

Journal of the Balint Society



2019

JOURNAL OF THE BALINT SOCIETY

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Contents	Page
Journal Introduction	2
The Balint Society	2
Calendar of Events 2019-20.....	3
The Web Site	4
Editorial.....	5
Personal papers:	
Balint Groups: Intention and Impact – Dr Jeffrey Sternlieb	6
Response to Jeff’s Paper – Dr John Salinsky	11
Balint Retreat Proceedings-Pakistan – Dr M. Shameel Khan	15
From Membership to Leadership – Scarlett Tankard	21
The Balint Essay Prize Winner 2019.....	24
The Balint Essay Prize Runner-up 2019.....	29
Balint Memorial lecture 2019 – Dr Peter Toon.....	31
Liztening and Reflecting – Oxford Keynote Address 2018 – Dr John Salinsky..	40
Iranian Balint Groups – Dr Ray Brown.....	44
Balint Group in Iran – Dr Fatemeh Moonesi	47
A Personal Reflection-Dr Jonathon Olds	49
Shared Celebrations – Dr Ceri Dornan, Professor Orsolya Papp-Zipernovszky and Esti Rimmer.....	54
Papers:	
Before Enid was Enid: The Birth of Couple Psychoanalysis - Professor Brett Kahr.....	57
Opening Others’ Eyes to Balint Work – Dr Ceri Dornan and Dr Louise Ivinson	66
Collusion of Anonymity: The Manager, his Players and the Team – Mark Budow, Andrew Elder and Donald E Nease	74
Obituary:	
Professor Marshall Marinker – Dr Paul Sackin.....	79
Reports:	
President’s Report – Dr Caroline Palmer	81
Report for the Journal on the May events 2019 – Dr Caroline Palmer	84
Regional Reports.....	88
Book Review:	
The Inner World of Medical Students: Listening to their voices in Poetry Dr Peter Shoenberg.....	104
A Fortunate Man – Dr Liz Lee	106
Announcements:	
The Balint Society Council 2018-19	108
Guidance for Contributors	108

Editor:
Tom McAnea

Cover image: *Physicians disputing while the patient suffers’
Johann Geyer 1807-1885 – Courtesy of The Wellcome Collection*



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.

The Society welcomes membership from any health or social care professional who works with patients and clients. We also welcome others who wish to explore professional relationships with their public using the Balint method.

Students are especially welcome.

Balint weekends are held each year in Northumberland or Yorkshire, Whalley Abbey, Lancashire, Oxford and now Ireland, alternating between Belfast and Sligo. 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 a member of 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 2019-20

11th-15th September 2019: **International Balint Federation Congress** in Porto, Portugal, hosted by the Portuguese Balint Society.

20th-22nd September 2019: **Oxford Balint Weekend**, Corpus Christi College, Oxford.

1st November 2019: **Balint Society Leadership Day in Scotland**, Edinburgh (for Scotland only).

6th December 2019: **Bristol Balint Study Day**

14th February 2020: **Balint Study Day and Annual Dinner** in Birmingham.

27th-29th March 2020: **Whalley Balint weekend** (Lancashire)

5th June 2020: **London leadership training day**

25th-26th June 2020: **2 day event in Newcastle**. To include Balint groups, Leadership training groups and a Balint Psychodrama group.

2nd-4th October 2020: Oxford weekend at Corpus Christi

Balint Group Leaders & Allied Professional Workshop:
The Tavistock Clinic, 120 Belsize Lane, Hampstead NW3. 8-10pm
Tuesday, November 5th 2019
Tuesday February 4th 2020
Thursday 14th May 2020

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

The Balint Society Website: 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).

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 2020 and sent to:

Ceri Dornan, e-mail - ceri.dornan@gmail.com

Guidance for contributors

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

Editorial 2019

Doctors and patients do not always have the same agenda, even in the modern medicine of shared decision-making and exploring ideas, concerns and expectations. This year's cover shows the 19th century German artist Johann Geyer's satire on doctors in the previous century and their obsession with professional reputation and intellectual vanity, usually at their patient's expense. It depicts the physicians debating the merits of one tonic over another, whilst the poor patient literally fades away. Medicine has moved on, has it not? Well, I wonder if some of my patients sometimes get what they want, but not what they need. They may leave with yet another prescription, or a referral, or both. Does this mean they are cured, feel better, have their inner need addressed?

Michael Balint spent much of his career exploring the dynamic in the consulting room. His work helps many of us understand better what is going on between clinician and patient. How they make us feel. This year's Journal has ample content on this subject, from a range of contributors, both old and new. Jeff Sternlieb and John Salinsky engage in an exchange about the value of Balint groups for junior doctors, exploring the effects both on the participants but also implications for group leaders. Jonathon Olds, a psychiatrist and group leader shares his experiences of running groups and the impact on his own clinical practice. A perspective from colleagues early in their career is in three contributions this year: our essay prize winner and runner-up, as well as in a piece by Scarlett Tankard, a medical student at Bristol who has made the move from group participant to group leader.

The international reach of Balint work is present in a submission from Shameel Khan, a psychiatrist in Pakistan who details her experiences of introducing Balint groups into her hospital after she left her career in the NHS to return to her home country. It is inspiring to read of how she has discovered a real need amongst her colleagues for the support that Balint work can offer. In Iran, Fatemeh Moonesi, a psychotherapist, writes of her experience of Balint work with junior doctors in her hospital. There is also an update on the 2018 articles on Balint work started in that country by Ray Brown, psychiatrist and psychotherapist in Bristol.

The UK Balint Society celebrated its 50th anniversary this year. The RCGP commemorated the work of Michael and Enid Balint with the unveiling of a Blue Plaque at their former home in London. There was a reception in the room where the original group meetings took place, followed by a reception at the College. Ceri Dornan and Caroline Palmer both write accounts of this event, as well as an article about a similar event in Budapest paying tribute to Balint's work in that city early in his career. A poignant note was struck with the death two weeks later of Marshall Marinker, GP, academic and a member of Michael Balint's original group in the late 1960s. Marshall gave a funny and fascinating account of his experience being interviewed by Michael Balint before being invited to join the group. An obituary marking his remarkable life is included this year.

The Society's birthday was marked in style by a Balint@50 event at the Wellcome Institute. A number of speakers gave excellent talks some of which are reproduced here, including the memorial lecture by Peter Toon. Again, the range of participants and the variety of work taking place in the UK and beyond is both inspiring and encouraging. It is clear there is a need for Balint work amongst many colleagues who see patients, one can hope this will grow in future to become a more integral part of training at both undergraduate and postgraduate level. I believe it makes us better practitioners, and more able to give our patients what they truly need.

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Balint Group Intention and Impact - Clarifications, Process and Disclosures

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Balint groups are often introduced to physicians in the United States during their residency training - (a junior doctor in a training programme) including Family Medicine, Paediatrics, and Psychiatry, among others. They are a formally structured group process designed to teach and learn about the complexities of relationships between doctors and patients. Approximately half of the Family Medicine residencies in the USA include some regular schedule of Balint groups in their training (Brock, C., Stock, R., 1990, Diaz, et. al., 2015). Approximately half of those groups have leaders who have completed a Balint Leader Training Intensive, a four day experiential training program sponsored by the American Balint Society. ACGME representatives, during residency accreditation on-site visits, have recognised that Balint groups satisfy a requirement to provide emotional support for residents. However, many Balint group leaders report difficulty in establishing and sustaining productive Balint group experiences for their residents. Some of the numerous difficulties that have been reported include inconsistent attendance, lack of program support, and difficulty with a focus on the relationship rather than on diagnosis and treatment.

