastly we descended to Garni, where there is a spectacularly simple Greek temple in a deserted mountain landscape. There followed more banqueting, outdoors in a family house, run as a restaurant – a very happy end to a wonderful few days.

Lastly, back to “MyHotel” for a few hours sleep, before waking at 2am to go to the airport for the 4:30am flight to Vienna. Back in London, at about 9am Monday morning, I could barely believe it had all happened. A wonderful, warm, rigorous Balint experience, in a country I had never expected to visit, and I will probably be going in the summer of 2016 for another dose!

# Report from the Balint conference

(Les Journées Balint) in Annecy May 3-7, 2016

by Henry Jablonski

L'Association Internationale du Groupe Psychodrame Balint, AIGPB is a member society of the International Balint Federation, but differs from all other member societies of the IBF by being an international organisation in its own right. It is Francophone, gathering participants from France, the Wallonian part of Belgium, Switzerland and Quebec. But you will also find odd participants from other countries with a strong Francophone tradition, such as Italy, Spain, Serbia, Portugal, Romania.

The Balint Conference of Annecy - Les Journées Balint d'Annecy - is organised by the AFB (Association de Formation Balint) composed of members of the Association de Relaxation Psychoanalytique Michel Sapir (AREPS) and of the AIPB. Its origins derive from a Balint group started by Michael Balint in the German part of Switzerland, and inspired Michel Sapir, a French psychoanalyst, to start Balint group intensives in the French-speaking part of Switzerland. The first seminar took place in 1972, in Divonne, (a small town not far from Geneva) and later moved to Annecy. Initially only doctors participated but today the conference is open to all kinds of care-givers: nurses, social workers, psychologists, midwives. Little by little from the mid-1980s on, the importance of the Balint psychodrama increased and the representation of the AIPB in Annecy became more important and influential. The method was developed by Anne Caïn, a psychoanalyst and a friend of Michel Sapir. All early psychodrama leaders were experienced leaders of "classical" Balint groups and members of the SMB (The French Balint Society).

Annecy in the French Savoy, less than an hour by car from Geneva, is a lovely city with its older parts situated on the estuary of a little river which flows into the lake Annecy with its crystal clear potable water surrounded by a tiara of majestic snow-glittering low Alpine ridges and peaks.

The conference moves between four different settings/techniques

- - The large group sessions
- - The Balint small group
- - The Balint psychodrama group developed by Anne Caïn
- - The Psychoanalytic relaxation - developed by Michel Sapir

Working intensely on clinical cases for four full days in large and small groups, makes for a very intense and inspiring experience.

I learnt from the organisers that the Annecy conference had its ups and downs. At its peak it would gather 100-150 participants, falling down to some forty some years ago. A recovery is taking place. This year saw approximately 80 participants - some 55 "regulars" and a core team of some 25 - the leaders of various activities and senior observers (leaders themselves) who play a significant role in the large group work, which occupies half of the scheduled activities of the conference.

The conference is preceded by a preparatory meeting for the 25 odd core team members, a leader's conference. Most members of this most international crew have worked together for many years and are very comfortable and open with each other. As an International Balinter I recognised the similarities in the "extended family kind of" - relatedness from IBF meetings. I felt included from the very beginning of the meeting where my position as an observer of every aspect of the congress work was defined.

The preparatory meeting aims at reflecting on last year's conference and to trim the



team for the intense upcoming four days. Four texts had been distributed beforehand to the leaders. I will mention two of them: one, written by a French psychoanalyst, A. Missenard, was a pertinent theoretical discussion of what a Balint group is and does. It would be worthwhile translating this paper to make it available to a larger circle of non-Francophone Balint leaders.

The second paper was a transcript of the recording of one of the large group sessions of the previous year. This allowed for critical reflection on the group process, the leadership, the case and the presenter. You discover many new things when you have the opportunity to do this kind of renewed retrospect in-depth inquiry. It seemed to me a very good way of preparing for the coming days. As the leaders meet after the conference end to evaluate and sum up, they also decide on which one of the eight large group presentations will be transcribed and discussed at their “kick-off” meeting the next year. The IBF has a lot to learn.

All the four days of the conference had the same structure: in the morning two large group sessions, after which the group of leaders and observers immediately convened to discuss what had been going on. This meeting also reviews the previous day’s concluding large group session and small group work, particularly if problems had occurred.

In the afternoons during the conference participants are offered two sessions of a small group of *relaxation psychanalytique Sapir* 90 minutes, and/or a small 120 minutes’ Balint psychodrama group. The majority of the participants take part in only one of these activities.

After that followed a Balint group for 1 hr 15 min (all afternoons).

The group size of all these small groups was 2 leaders and 10-12 participants.

The day ended with a large group gathering where rather than discussing cases, the participants would discuss and digest their experiences of the day.

The two morning large group sessions lasted 1 hr 15 minutes each. One case was presented in each of them.

Stage setting: Two group leaders and five empty inner circle chairs; three concentric outer circles to house all the 75 participants of the conference. Two microphones directed by the two leaders were passed around through which all comments had to be made (good for structure and transcripts!). None of the other leaders and senior observers was allowed into the inner circle. Everyone who takes an inner chair is expected to be prepared to present a case. But the one who first jumps at it will be allowed to present without further inquiry. Though the discussion of the case starts in the inner circle, it does not develop distinctly into a working group in itself. The boundaries with the outer circles are vague, as I perceived it. From early on the the microphones move freely between the inner and outer circles. To me the inner circle seems mainly to have a ritual and emotional purpose of creating an “inner holding body environment” for the presenter. I would think that during a session about 100 questions are raised and the presenter answers every second to fifth of them. The leaders participate quite actively in this collective inquiry into the case. The majority of the interventions are in the form of questions directed to the presenter. I was curious and actually a little worried about how the presenters would manage such a bombardment. On the whole it worked well thanks to the “arglose/friendly” atmosphere and the sincere clinical interest expressed in the interrogation by the participants. But you could see that at times it was too much, intellectually and emotionally, to digest for the presenter. I was then fascinated how the other leaders and observers in the outer circle spontaneously intervened, addressing issues that brought relief to the presenter and the entire group and allowed for more space to speak and reflect from a different angle. I would think they acted as spontaneous

auxiliary leaders and that it worked because the core psychodrama people know each other and share the responsibility for the conference collectively.

As said, as the morning sessions end, the leaders and observers convene for an odd hour to discuss everything that has taken place primarily in the large group work. Any problems in the small groups will also be discussed. I raised the issue of “bombardment” of the presenter which might block him, as opposed to having an exchange between a lot of people, which could be more productive. I could sense that this was well taken in this open-minded group. One of the leaders immediately asked: “What would you have done?” This was a bit of a parallel process with me as the presenter. I answered that I would rather stick to my own impression rather than posing a question, i.e. by saying: “I feel that the presenter is feeling very lonely and exposed in what he has told us” and be keen to know what others were thinking about it. “I think you are too keen to try to cure the presenter all the time”, I added. This comment elicited friendly laughter.

In the afternoon the participants could choose between *Balint psychodrama* or *relaxation psychanalytique Sapir* for 2 or 1.5 hours, respectively. This was followed by a 1 hour 15 minutes Balint small group work and ended in a one hour large group session - a summing up of the experiences of the day and with the same setting as the large group morning sessions.

The Balint psychodrama group, which has been presented and demonstrated at several International Balint congresses, aims at enacting very specific clinical situations in order to re-examine the clinical encounter and the patient in the group with the purpose that this exploration will bring about a deeper understanding of the entire doctor-patient relationship. Of course picking the adequate situation is crucial and very much depends on the animator's/leader's intuitive and experience-based understanding and preconception (Vor-vorständnis - fore-understanding to use a meta-scientific hermeneutic term) of the core of the case. The leaders divide the task between them very much as we are used to in the IBF settings – one active and the other one more withdrawn, listening and commenting “in depth”. The presenter starts telling about the clinical situation but soon enough the active one of the animators gets involved in a dialogue with the presenter. This gives you as a group member or observer a feeling that the presenting doctor literally enters into his surgery accompanied by the animator (Dante and Virgil comes to my mind). The setting is described in detail; the presenter will pick members of the group to act the role of the patient, a staff member, other patients in the waiting room etc. The scene evolves gradually involving other members of the group and the animators/leaders being able to share their impressions by “dubbing” i.e. you raise and stand behind one of the protagonists and verbalise (make a soliloquy) what you imagine might consciously or pre-consciously be going on - a thought, a feeling affecting the consultation i.e. “Hm, that doctor is not so stupid after all” or “I wonder what this patient wants out of me. I am out of my depth”, into “I think he is drinking too much. I will have to address that” to the patient's reaction “Yeah, he nailed me, why can't he leave me alone and just prolong my inscription on the sick list? .....but he seems concerned, I see no malice or contempt in his face”. (These illustrations are fictional).