In general, individual and administrative buy-in to Balint groups suffer from two primary challenges: insufficient research demonstrating its effectiveness (Van Roy, et. al., 2015) and ineffective description or introduction to accurately describe the process, the goals and the expected outcomes. These challenges are connected. That is, if these descriptive details were made clear and more accurate, research approaches could be developed that would be more productive. The following three distinct suggestions may help clarify expectations on the part of participants and may provide direction for leaders who are working with individuals who are unfamiliar with this work. In addition, some reminders for beginning participants are presented.

Full Disclosure

First, we might consider full disclosure about the intended content targeted by Balint group participation, both for Balint group participants and for future Balint group leaders. Michael Balint's observations of doctor patient relationships included:

"...that by far the most frequently used drug was the doctor himself..."

"...no pharmacology of this important drug exists yet."

"...no guidance whatever ... as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and his maintenance doses should be, and so on. Still more disquieting is the lack of any literature on the possible hazards of this kind of medication, on the various allergic conditions met in individual patients which ought to be watched carefully, or on undesirable side effects of the drug." (Balint, 1957)

It's as though Balint was advocating the establishment of what we now know in the United States as a drug warning label which provides information about pharmaceutical's

uses, recommendations, possible side effects and remedies. It is probable that his seminars, planned as continuing medical education for family physicians, were intended to teach and develop in physicians the full potential of this drug - the doctor himself. His explicitly stated desired outcome in creating the seminars was: "...a limited, though considerable change in his (the doctor's) personality." (Balint, 1957) Balint further clarified that: "The aim (of the seminars)... has been to:

- "...develop in the doctors a sensitivity to their patients' emotional problems,
- ... to enable them to understand these problems more safely and at a greater depth,
- ... to help them acquire skills in using this understanding for the goal of therapeutic effect." (Balint, et. al., 1966)

These three goals were Balint's initial intended primary effect of Balint group participation. Any other outcome might be considered a secondary effect, including teaching empathy, burn out prevention, increasing psychological mindedness, and others. The essential relevancy of these primary aims relates to the intensity of residency training. It is not unusual for residents to disconnect from their patients emotionally and to disconnect from themselves emotionally. The pace of residency training leaves little time to recognise or process the range of intense emotions stirred up by patient care. Becoming aware of these disconnects may be another secondary benefit of Balint group participation.

Inductive Reasoning

Second, it is not always clear that the learning experience inherent in Balint groups is an inductive one. This is in marked contrast to most other aspects of medical training which are primarily deductive. Deductive learning is teacher (or preceptor or attending physician) oriented. That is, the instructor decides what the learner needs to learn, teaches it (by lecture or assigned reading, for example), and it is up to the student to incorporate what has been taught into their already learned body of knowledge. In contrast, inductive learning is more learner-centred. It is up to the Balint group participant to notice patterns, connections and even layers of emotions that get stirred up by cases that are presented by group members. Not only would it be helpful to Balint group participants to be apprised of the nature of this learning opportunity, it is essential that Balint group leaders also be explicitly aware of this in order to be able to support residents who struggle to benefit from these group experiences. That support cannot be a summary of learning points about a particular case; rather, it is in the expressed confidence that learnings will become apparent to the resident as they consider their own internal reactions to cases and the discussion generated by their group.

The Beginner's Mind

Thirdly, it is most helpful if one's mindset upon entering a Balint group discussion is decidedly different from the doctor's mindset when entering a patient's room. The primary intent of most aspects of medical training is the accumulation of knowledge and skills that will equip residents to graduate and ethically and competently practice medicine. At a minimum, residency is a time of developing their sense of medical expertise. It doesn't take too long for residents to be the primary source of information for interns and medical students. In contrast, the primary intent of Balint groups is to discover aspects of patient care that are unknown to the physician. In particular, Balint's aim was to help identify and better understand the role and impact of emotions in illness stories. A secondary effect is an increased awareness of possible blind spots, uncertainty, and aspects of relationships we may not have considered. Therefore, it would be a better

learning experience if they approached these Balint groups with a mindset which values uncovering what they do not know rather than using what they do know. This stance has been called the beginner's mind which is in contrast to the expert's mind. "In the expert's mind, the possibilities are few; in the beginners mind, the possibilities are many (Suzuki, 1970)." This is one more counterintuitive directive to maximizing one's benefit of a Balint group experience.

The Beginner's Mind - Vulnerability

A corollary of this third suggestion relates to one's vulnerability. Part of having a beginners mind is openness to a wide variety of experiences. This includes, of course, emotional experiences within one's personal or professional life. While any recent personal experience of traumatic events may clearly be too unsettling and destabilizing, some degree of vulnerability may increase one's sensitivity to both the patient's experience and the physician's emotional reactions and struggles in their professional role.

The Beginner's Mind - Emotional Availability

Like Russian nesting dolls, embedded in the issue of vulnerability which is embedded in the issue of beginner's mind, is the question of emotional availability. One can be vulnerable but not emotionally available. Emotional availability includes self-awareness, having an emotional vocabulary, and ideally, the ability to recognise and name one's feelings.

Not all physicians have equal comfort with or awareness of their own emotions. It is not unusual for medical students to choose specialties based on their comfort level with the importance of developing relationships with their patients. Some students chose specialties like surgery or pathology where long term relationships and therefore emotions play a very small part in their work. Their primary tools are based in logic and intellect and support diagnostic and treatment strategies. Other students seek specialties like primary care that emphasise long term relationships with patients, and in addition to the role of intellect in medical diagnosis, emotional intelligence becomes a primary tool in developing therapeutic relationships.

In summary, three areas described above may better prepare residents for participation in this atypical and foreign educational process that relates to the emotional aspects of practicing medicine:

1. the emotional content of these groups
2. the nature of inductive learning
3. the beginner's mind + vulnerability + emotional availability

These same 'disclosures' may be helpful to share with leaders in training. They may better benefit from that training and may be better prepared to describe this process to their residents.

For the beginning Balint participant and leader:

Some reminders...

Balint groups are different from any other part of your formal medical education and likely different from most post-graduate continuing education experiences. Depending on when the group is scheduled in the business of a physician's day, it may be helpful to acknowledge the need to "change gears" and even provide a brief suggestion to think about the patients they have seen recently to help this transition and enter the space of the Balint group. Since residents all bring their own unique set of emotional experiences to the group, they may be unequally prepared to delve into patients and patients'

emotional lives. They may also have varying degrees of discomfort in talking about their own feelings. Fortunately, this is not a competitive process, and since residents will all relate to every case differently, it is important that they all share what they can because the group needs all of their reactions.

This might not be a good case, but ...

A frequent and a relatively apologetic introduction to a case offered to many Balint groups begins with this concession and what almost sounds like a plea for forgiveness that it might not turn out to be a 'good-enough-case.' Ironically, it is almost always a great case with multiple issues and depth the presenter never imagined. There is a very good reason for this state of the art of case presentations: many cases are like ice bergs! We see enough of the case to take notice, but the reasons the case stays with us is the weight of what is under the surface, literally and figuratively. And we cannot see it clearly, if at all. It is only when we take a look at what may be under the surface that we understand why such a case 'stays with us.' We do not know the significance of a case until we share it verbally. The case description is the entrance for the group's discussion allowing it to be examined in greater depth. Imagine the possibility that if these cases with their unexplored significance go without any presentation to any group, the physician might unknowingly hold the case's importance as a ghost with the potential to haunt. Conducting Balint groups is not only an imperative; we need to encourage these 'not quite good enough' cases to expose the burdens of practice.