Those who had presented cases in the evaluation at the end of the group work – both the Balint psychodrama and the small Balint group – appreciated the way the group had worked. The presenters were relieved and felt they had a calmer and more comprehensive understanding. I was asked to give a comment as the observer.

With the psychodrama group, I pointed at one crucial issue for the understanding of one of the cases: that the particularities of the referral, which seemed important, had not been addressed as it was outside the scene so to speak. The presenter recognised this

as did the leaders and the group. This triggered additional comments about a couple of other important transference and counter-transference issues that had been left open-ended. It seemed as a constructive way summing up and accepting that you cannot do everything in one session. However, just mentioning what is missing makes a difference.

With the “regular small Balint group” I commented that to me it seemed like a *psychodrama Balint group without the psychodrama part*, and that it also imitated the pattern of exchange of the large group sessions. The presenter thus became the target of inquiry and, to my taste, far too much involved/enmeshed, rather than allowing the group members to interact and discuss the case so that a hypothetical clinical multi-faceted body of thought and feelings be allowed to rise in the middle of the room for the presenter to digest and comment. The leaders took a very active part in the inquiry, and also their didactic and interpretative input was more extensive than I see with many other Balint group leaders including myself (though I hardly can be criticised for refraining myself from teaching and preaching). I also said, that to my mind, too much energy was spent on understanding the case, i.e. the patient and his natural environment, rather than the interaction between the doctor and the patient and the counter-transference quagmire of the doctor. This was well taken and recognised by the leaders and group members.

Again, this “flaw” in facilitating group dynamics was well compensated by the friendly atmosphere, the truly *arglose* inquiry, the astute remarks, which all allowed the presenters to digest while responding to the considerable bombardment of questions. However, I still think that the meditative, reflective space which we create by a sensitive use of the “push-back” is on the whole more helpful for the presenter and facilitates the free exchange of ideas between the group members. After all, this is a mutual consultation, neither teaching nor supervision. Then again, a rigidly performed “classical” technique including push-back can be quite inhibiting for the presenter as for the group.

*Relaxation psychoanalytique* is a group method developed by the Russian born psychoanalyst Michel Sapir who via Poland landed in France in the thirties. It was developed as a therapeutic method, “une médiation corporelle”. However, Sapir and his colleagues very soon discovered that it could also be used in the training of doctors and other care-givers to help them to feel and recognise *the importance of the body* in their relationships to their patients - both through their own bodies as much as the bodies of their patient.

The name of Michel Sapir carries a similar iconic trait to that of Michael Balint - and the ‘Enid of Anney’, the psychoanalyst Simone Cohen-Leon, is still around! It took me some time to recognise her importance. Her contributions - not very many - are warm and distinct at the same time. There is something about her presence so intense and yet unpretentious, something about her listening that adds a special dimension to the entire staff group work. Again, she is not alone! There are many other staff members who bring this “work-committed charisma” into the meeting.

The demand for *relaxation psychoanalytique Sapir* is by far bigger than there are openings in the two parallel groups offered. I think this illustrates the importance and need for care-givers to get in touch with themselves, and thus to care for themselves, to listen to their own repressed thoughts and feelings, to become free-floating for a while.