The group member to group relationship:

The relationships among group members is an evolving one, often following the typical stages of group formation (Tuckman, 1965). At first, it involves getting to know each other, and although there is often a competitive quality to these relationships, leadership can be helpful in minimizing the impact of less helpful motives. It is inevitable, however, that the nature of the cases presented may be seen as a reflection of the competence of the presenter. Self-judging may be a more significant factor than judging each other. "If I were a better clinician, this case wouldn't be a problem for me." One other group dynamic consideration is the potential presenter's wish to provide a case worthy of their group and the Balint process. Whether it is subconscious or unconscious, there may be pressure to provide a case that has sufficient depth or complexity to be worthy of asking the group to work on, or there may be this sense that 'what's wrong with me that I can't deal with this case or these emotions?'

In either instance, the group's work ultimately validates the worth of the presenter's case, alleviating their fears and concerns. For leaders of groups struggling to 'find' cases, a simple encouragement may suffice: "I'm confident that each you have a case worthy of this group." Again, leadership can help by emphasising everyone has their own blind spots, and part of the group's value to its members is that anyone can present any case that is a struggle.

The meaning and management of silence:

One of the most challenging situations for beginning Balint group leaders involves the group's silence. There is a certain security in leading a group that is talkative. It feels like the group is going well. So, how can it be a good group discussion if the group becomes silent? And the silence is often followed by the leader's self-questioning: How should I respond to the group when they are totally silent, or How long should a silence be allowed to continue, or even What do I say to 'break' a silence? As is the case in understanding

complex relationships, understanding silence starts with considering the context and the numerous reasons for the silence. There are some instances of predictable silence based on timing - immediately following the leader's invitation of a case and during the discussion when the group seems to run out of things to say.

Sometimes, a group member arrives at the Balint group prepared to offer a case to the group. However, a more frequent occurrence is that residents are not usually 'carrying' those challenging cases in the forefront of their minds. There are more immediate and probably more mundane concerns they are holding. The invitation of a case requires reconnecting to their clinical mindset and to the emotional turmoil they may have felt, and only then are they able to consider whether to present a particular case. The group's silence is necessary to allow this individual process to occur.

A second scenario of silence may occur when an active discussion stops, all of a sudden. Again, understanding the context may guide the leader's decision. Does the silence mirror the case, such as in a very depressed and unresponsive client? Or is there an issue that the group is hesitant to address such as prejudice in a mixed race group or a miscarriage in a group with a pregnant group member or a case with a profoundly sad outcome? In any of these, the context is crucial. In some of these situations, the leader can just name or tentatively suggest the reason the group is being cautious, giving the group permission to be silent and then to speak up with that understanding. It is no different than a reflecting reframe of an emotion that a group member expresses.

In summary, these examples of case selection, group dynamics and silence in groups can inform leaders about issues to be prepared to manage, all in service of their group's learning. Hopefully, these examples suggest a process through which leaders may consider the meaning and significance of group events, leading to their decision about intervention. Ideally, every group will end with differing perspectives to think about - and every participant will have different insights that stay with them. All participants have this opportunity for self-exploration, self-awareness and self-knowledge. I encourage all group members to treat Balint as a platform for growth - professional development - designed to broaden the physician's repertoire of patient care sensitivities and skills.

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Balint group Intention and Impact – Clarifications, Process and Disclosures

On the other hand...

A response from John Salinsky – and a conversation

Dear Jeff

I thought your paper was very stimulating and I have now read it several times!

I would now like to respond to it with some thoughts of my own.

In your introduction you state that there are two primary challenges to Balint 'buy-in': namely, lack of good research and ineffective description of the purpose of the group.

Lack of good research

I agree that most of the Balint research done so far is aimed at 'proving' that those who take part in Balint groups are less likely to suffer from 'burnout' and more likely to find their work satisfying. I think this has been reasonably well established. After all, if the Balint-trained doctors are feeling emotionally supported, enjoying their work more and not feeling like quitting – I don't see why we should disbelieve them. Especially if they are still in practice.

It is much harder (probably impossible) to prove that they are better doctors. Claims that Balint makes doctors more empathic are based on the doctors' own statements so all we have learned is that they *believe* they are more empathic. What we want to know is whether (a) the Balint process has enabled them to work in a Balint-influenced way and (b) this has had a positive effect on their patient's welfare. (b) is extraordinarily difficult because of all the confounding factors.

I note your comment that residents in Balint groups often have difficulty in focusing on the doctor-patient relationship and this is my experience too. Balint himself considered, ruefully, that only a small percentage of those who passed through his groups really grasped what it was all about and were observed to be relating to their patients with greater insight. (Balint M, Balint E et al 1966)

Full disclosure? Don't mention Freud

The other problem you mention is that we often seem reluctant to disclose to beginners the theory of the Balint group, the nature of the process and the intended outcomes. I remember being puzzled by this for months after I joined my first Balint group 45 years ago. One reason, which I shall return to later, is that Balint work can only be really understood by taking part and experiencing it. Like learning to ride a bicycle, it's better not to spend too long on the theory but just get in the saddle and trust the process!

However it's also true that we are very reluctant to tell our beginners anything about the Balint group's origins in Freud and psychoanalysis. It feels like having to explain sex to a child. We get embarrassed and speak about reproduction but not about desire. Or in our case, we talk about the doctor-patient relationship but don't mention the unconscious.

Indeed, when the UK Balint Society had the brilliant idea of offering Balint Weekends which were open to any GP who was curious about Balint, there was a deliberate omission of any mention of psychoanalysis or Freud. We thought, probably

correctly, that it would frighten off the punters. Instead, we described the Balint group as somewhere you could go to talk about your problem patients, ‘revive your empathy’ and save yourself from burnout. All of which was perfectly true. But we knew there was more to it than that.

Jeff: Aren’t there other ways to talk about these things without using the words Psychoanalysis or Freud? Like: what might be under the surface? Or we can discuss blind spots or just acknowledging our own defence mechanisms. These are all ideas in general parlance without needing the Freudian dots to connect. We understand the value of interventions by what happens next - what if we judged the value of disclosures by following the participants’ use of Balint?

John: I agree that psychoanalytic ideas have permeated everyday discourse and can even sound like simple common sense. As you say, blind spots and defence (or defenses as you spell it!) are recognised by everybody. Perhaps what is missing is the wider concept of the Unconscious which we owe to Freud and those who followed him. In particular, as Gearoid Fitzgerald says in his excellent lecture (available as a Balint Society podcast) the slightly weird idea that the unconscious mind of one human being can react with the unconscious of another without passing through the consciousness of either of them!

For example, when a patient who feels useless himself, treats a young doctor with contempt and hostility the doctor begins to feel that she is the one that is useless. Yet neither is aware that this is happening. As leaders, we can helpfully point this out to the group when we observe it and I don’t think it would do any harm to tell our beginners that Balint work was born as the result of the union of two parents: psychoanalysis and general practice. It might help to demystify Balint for beginners and we certainly don’t need to use any technical terms.

Under ‘Full Disclosure’, you discuss the use of the doctor as ‘a drug.’ You mention the change of personality and then go on to quote three primary goals of Balint group participation set out by Balint. The third goal – to help them to acquire skills in using the understanding for the goal of therapeutic effect, like much of the content of *The Doctor, his Patient and the Illness*, seems to me to belong to the first phase of Balint-work (1950-1965).

May I insert a bit of history here?

Initially one of the Balints’ aims was to enable GPs to offer a limited kind of psychotherapy to selected patients. It was clear to the doctors after a while, that before they presented a case, they were expected to have had a long interview with the patients of up to an hour outside the usual surgery time. (See the chapters, ‘How to Start’ and ‘When to Stop’ in *The Doctor, his Patient and the Illness*)

Some of the GPs had good results from that interview and then decided to revert to ordinary consultations. Others who were more ‘psychotherapeutically’ minded went on with further extended consultations in which they made interpretations like a psychotherapist. Some of these ventures were successful but in others ‘the correct dose’ of the doctor proved difficult to determine: it was either too much or not enough.