The two relaxation sessions lasted for one and a half hours each and involved 12 participants. All were women except for one, and led by two leaders (a man and a woman). I was introduced as an observer, sitting next to the two leaders who were seated on chairs. The group was sitting on the floor. The group participants are invited to lie down in the room and at the soothing voices of the leaders the progressive relaxation of the body from head to toe is induced. After some 15-20 minutes the leaders take on half of the group

members each, quietly moving around touching the participants, on their heads, shoulders, hands, hips and knees, and bellies (which were *not* touched in the first session, I noticed, thinking it wise). After 45-50 minutes the participants are asked to get out of the relaxation at their own pace, and move into a sitting position. A discussion ensues about the bodily and emotional experiences during the relaxation and about the method in general. I was impressed that the majority of the participants could put into words a variety of feelings and thoughts that fluctuated through their consciousness – often expressing strong ambivalence, i.e. pleasure, longing and pain. A few seemed more intrigued and withdrawn. Most of the group members seemed to relax, one even fell asleep snoring. But a few seemed tense and a bit apprehensive, particularly at the touching which became the focus of talk after the first session. Some wondered if they had been touched by the male or female leader. One of the participants felt convinced that she had been touched by me. By reporting that, some doubt arose in her, ending in her recollection that I was the observer. Questions about the applicability of the method for treatment of patients were raised but the answers were a bit vague and left for further participation in group work.

I felt sympathetic to the use of the method as a way for care-givers, who spend all their time to care for others, and forget about themselves and the bodily and mental investment they make in their patients, to get in touch with themselves once or a couple of times a week. I learnt some participants do this regularly at home as a self-therapy and part of their professional maintenance.

To me, *relaxation psychoanalytique* seems quite similar to the body therapy developed by Moshe Feldenkrais which also contains a mix of verbal suggestions, body touching and a discussion afterwards in order to learn about the feelings and memories that we harbour and hide inside of our bodies. In both these methods you will find elements borrowed from yoga-inspired relaxation techniques.

As with the Feldenkrais method I am more at a loss about how to apply it to patient work, say patients with psychosomatic disorders. Probably it can help some patients whereas I fear others could even deteriorate. Even with a very good guide it could be too much for many patients with severe psychosomatic disorders and a fragile personality, I would think.

In order not to mislead the reader, I must emphasise that my report is subjective and based on a very limited small group participation. It may not be representative for the entire conference.

Generally, an “ad hoc conference small group”, both in Annecy and at the IBF meetings, cannot possibly work to the same extent as a well functioning long-term Balint group. One has to recognise that there are significant limitations, aspects that will inevitably be left out because of lack of time and no follow up. I think it is inevitable that during a conference some presenters contribute to the meeting much more than they get back. This may happen for a complexity of reasons, including the (in)ability of the presenter to digest the feedback from other participants. Still, my impression from Annecy is that the presenters and the group members really seemed to benefit to a very high degree. It is only recently that the IBF congresses – facilitated by bringing leadership issues to the fore - have started to secure the group frame similar to what has been done in Annecy for many years.

I left Annecy very impressed by the work done there on difficult clinical situations, which were dealt with in an open and imaginative atmosphere. The conference provides a most friendly and supportive environment allowing for “unpleasant”, difficult and crucial issues to be discussed. The leaders of the sessions and the leaders/observers share

in a most sensitive way a joint responsibility for the openness and security of the conference. In the debriefing sessions for the leaders I was struck that such a diversity of individual voices could shape into a fairly cohesive “Choir of leaders”. The few dissonances between individuals that I could perceive had a benign character. Surely, I would not have been so outspoken in my critical remarks had I not felt the friendliness, the agility and the broad-mindedness of the participants. I think both the IBF and the AIGPB will benefit from an increased exchange in the future, and such wishes were voiced by many in Annecy. With my miserable French I can testify that language barriers are only relative! I understood surprisingly much, but I had to rely a lot on colleagues translating my interventions from English. But at the farewell dinner I was surprised that I could join in singing George Brassens – words from the 1960s that I would have thought lost for ever.

*“Au bois de Vincennes, y a des petits fleurs, y a des petit s fleur  
Y a des copains, au bois de mon coeur, au bois de mon coeur  
Quand-il n y a plus de vin dans mon tonneau,  
ils n’ont pas peur pour boire mon eau....”*

I left my friends in Annecy having shared their wine and some water, and this report is a small flower of tribute to their work, commitment and open-mindedness.