Then, came a group led by Michael and Enid Balint which brought about a seismic change: ‘*Six minutes for the patient*’ group which met from 1966 to 1971.

Its work is described in the book ‘*Six minutes for the patient*’ (Balint E and Norell, 1973). Some of the doctors had felt for some time that by focusing on a few patients who were given interviews they were neglecting all their many other patients. Michael

responded to this challenge and said that from then on long interviews would be out. They were 'a foreign body in the general practitioner's normal routine' and made the doctor behave like 'the great detective'.

Michael said that he wanted to hear only about normal length consultations. 'Can't somebody present a patient with a cough?' he said. The idea was to see what doctor and patient could learn about each other from a single brief consultation or a series of them. This is the kind of Balint we do now - we no longer try to be psychotherapists. We just concentrate on the doctor-patient relationship. However, the key skill that was always reiterated and retained was learning to listen very carefully to what the patient was saying and base your responses on what seemed to be on his mind. So we need to be clear what we mean by 'help them to acquire skills.'

I agree very much with you when you say that empathy, burnout prevention etc. were never the main aims. As far as empathy is concerned, the skill is to be able to feel the patient's emotion but then detach yourself again and assess what is going on objectively. To see things only from the patient's point of view can be as misleading as having no empathy at all. I think there is a lot of misunderstanding here.

Inductive reasoning

I think you explain the difference from deductive reasoning very clearly. The question in my mind is: how should we enable the beginners to understand this? Do we explain the theory of countertransference; or do we enable our group members to learn *through experiencing it* with their patients and in the group? In other words, do we tell or do we show?

Jeff: I think this is ripe for a significant discussion. Show or tell? I'd like to suggest you consider some combination. Of course we show: it is the essence of the Balint group process. The challenge for the leaders is to open up paths to insight. Is it or would it be some form of heresy to tell?

John: Michael Balint says in his 'Appendix on Training' (Balint M, 1957) that everything depends on the 'attitude of the leader'. In other words, if the group members feel that they are listened to by the leader in a way that makes them feel understood, they will learn to do this with their patients too. This is certainly an example of 'showing' how it's done. But

I do think some of our interventions are also helpful if we point our things that the group does not seem to have heard or point to places where they are reluctant to go.

Jeff: This is true especially in the case of a part of the presentation of the case that the group 'forgets' or misses or avoids. So the leaders' task is primarily listening and saying what they have heard and what they are hearing and, finally, what they are surprised at not hearing.

The beginner's mind

John: I certainly found it difficult as a beginner, I couldn't understand why the group leaders, who were clearly experts, didn't just tell us how to make the diagnosis and manage the 'underlying' problem instead of making us try to speculate and - worse still - have fantasies. But as time went on I began to get the idea.

You mention the discomfort of many beginners in dealing with their own emotions. I think it is important, where relevant to say, 'this feeling you have may really belong to the patient'

(It may resonate powerfully with them, because it touches an area where they resemble the patient: but they can think about that later, if they want to). Also seeing and hearing other people in the group expressing their emotions may act as a release for the reticent.

‘This might not be a good case’ and the management of silence

I like your section about the not quite good-enough case: as you point out, they are nearly always great cases. I also admired your analysis of the different forms of silence. Beginners may find these disconcerting and it is important to realise that silence doesn’t simply mean that the group is bored or has run out of steam. If we demonstrate patience, wonderful things can emerge! Again, we have to think about whether we ‘Tell or Show.’ In having given the group a chance to feel the silence it does no harm if the leader says something like: ‘perhaps we had a long silence because we had touched on a topic that would be uncomfortable for us to visit?’.

Finally:

Jeff: I think in this discussion I have come to a more appreciative understanding of the subtleties of listening/What are we listening to, listening for, what have we heard and how do we understand or take meaning about this case and what have we not heard that we might expect? Finally, how do we bring any of this to the group’s attention? Are these the skills and the change in personality that Michael Balint referenced? If so, might this frame better inform research effort designed to document and hence support the value of these groups?

Less than full disclosure seems like we are hiding something - a secret. No wonder Balint groups are mysterious and the Societies supporting them seem like a clique. Maybe we need to explore the proper dose for our group members as well as for the patient?

Additional References:

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Balint retreat 2019- a progress report from Karachi, Pakistan

It gives us pleasure to write the first progress report on a recently held Balint retreat event at Aga Khan University hospital, Karachi. Pakistan historically has seen its own fair share of challenges in the shape of partition, terrorism and anti-groups but simultaneously has had an amazing ability to resurrect itself through the labour of love. The task of laying the landscape for Balint in Pakistan started in 2016. At the time Balint was completely unknown territory locally but over the last three years it has gradually but steadily learnt how to find its anchoring within the local systems and processes.

The Endings:

Four years ago, when I decided to relocate to Pakistan, I was not sure if the risk that I had taken would pay off in any shape or form. Leaving the UK meant not just giving up my NHS career but also temporarily putting on hold my psychodynamic interests. The parting comments of my analyst “Why not? You just go and do your Pakistan experiment” served as an endorsement to an already suggestible heart that had long been gravitating towards Pakistan. Little did I know that Balint would contribute so significantly in helping me metabolise and synthesise my own re-integration back home; a home that had changed in paradigms of both time and space with new characters, narratives and landscapes.

I must thank the Balint Council UK for their continued support, supervision and mentoring in helping me and my team lay down the framework of Balint in Pakistan. The Balint working group, Pakistan now includes 8 mental health professionals comprising four psychiatrists, one clinical psychologist and 3 psychotherapists. Five of these mental health professionals (including myself) work at Aga Khan University hospital and three members of our working group work privately but have a close professional association with our department of Psychiatry.

The Beginnings:

In 2016, Oncology and psychiatric services came together to establish psycho-oncological pathways of care taking into account high levels of psychological morbidity in patients receiving oncological treatment. As our collaborative work grew, there was a shared realisation to address psychological needs of oncology nursing staff as well, who were felt to be at risk of burn out and compassion fatigue. The journey of Balint in Pakistan therefore started from Oncology and nursing which was a rather unconventional place to begin from, taking into context the history of Balint work. Little did we realise at the time that sometimes unconventional beginnings lead to innovative outcomes. The Aga Khan university Hospital has a well-established school of nursing and this was the first Balint group to be piloted with the oncology nursing staff. It was myself and Dr Aisha Sanober who co-led this project and ran this Balint group for a year. Here I would like to express my special gratitude to Dr Gearoid Fitzgerald under whose supervision this initiative became not only possible but it also helped in laying a foundation milestone for Balint work in Pakistan.

In 2017, Dr Aisha and I presented the paper related to our nursing Balint group at the International congress held in Oxford. We both were humbled to see such a warm and encouraging response from the audience in relation to the work that we had undertaken and what we had experienced as well as observed during this process. We

learned during this process that Balint in Pakistan will require an organic intimacy with the socio-cultural fabric and local context. Such intimacy, although, came packaged with its own set of challenges but these subsequently became potential opportunities for further expansion of Balint in this part of the world.

Balint working group-Pakistan:

While we were undertaking Balint group work with oncology nursing staff, a parallel similar group was taking its shape and form with a cohort of psychotherapists, psychologists and psychiatrists. All the psychotherapists included in this group were working privately outside hospital settings but they had pre-existing working partnerships with our department of Psychiatry. These external psychotherapists were keen to create a platform where we all can come together and explore the relational aspects and challenges of our clinical work. The members of this Balint group went on to develop an excellent working partnership that became like a cementing bond between professionals working within the hospital and those working outside privately. In Pakistan, there are sharp divides not just with respect to gender roles, social class and religious affiliations but there is also an over-arching unseen hiatus between professionals who work in hospital settings versus those who operate autonomously, in private settings. The lack of understanding about each other's clinical work processes can create disillusionment and at times misinformed perceptions about each other's clinical practices. The department of Psychiatry at Aga Khan University hospital has had long term working partnerships with a select cohort of external psychotherapists working outside hospital settings. As a department we would often refer patients for therapy to these external psychotherapists depending on clinical need and contextual demands of particular clinical cases. We however haven't had as yet a singular platform where these external psychotherapists and professionals (working within the department) could come together to think jointly about the nature of their work. Balint fortunately became that platform that served in bringing together professionals working within the hospital with therapists working outside the hospital; this integration between the inside with the outside led all of us to mentalize better about the difficulties that we each experienced irrespective of the systems that we operated within. The members of this second Balint group developed a strong working bond and this subsequently led to the creation of Balint Working group in 2018.

The aims and objectives of our working group were to promote and facilitate the expansion of Balint work in Pakistan, both within the hospital community as well as outside in partnership with other organisations. We held our first Balint retreat in March 2018 which was attended primarily by psychotherapists and psychologists working outside hospital settings in institutes/organisations external to our own hospital. This retreat also had a talk from Dr Gearoid Fitzgerald on Balint groups and the participants thoroughly enjoyed the relatability of Dr Fitzgerald's talk, his humour and the deep insights that he generated within the audience.

Proceedings from Balint retreat 2019:

Following the successful Balint retreat in March 2018, we had planned a similar recurring event every year but with a view to include greater participation from physicians working within the hospital community. The planning of this retreat was a major task and I want to thank the members of my working group for their dedication, commitment and support that I received during the planning, organisation and execution of this successful event. Prior to this retreat, our working group had to endeavour in relation to raising the agenda of Balint groups on various hospital forums. What we found was that there was a need

for Balint to be packaged as a measurable tangible outcome especially if it is to survive in the harsh cost cutting economic climate of a private healthcare setting. We felt that we were heard more by the management when Balint was packaged as a possible preventive intervention for combating physician burnout, compassion fatigue and improving psychological resilience. Coming from a psychoanalytic background, I must confess I initially had some internal resistance to coupling Balint with measurable outcomes as the work of Balint (or any group work) can't always be measured in the here and now. We however realised that the setting in which we work expects us to adapt, so that Balint is not seen as a hijacked western intervention but a rather contextualised framework which is applicable as well as sensitive to the local systems and processes.

So the working group chose the theme of Balint retreat 2019 as "*Addressing professional burnout and improving resilience – The Balint way.*" The idea was to launch and project Balint to the medical community within the hospital in a language that they could relate to and resonate with. Up until now Balint had largely been perceived in our hospital as a reflective tool that had been used either with the nursing staff or with psychologists/therapists. Bringing Balint closer to the mainstream medical community required networking with training programme directors, service line chairs and heads of departments to help them appraise the utility of Balint both in postgraduate medical education as well as ongoing professional development of clinicians. We therefore sent individual e-mails to service line chairs, mentors and training programme directors in relation to the event details, methodology of Balint groups and how it would be useful for the participants. We also requested them to nominate people from their respective departments for this event. From our own end we agreed to fund places for up to 6 participants for this event. The money to fund places for these participants was generously donated by our own service line i.e. *mind and brain* as well as *office of the dean of students* who allocated us a proportion of training funds considering the potential value of this initiative. It was indeed encouraging to receive positive replies back from service line chairs/heads of departments who were very appreciative of us organising such an event and nominations subsequently started pouring in. Registered participants included those working in paediatrics, oncology, internal medicine, psychiatry, psychology as well as medical/nursing students. There was representation from both within the hospital community as well as some participants who were working in organisations external to our own hospital.

We also invited Dr Faisal Shaikh to this retreat who is a Consultant Psychiatrist practicing in the NHS and an accredited Balint leader himself. I met Dr Shaikh for the first time at the Birmingham leadership workshop in 2018. This workshop gave us a chance to network, share details of each other's work as well as explore possibilities of collaborations in future. Since our first meeting, Dr Shaikh and I had remained in contact with regards to developments happening at the Balint front in Pakistan. He once also joined us through zoom in one of our working group's meeting where he was introduced to our other members. Dr Faisal was kind enough to accept our invitation to attend the Balint retreat held in April this year. The working group is extremely grateful to Dr Faisal that he took the time out to attend this event and contributed hugely towards our learning and development as a group.

Balint retreat 2019 was held over a period of 3 days between Friday 26th to Sunday 28th of April, 2019. Using the format of retreats held in UK, we started the retreat late afternoon at 3:00pm on 26th April 2019. This allowed physicians and other professionals in the hospital to meet their clinical commitments earlier that day rather than taking a whole day off on a working day. Because the majority of these professionals had previous

little to no exposure to Balint, we therefore gave them an induction regarding Balint history and methodology at the start of the retreat. We divided the participants of the retreat into two groups with 8-10 participants in each group. One group was led by myself and the other by Dr Faisal Shaikh. The two groups were co-lead by facilitators namely Dr Nargis Asad (Clinical Psychologist, Department of Psychiatry), Dr Humera Saeed (Consultant Psychiatrist, Department of Psychiatry), Dr Aisha Sanobar (Fellow/Higher trainee, Department of Psychiatry), Alya Mian (Psychotherapist), Atia Naqvi (Psychotherapist) and Mehvesh Yousuf (Psychotherapist). Given we had more facilitators and fewer groups we decided to offer facilitators the chance of co-leading in turns with the two leaders. On those occasions when they were not co-leading, the facilitators became members of the group in which they were present. This model really worked well for two reasons. Firstly, it served an educational and training purpose for the co-leaders in terms of their capacity building. Secondly and more importantly, the inclusion of co-leaders as members of the group helped in positively modelling and grooming naive participants who had no prior exposure to Balint methodology.

Before we divided the participants into two smaller groups, we also ran a fish bowl group where the peripheral group comprised retreat participants and the internal group consisted of myself, Dr Shaikh and the other retreat facilitators. The idea was to use fish bowl as a teaching tool for participants most of whom had no previous knowledge of Balint work. It is true that for some physicians group work can trigger paranoid schizoid anxieties especially if it involves exploring their vulnerabilities in front of other clinicians from the same hospital. The utilisation of fish bowl for induction to Balint methodology worked quite effectively in alleviating such prevailing fears within the larger participant group. The anxieties of participants related to being part of a reflective group became more manageable when they observed a typical Balint group happening in front of them with regards to its process, methodology and ground rules.

On the second day we divided the participants into two groups with one group being led by myself and the other by Dr Faisal Shaikh. My own group was co-led (in turns) by Dr Aisha Sanobar, Alya Mian and Mehvesh Yousuf. Dr Shaikh's group was similarly co-led (in turns) by Dr Nargis, Dr Humera and Atia Naqvi. On the second day of the retreat we had altogether three small groups and one large group at the end. A number of themes that came up in our discussion had to do with life and death issues, trauma of loss and bereavement as well as the vulnerability of clinicians and physicians when dealing with death in hospital settings. Balint provided a safe place to these clinicians to explore the relational and emotional aspects of cases that otherwise largely remains unprocessed due to the mania of clinical work on the floors. The forum of Balint retreat also provided the participants that long needed platform where they can share, mourn and grieve for losses that still resonated in their sub-conscious due to the powerful impact certain patients and families left on them.