**Henry Jablonski**  
**May 2016**

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# Balint Society Supervision Workshop

February 2016

In the Balint Society, the accreditation procedure for group leadership co-leadership with a Balint Society accredited group leader, who may then act as supervisor, is the simplest means to gain accreditation. Where this is not possible, it is necessary to work in a group with outside supervision from a Balint Society supervisor. With increasing numbers of people wanting accreditation, often not linked to an accredited co-leader, the Society has been trying to address increasing the number of supervisors available. The Society first drew up a list of “accredited leaders” in 1999, naming those leaders who had been running groups over the 40 years before, and who were members of the Balint Society (a grandfather clause arrangement). After that we instituted a loose procedure whereby to become accredited people would either co-lead with an accredited leader, or co-lead at the Oxford (or other) weekends on several occasions (until thought competent by informal peer feedback), and often present their ongoing group at the Tavistock Balint Group leaders workshop in London. This became outdated as the Society and number of leaders seeking accreditation grew, coming from all over the country. The new accreditation system was set up by the Council of the Balint Society and is now managed by the Leadership Group.

This February, on Saturday the 6th, was the third Balint Society supervision workshop. It was held at the Swiss Cottage Hotel in London, led by Dr Shake Seigel, portfolio GP, Dr. Val Parker, psychotherapist, and Dr Helen Sheldon, retired NHS psychoanalytic psychotherapist. There were 15 attendees, accredited leaders wanting to either improve their supervision skills, or wanting to start supervising. The workshop was all day, starting, after an introduction, with a brain-storming session about what supervision in Balint work was, then two practical sessions. For these the whole group split into two, allowing participants to be supervisees, or supervisors, bringing, in one session a recent group, and in a second session, an issue in their group. The large groups then discussed the work of the dyads. We ended with a discussion plenary of an hour. Not surprisingly, discussion of what supervision is led to discussion of what a Balint group is. An open space to discuss problems with patients/clients, trying to take account of the unconscious, focussing on the doctor-patient relationship. There was talk about how much the leaders might be active in training groups, or that in other countries leaders may be more directive (we were lucky to have two visitors from Russia), a particularly interesting point being the common use by the leader of the question after the presentation, of “and what is your problem with this case”. I will summarise the whole day’s discussion after briefly covering the hands-on supervision sessions.

The two practical supervision exercises were interesting as they proved quite different, at least in the group I was in. The discussion of a recent group felt rather like a one to one version of the Tavistock Leaders workshop, with the supervisee describing the group, and the supervisor trying to help the supervisee think/feel more deeply about the group-what was going on, what was going well, what were the possible problems. In the session dealing with an issue there was much more feeling that the supervisee might want or need advice and guidance from others, in this case the supervisor. Both those actively participating, and the larger group found these exercises extremely helpful, and confidence building, while making us all aware of the difficulties of supervision work.

Balint group work is not supervision as the groups are of equals and the leader is really supposed to be a facilitator, though this can become blurred in groups for trainees,

or medical students, or just very inexperienced groups. With a supervisor there is a more power/knowledge differential, such as in the accreditation process for Balint group leadership. But the part of the work of the supervisor which feels like Balint group work is the creation of a space for the supervisee to talk about their work in an open and constructive, rather than critical atmosphere. What about supervision of already accredited leaders? Several psychotherapists thought that they should all remain under personal supervision for their Balint group work, preferably with their co-leader being supervised with them. Others, perhaps mostly GPs, felt that ongoing participation in a peer group supervision (like the Manchester, Newcastle and London groups) was more realistic and sufficient, alongside participation in Balint weekends occasionally, either in leader workshops, or as leaders. The need for ongoing personal supervision was justified as the difficulty of the leader being able to place themselves in a “third position” to analyse what was going on in the group and their leadership well.

This is obviously true, but surely one of the functions of Balint work is to enable the doctor or therapist to be better able to find the third position in their client work, and so much of the work of the leader is to be finding the third position in the group work. There is also the point that in Balint work we are not treating patients who may be vulnerable and need protection. The work is with adult professionals, who are aiming to develop themselves professionally, and perhaps in a limited way, personally. We all certainly agree that that some ongoing reflective work about one’s group leadership is essential for remaining a good leader. Whether this becomes specified by the Balint Society, and how, in the years to come, is an ongoing work of both the Council and the Leadership Group.

Anyway, these supervision days are proving useful for provoking thought, and providing more supervisors for prospective accreditation candidates who need a supervisor.

**D. Watt**

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# Reflection in action

Introductory talk for the Oxford Balint weekend

2nd October 2015

Ceri Dornan

One way of helping people to understand the purpose of Balint work can be to describe it as a form of reflective practice, which is a familiar term to many in healthcare professions.

There are pros and cons of this, as in learning and professional development, the term reflection is in danger of suffering the fate of many others, such as ‘evidence-based’ and ‘empathy’, of becoming so absorbed into the vocabulary of ‘good things’ that we lose the original meaning.

Those of you in training now or recently, will probably have been required to write reflective accounts of your experiences as part of an assessment process, though evidence that such accounts can be assessed reliably or that they demonstrate true reflective ability in the writer is so far lacking<sup>1</sup>.

The notion of compulsory reflection doesn’t sit easily for many students and professionals. Here are some of the spontaneous comments about their Balint weekend experience shared by two medical students at Whalley Abbey in 2015, captured in a recording, which they agreed could be shared. I quote:

Ruth: *If you do reflections for a portfolio, there is a big part of it which is trying to look appropriate, like you’ve already gained stuff. This (Balint) is more from doing the actual gaining, insight into how you do it.*

Mia: *It’s more honest.*

Ruth: *Yes, it’s not having to do that “and from this I learned blah blah blah....” This is doing the learning.*

And Mia talking about reflection with a supervisor:

*“Oh I think I could develop my skills in x-field and I will try a little bit harder and hopefully it will get better. This (Balint) is a lot more personal, it’s about the way you express yourself as a person in terms of your patients, and how you behave as a doctor and maybe that changes when you are with different patients and in different situations.”*

I took from this that Ruth and Mia saw Balint work as an authentic and personally relevant form of reflection, and something where they learned by doing, responding to their intuition.

Here is a quote about intuition attributed to Einstein, but more likely derived from his ideas:

*“The intuitive mind is a sacred gift and the rational mind is a faithful servant. We have created a society that honours the servant and has forgotten the gift.”*

It seems that little changes.

David Watt chose ‘Reflection-in-action’ as the theme for this weekend and at first glance you might think that the words ‘reflection’ and ‘in action’ don’t go together. ‘Reflection’ has connotations of time, space, quietness, whereas ‘in action’ suggests something dynamic and immediate.

The term ‘Reflection-in-action’ was coined by Donald Schön, a 20th century scholar who became interested in how people and organisations learn, particularly in changing environments and promoted the idea of life long learning<sup>2</sup>. He was a key contributor to the field of reflective learning. He distinguished between ‘reflection-in-action’ and ‘reflection-on-action’.



Much has been written by others in the field about just what he meant, but one view is that 'reflection-in-action' is an ability to notice that which is unusual or unexpected in an otherwise familiar situation. This might be in a consultation or in teaching a class. It might amount to a feeling or intuition. The practitioner then has the opportunity to respond to, or maybe note their experience for further consideration.

Reflection-on-action is thinking applied in retrospect and in many settings the focus will be on what happened, what we did, the outcome and what we might do next time, and is likely to be familiar from supervision and teaching experiences we have had. Feelings may or may not be addressed.

For those of you trained in psychotherapy, you are likely to see a parallel between Schön's reflection in action and Patrick Casement's idea of an internal supervisor, active in the therapist's mind during sessions with a patient<sup>3</sup>.

It is an ability to think on our feet which goes beyond the competence to handle an apparently routine situation, where there is a danger of becoming personally distant, especially when tired and overworked.

So what do we do in a Balint group? Is this reflection in or on action and does it matter? There is an element of both in that we hear in retrospect about a patient and consultations described by the presenter, but by hearing the story and the feelings experienced by the presenter, the situation is brought alive into the room.