For the leaders and co-leaders, managing the dynamics of groups who were primarily operating at an 'Eros versus Thanatos' level was challenging but at the same time a uniquely evolving experience. During the group process, I resonated with my own endings and loss in 2015 at the time of leaving the UK and how those subsequently led to new beginnings in Pakistan. This led me to think whether processing loss and endings is sometimes an integral prerequisite for a group to undertake before it can proceed on any pathways of new beginnings. Dealing with the predominant themes of death and dying in both groups was almost similar to containing the primitive anxieties of a newborn who is suddenly confronted with dealing with the harsh conflict between life and death following birth. Our groups had similar primitive anxieties including the anxiety of being

able to survive and hang on, thrive and grow when they heard each other's often relatable stories of pain and loss. As leaders and co-leaders, we realised that the groups were demanding primarily holding and containment to help them metabolise extremely raw yet organic affects, stemming from their encounters with patients and families. The prime focus on holding, containment and nurturing allowed both groups to develop a mental gut of their own using which they were eventually able to process intimacy with emotions both at a group as well as an individual level.

Another observation on our behalf was the diversity within the groups where physicians belonging to various specialities, perhaps for the very first time, got the opportunity to be in a reflective group with therapists, medical students and nursing staff. The inherent diversity created rich narratives within both groups which enabled members to mentalise about the nature and challenges of each other's work in an empathetically mindful manner. Balint therefore has another important function especially in cultures where hierarchal power imbalances lie deeply imbedded within the health care system. Balint in such settings might become a catalyst for temporarily dissolving such power imbalances between health care professionals which otherwise can come in the way of exploring professional vulnerability associated with patient care.

On the third day of the retreat we had two groups in the morning and subsequently an open feedback session. The feedback session also discussed the next steps and ways ahead with regards to taking Balint work forward. It was indeed encouraging for our working group to hear from a very prominent Lead Consultant recommending Balint for postgraduate trainees to address the relational and socio-emotional complexity of our day to day clinical work. Before we ended our retreat, we chose a video song of a notable poetry singer as a way to conclude our retreat. The theme of this video song was healing within a group and how human connection and empathy can transcend boundaries of words, age, gender or culture.

Feedback from participants regarding the Balint retreat workshop was strongly positive with emphasis on arranging such events on a more frequent basis. A suggestion was given in relation to picking a venue outside hospital settings next time. Some excerpts from the feedback given to us by participants are as follows:

Participant A: "It made us feel relaxed, lighter and helped in preparing ourselves to do what we usually do day in and out all over again with the same compassion and empathy. Absolutely something worth attending!! Hope we can spread this out more in our own departments and help them to heal whenever they find the need."

Participant B: The feedback asked about the strengths of this activity/event to which one of the participant responded "The diversity and the space provided plus the overall methodology and experience"

It was a moment of delight for the members of our working group to eventually see Balint take its shape, form and function in a setting like Pakistan where group work comes with its own set of unique challenges. Creating a contextualised identity for Balint in Pakistan has been a challenging but simultaneously an opportunistic task. It has helped in creating innovative forums for clinicians where the platform of Balint can be used in a rather subtle way for professional as well as personal growth of health care professionals. Balint is a simple yet powerful intervention and the retreat certainly helped in generating that high tide that was necessary to surf its agenda on a hospital wide forum. Balint is here to stay, thrive and evolve as the working group continues to work closely with

hospital leadership in relation to integrating it within the postgraduate medical curriculum. Hopefully we will have more updates on our progress and challenges ahead, as Balint becomes organically integrated within the DNA of our local systems and processes.

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“From membership to leadership”

– Scarlett Tankard,
Intercalating medical student (between 4th and 5th Year),
University of Bristol

This is a reflective essay discussing my experience of Balint groups as a medical student, both as a participant and later, as a leader. This is an edited version of a speech given at the Balint Society 50th Anniversary event in London on 17th May 2019.

Introduction

My first taste of Balint was joining a group as part of the Bristol Medical Student Balint Group Scheme in 2016. Balint was completely novel to me, I had no understanding of what it was about, why it was necessary or how it could be helpful. I soon realised that I had been given the opportunity to be able to speak openly and honestly about my experience with patients and also the experience of transitioning from being in lectures at university, to being in the hospital. This safe space, created by the leader, was the first time I felt comfortable, really thinking about my interactions with patients and aspects of my role as a medical student. It helped to spark my enthusiasm for reflective practice and left me intrigued to find out more.

Following on from this, myself and my colleague Julia McLaughlin spoke at the Royal College of Psychiatrists’ Medical Student Psychotherapy Symposium in 2017. We spoke about our experience of being in one of the Bristol groups. This led to us attending the International Balint Federation Congress in Oxford where we started to grasp a better understanding of how a Balint group is run. With the generous support of Judy Malone, Ami Kothari and Clare Trevelyan we were able to attend leadership training days. We were then each partnered with one of the more experienced trainee psychiatrist leaders and began co-leading Balint groups last year, attending supervision with our co-leaders.

I have just finished co-leading my third Balint group which I was able to speak about at this year’s Royal College of Psychiatrists’ Medical Student Psychotherapy and Balint Group Symposium. I’ve learnt so much about Balint and Balint leadership, but also about the student role, student anxieties and the challenges we face in our training, particularly in learning about the emotional aspects of medicine.

My learning so far

If it will not help them towards achieving high marks in exams, they might not attend

A common problem with medical student groups for the whole cohort is that you will inevitably come across the sceptics. The ones that call it “fluffy medicine” or complain that we reflect “too much”. I knew about this before, but naively when I first started co-leading I thought my keenness and enthusiasm for Balint would be infectious. Sadly, it’s just not for everyone.

Nonetheless, having a senior medical student as a co-leader in a group can help to “mind the gap” between the 3rd year students and the psychiatrist in training. Instead of the dichotomy between them and the more parental psychiatrist, my relationship with the students felt more equal. As a medical student leader, I was able to encourage the group members, modelling the usefulness of the sessions by drawing upon my own experience, partially joining the group and enabling student involvement.

Sometimes you might disagree with the students

There was a chilling case that I haven't forgotten. The presenter described it as something that "wasn't very traumatic" yet went on to explain that a 21-year-old man had a cardiac arrest during a 'bleep test' at the gym. The test involves participants having to sprint each time a 'bleep' noise is played and reach the other side of the gym before hearing the next noise. The patient told the presenter that his next memory was waking up in hospital to the sounds of the monitors 'bleeping'.

Bleep... bleep... bleep.

I remember shivering when I heard the case and the words "wasn't very traumatic" felt like they were hanging in the air between myself and the students. It turned out in fact that all the students had seen this man during 'bedside' teaching and everyone participated in the group discussion. What was noteworthy about the discussion was the students didn't talk about their interaction with the patient or with the doctor. The lack of this discussion felt inhumane. Robotic in fact. Chilling. It felt like they were already barricading their emotions in order to protect themselves, something they had possibly learnt from witnessing senior doctors. By intervening to encourage an alternative view of the case and identifying the complex intense feelings that were being kept out, we enabled the discussion to develop. The students seemed to move towards being able to think more holistically, have more understanding and feel more empathy towards the patient.

It is a shared learning experience for both the facilitators and the participating students

A similarity between the three groups that I have led has been the topic of power and hierarchy within the healthcare system. A recent case discussed the role of the student in the patients care and whether or not they would feel confident answering a patients' questions surrounding their healthcare. There was a split between the group, one side argued that they would and the other would not. A mirror of the stereotypical confident consultant versus the junior staff evolved throughout the discussion. It felt like a tennis match. One side were unified in feeling stupid, inept and they worried about humiliating themselves in front of senior doctors. The other side, interestingly the only males in the group, were extremely assured in their abilities to answer questions from patients or doctors. Myself and the co-leader struggled to keep up with the pace and energy of the conversation. It felt important to allow the students to listen to each other's points of view but also to bring the case back to the patient, who was easily lost, and back to the student-patient relationship. Interestingly, no-one spoke about the discomfort in the student role being between patient and doctor yet having a valuable position being able to be with the patient and hear the patients' concerns and potentially even liaise between patient and doctor.

The inability of the females in the group to see their usefulness resonated with me. I reflected on my own experiences during the discussion, as I too still feel at the bottom of the hierarchy. I wondered how this affected their interactions with their patients. Being able to validate their experiences as one that was shared enabled the group to discuss the impact this may have on their barriers to empathise with patients. I learnt so much from them about how I could change my practice and how I could encourage students that I see in the future to have more confidence whilst in hospital.

Conclusion

Leading a Balint group has been a unique experience and one I hope to carry on developing throughout the rest of my career. To be able to recognise the emotional climate of the case and the group response, to attend to the feelings that arise and most importantly to retain the focus on the student-doctor-patient relationship are key to successful leadership.

This journey has been such a privilege and a testament to that first mandatory session in Bristol.



A musical interlude at the Anna Freud Centre.

The Balint Essay Prize Winner 2019

Mrs P: Balint Group Essay

by Jenna Crosbie

I met Mrs P over 6 months ago on my first day of clinical medicine. She was an elderly lady who had been in hospital for several days at least, and a fellow student and I had been sent to her to try out taking a history. I have forgotten many of the medical details of the situation; I'm not sure which conditions she had, or even the reason that she had been admitted to hospital. However, the way she interacted with us and the emotions she displayed to us left a strong impression upon me which I have been unable to forget.

In this essay I will first reflect on the details of our encounter, describing my response at the time. I will then examine my thoughts after our interaction, and how her case was discussed within my Balint Group (to whom I presented it in our first meeting). Finally, I will summarise what I learned from the experience and the discussions it provoked; and explore some possible implications this could have with regards to how myself and other students might approach similar situations in future.

Back on that first day of placement, my interaction with Mrs P began pleasantly. My friend and I were able to introduce ourselves, ask Mrs P if we could talk about what had brought her into hospital, and start gently gathering information. Although there were plenty of pauses as we tried to remember which questions to ask, I think it helped for two students with no real prior experience that Mrs P's 'little old lady' character was relatively non-intimidating to approach - and she seemed happy enough to talk with us. I found her history at first fairly unremarkable; she had a number of ailments as many elderly patients tend to, and she took a multitude of tablets, most of which she couldn't name. She lived in an elderly care home and needed help with most activities of daily living.

Though I didn't contemplate it fully at the time, Mrs P's succession of answers began to paint a very sad picture of her life. Her husband had passed away and she had no close friends or family except her son, whom she hoped would visit her soon. I found myself hoping that when asked a question like "Are you able get out of the house sometimes?" or "Do you have any hobbies?" or "Does your son live nearby?" she would 'light up' and give us something to smile or laugh about. Instead every answer only pulled the conversation down further. I think that she was aware of this too in a way, and I felt uneasy, as it was like our questions were drawing these negatives to the forefront of her mind and saddening her.

At some point perhaps 20 minutes into our conversation, Mrs P's mood visibly changed and she became emotional; telling us how she "knew" she was nothing but a burden on everyone. She was convinced that her son wasn't going to come to see her, and that he would be better off getting on with his life without her. She told us that her care home nurses didn't like her, and she was just a burden to them too - nobody needed her. With tears in her eyes, she said that she sometimes wished that the doctors and nurses would just "let her go", as that would be "better for everyone".

Upon hearing this I was overcome with sadness - I remember thinking "nobody should feel like that". I also was acutely aware in that immediate situation that I had no idea what to do or say to stop her crying and make her feel valued. The whole thing was

very upsetting and my gut reaction was to crouch down by her bed and take her hand in a gesture which I hoped was comforting and not too awkward. My friend stayed standing by my side and didn't say anything, so I started speaking without really knowing where my sentences were going, saying a couple things in a fluster along the lines of "don't feel like that... you aren't a burden... he's your son and you've cared for him all his life, of course he needs you". I really struggled to come up with words, and kept muddling my sentences. Racking my brains for anything comforting to say, I drew inspiration from a conversation I'd had with my grandmother several years ago: "hospital visits can be very stressful I know - my nan finds it the same when she comes in... she'll always be worrying for weeks before a little appointment."

Mrs P did react to my efforts and stop crying, and she asked a few questions about my grandmother's experience which seemed to interest her - but I sensed that my words had sounded half-hearted, and I doubted I'd managed to express at all why she should value her life. My colleague and I exchanged glances; we hadn't finished our history-taking but it felt impossible to move the conversation on and find out any more medical information after this. Besides, we were now running late for our teaching. We left Mrs P awkwardly, with half-smiles and a "take care" which felt very insufficient.

Afterwards a group of us (quite large - at least 15 students) had teaching from an F1 doctor to feedback on our histories. There were too many of us to present our cases, but he discussed some tips and asked if we had any questions. I wasn't able to explain the situation I had encountered, but asked how to deal with history-taking bringing up negative emotions, and how to react if a patient says something to us implying they don't want to live anymore. His answer was to always, if unsure, use the "medical student card" and try to move the conversation on. Later, I went to pick up my bag from the doctors office and spoke to another junior doctor about Mrs P, mentioning what she had said. A few doctors looked at me with sympathy, saying that she has anxiety and "can be a bit like that". They seemed to feel sorry for me, as if the sad point of the situation was that I hadn't picked an easier patient for my history-taking.

It all seemed innately wrong to me somehow, and left me feeling uncomfortable and unsatisfied for days afterwards. Even now it is hard to pin down the components behind that feeling. The pessimist in me wondered whether it had simply exposed me to two uncomfortable truths: 1) that some patients have lives that they don't value and I can't justify them valuing either, and 2) that even doctors didn't seem to have any real advice on how to react and what to say in that situation. Maybe I had come into medicine disillusioned that doctors should always know what to say to upset people in awful situations. If anything, it seemed that the doctors I spoke to had become preoccupied with how to get out of that level of interaction with patients like this, which worried me about how I might become in the future. Maybe my worries stretched even further into the future; what kind of a society lets elderly people get into situations such as Mrs P's?

At the time, all I really knew was that I had this uncomfortable feeling, and I wanted some kind of reconciliation. I searched on the internet for advice and spoke with a couple of friends and family members about the situation, trying to find out what I could've said or done differently. This helped me to pin down one of the things I'd found so hard in the moment that Mrs P had revealed her thoughts about wanting to be "let go". Often with upset people, and with other patients since Mrs P, I would draw up a comment to try and make them smile again - usually something about them getting home soon, their grandchildren, husband, siblings, friends, neighbours, dog - even their passion for line-dancing. This situation was hard in that there was nothing in Mrs P's history that I could think to use; she had no family to rely on, she didn't want to go back to the care home,

etc. I realise that this is an extremely crude and flawed way to judge somebody's quality of life, but it unsettled me all the same and was one of the reasons I'd felt so sad to be lost for words.

On reflection I also realised that it was not only being unable to find words, but also some of the things which I had chosen to say, which dissatisfied me. For example, I was retrospectively unsure how helpful it had been to say "don't feel like that". Even at the time it had felt like what I can only describe as 'filler-words' whilst I tried to think of something better - I just wanted to break the silence following what she had told us, and for her to feel that I cared about her emotions. It had been too easy to start trying to solve Mrs P's problems as if I understood them entirely.

My parents gave me some advice on this which I found very poignant; they advised me that, although tempting to, it is best not to say things or make promises like "of course your son needs you" because this relies so heavily upon assumptions about that person's situation. They both work as window-cleaners on the Isle of Wight, and have many elderly customers - they've seen numerous cases in which accounts between elderly people and their children in situations like this have been revealed to be highly misleading. For all I know, Mrs P's son cares nothing for her - she may have been malicious to him, or involved in a family feud of some sort. The same goes with her comments about the care home nurses; me saying that the nurses are there to do their best to care for Mrs P is one thing, but reassuring her that "i'm sure they do like you!" is another, particularly not having heard an account from their side. This illustrated to me how easy it is to side with the patient sometimes, when actually this could encourage dangerous and easily-shatterable false hopes, or even just make the patient feel that you are not understanding them because you are assuming things about them without knowing what the real situation is.