It is by bringing the patient – clinician relationship alive that we begin our work in the group. We are encouraged to respond to our own feelings and intuitions and share these with the group in a form of collective reflection-in-action. We are discouraged from focussing on the clinical facts and actions which might be the focus of reflection-on-action.

So as we go into our groups, maybe thinking of Balint group work as reflection-in-action can help to keep us in the moment, especially when strong feelings are aroused in us, which we may prefer to escape by drifting into anecdotes or offering solutions.

## REFERENCES

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## Balint Society Secretary's report 2015 – 2016

Our Society continues to grow, with full membership number now over 200 for the first time. There is a steady change in the proportion of different professions within the membership, as the strong leadership training programme attracts more people from psychiatry, psychology and psychotherapy to join, so GP members are now in the minority. We have a few members from nursing professions and a dentist. We are working with colleagues in the Republic of Ireland who are promoting Balint interest there, initially as part of the UK Balint Society, with a view to forming their own Society in the future. The Royal College of Veterinary Science is currently looking at the Balint method, and a group for teachers has been started by one of our leaders, so we could see a very different membership in future years. Onwards and outwards for the Balint Society perhaps.

People sometimes ask how many Balint groups there are across the UK. The answer is that we don't know, but would like to. One of the benefits of coming to our events is the opportunity to form and expand regional networks, so the more knowledge we have of activity 'out there' the better. **If you are a member of a group or are leading a group, please let us know.** We are always looking for contacts so those approaching us for local information can be given something positive to follow up. Growth areas for Balint groups are in Medical Schools, thanks to the Royal College of Psychiatrists' initiative and the pleasing take up by institutions, in Foundation Doctor groups and in Psychiatry beyond the obligatory groups held in Core Training. Wake up General Practice!

What has the Society been doing in the last year? To find out, read the Regional Reports to see how much activity there has been with more day events for leadership training and supervision, as well as the regular weekends. The study day held before the Annual Dinner is now a popular event, with a reminder of the theory behind Balint work given in a talk by Gearoid Fitzgerald. This can be heard as a podcast on the Balint Society website (<http://balint.co.uk/our-podcasts/>). The Annual Dinner was well attended and we heard from Professor George Freeman about research into continuity of care, a subject close to the heart of many doctors in our increasingly fragmented care system.

The Balint Society Council has met four times. Members will be aware that we have worked on a new Constitution, now adopted, to align the document to our present needs and represent the wider scope of membership and activity beyond General Practice. Thank you to all of you who contributed comments and supported the changes with your approval. We are having a big push to modernise our infrastructure with on-line application for membership and events via the website. Please bear with us during the early stages of this work, which will inevitably have some teething troubles. We anticipate having a more accurate database of our contacts and the ability to search for information in a 21st century system. Of course there will still be a need for humans to know how to work with this and we are having expert guidance from an IT specialist in both setting everything up and in training those who need to know. **If you have a passion for websites and in particular WordPress, then do let us know.**

We are very keen for Council to be seen as an accessible and representative body. Our job is to use the assets of the Society to fulfil its charitable purpose, the end point of which is to benefit the health and wellbeing of the population served by our members. It can be hard to interest people in committees, but Council tries to be a creative and enabling body and thrives on new ideas and enthusiasm. You may not see Council membership as something for now, but if you want to see what happens, you are welcome to attend a meeting as an observer. Let us know via [contact@balint.co.uk](mailto:contact@balint.co.uk).

As a member of the International Balint Federation we try to keep in touch with as much international activity as possible, including ways of training leaders. This is always enriching for us and we hope, for others. We had good representation at the IBF Congress in Metz, France, last September, including presentation of their work with medical students by members Judy Malone and Ami Kothari. Members have attended Balint Conferences in Austria, Hungary, Russia and Germany and been active in presenting Balint work at WONCA Conferences in 2015 and 2016. We frequently have international visitors at our weekend conferences, so do consider attending one in another country. See the IBF website for upcoming meetings (<http://www.balintinternational.com>). We share many things in common and any variations in approach to Balint work give valuable food for thought. Language is no barrier, especially for we fortunate English speakers.

**Ceri Dornan**  
**Honorary Secretary**  
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**The Balint Society**  
(Founded 1969)  
**Council 2016/2017**

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## **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](mailto: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.