Conversing about Mrs P within our Balint group was a highly constructive experience. Despite it being our first session, and quite a heavy and sad subject, as a group we talked through a number of points which gave me new perspectives and lenses with which to look at this situation through. Right away I was faced by people in this attentive and thoughtful space also saying that they weren't sure what they would've done either in this situation. One of the girls even said that she'd have reacted in the same way as I did. This both relieved me of some of my self-criticism (hopefully because it meant I hadn't missed an obvious solution or made a huge mistake) as well as frustrated me. The group picked up on the cause of my frustration too - they said that it seemed that through the language I was using, I was looking for an answer; a phrase to say; the "right thing to do": they were definitely right.

In terms of a right thing to do, the consensus was that there probably is no right way to react. One of the leaders explained that when medical schools used to give out lists of phrases to say in situations, the feeling was that this was too prescribed and limiting. And besides, a hugely useful point raised was that in worrying about myself and my own reaction to this situation, I missed thinking about the patients side of the interaction. We established that sometimes it can be therapeutic in itself for a patient (or indeed any human being) just to speak worries aloud and be listened to.

From this, I realised (whilst sat in the Balint group) that often when I personally have an issue, I tell others about it not necessarily with expectations that they will provide a solution, but just to have the knowledge that someone else knows what I am going through, and maybe can help me understand what I am feeling. I appreciated more that spilling out your problems to another can be helpful almost regardless of what that person says back to you. This eased my worries that I hadn't been able to react sufficiently to help Mrs P. By this logic, her just speaking about her worries and us listening had

hopefully given her some relief. However, I could maybe have furthered that relief by actively listening, and asking her more about what she had said.

Something else helpful that I took from the group was that the divulgence of sometimes wishing not to live anymore is something which I could've considered less as a personal problem and more as a medical problem. Perhaps medicalising this problem would help guide me in how I reacted. For example, I could treat it as a symptom and explore it more; asking "How long have you been feeling like this? Why do you think you've been feeling like this? Does it come and go? Does anything make these feelings better or worse?". Part of me wonders whether this would help the patient more or not. I worry still about bringing more sadness to the surface and making patients hyper-aware of the extent of their problems. However overall I think it would be a useful strategy to ask medical questions when faced with such a disclosure, as it encourages you to worry more about their problems and not your own response (as mentioned earlier), and it may yield more clinical information which could be fed back to doctors and used to benefit the patient's management.

We also discussed how we might handle this case were we doctors, not students. It came out that there was a fear amongst the group that listening to patients' problems and taking on their emotions and worries could create a situation where a patient grows dependent on you as a doctor for continuous support, which may not be possible to maintain after the patient leaves the hospital. We all loosely agreed that doctors should maintain a professional distance from their patients, but struggled to define what this meant, particularly in terms of problems like these which were so deeply emotional, "hard to fix" and involve lengthy, time consuming conversations.

What we then considered was that as doctors, even if asking some questions might lead to an upsetting conversation which in the short term leaves patients feeling worse, this could be for their greater good. We reasoned that if you ask difficult questions despite your fears, and a patient consequently opens up and has their problems further explored and "quantified", hopefully both patient and doctor will understand each other better, and that patient will trust their doctor to make decisions about their health in greater knowledge of their current situation and emotional state. Furthermore, questioning beyond the surface has the double benefit of encouraging patients to vocalise their problems to another person, which may be therapeutic in itself, given what we had established earlier. Perhaps the notion of 'short term pain, long term gain' applies here.

A final thought, developed both from points raised in the Balint group and a conversation with a friend afterwards, concerned my motivations for wanting to reassure patients and make them happier when they get upset. Did this really come from some internal altruism? Or did it come from my discomfort with the situation and my fear of seeing them be upset? My friend introduced me to the word 'platitude', which I think describes the idea I am getting at. Platitudes are generally said to try to quell the user's unease in a situation - to emotionally flatten it out. But as my friend, quoting Dr Brené Brown, pointed out: "rarely, if ever, does an empathic response begin with 'at least'". If I want to empathise with a patient, perhaps I need to focus more on understanding their problem, rather than trying to alleviate it.

Overall, my experience with Mrs P drew several novel ideas to my attention, and left me with lots to reconsider. Subsequent discussion in my Balint group helped me better come to terms with an interaction which I had dwelled on frequently over the prior few months, and gave me ways to look at it in a new light. I know that even without this discussion, in future scenarios akin to this one, my approach would be different as a result of having more confidence speaking to patients and being on the wards in general.

However, following our Balint discussion, I hope my approach might change towards concentrating less on saying the “right thing” and focusing more on listening and exploring the patient's thoughts as to why they feel this way, and being less afraid of their potentially unhappy and difficult emotions. I feel reassured now when speaking to patients that I am more prepared for this situation should it arise, and I’m not sure that I would’ve come to this conclusion myself had I not been lucky enough to partake in the Balint group scheme. Hence, I personally would thoroughly recommend having the option to join Balint groups as a part of medical education for all medical students in the future.



Balint event at the Anna Freud Centre, December 2018.

The Balint Essay Prize Runner-up 2019

Personal experience of a Balint group

by Natasha Poveyn

I am a UK medical student who recently experienced participation in a Balint groups for the first time during a psychiatry rotation. I wish to compare my experience of the Balint group to the literature, to suggest methods to best utilise this method in order to benefit students. The ultimate aim of the Balint group is to improve the student's awareness of emotion and the psychosocial aspects of illness, ultimately influencing the doctor-patient dynamics⁽¹⁾. Medical students have been identified as struggling to maintain their empathy, suggesting these Balint group sessions to potentially be of real benefit^(2,3).

The layout of our Balint group was similar to Balint groups described in literature⁽⁴⁾. We had a group leader sitting amongst the students within a circle of around 15 people. A student volunteered to talk about a patient who had been on their mind, we listened to this story without interruption, the presenter would then leave the circle and sit in silence whilst the group discussion commenced. The group then talked about potential feelings from the doctor and the patient and possible explanations for those for around 30 minutes and then the presenter re-entered the circle.

Initial feelings & group dynamic:

Before attending the Balint group I didn't really know what to expect. Without doing any prior research I naively assumed that the sessions would be highly emotional - I thought that students would directly make connections between their own personal lives and patients' stories. I also thought that the group size would be smaller with a lot of discussions and little time for silence. This naïve assumption was different to reality, the initial session was quiet, and although all members of the group did contribute everyone appeared to be quite nervous and reluctant to fully explore their thoughts and analyse their statements for the group. Despite this, the case presented was very interesting and I feel that different viewpoints were explored by members of the group. This made me think that perhaps the group dynamic affected how open we were with each other. The group size was relatively large which made may have made us more inclined to depend on other group members to vocalise their thoughts rather than contributing our own ideas. In a study by O'Neill et al (2016) students stated that they benefited from the 'open' non-judgemental nature of the group in addition to the small group size⁽¹⁾. I felt that during our session although all group members were polite I did feel they were quite judgemental. Often facial expressions during the session suggested that other members of the group had very different thoughts and did not appreciate a different interpretation, making us reluctant to comment. The group size also felt quite large which made limited a feeling of unity. I feel that to address this feeling of judgement and hostility student education maybe vital. If students were aware of the purposes of the Balint group and the need to not express judgement, it would have encouraged a better group environment, enabling us to gain more benefit from the experience. Additionally, education in the Balint process will aid students understanding about it, as evidence suggests the process is relatively difficult to understand^(5,6).

Improving empathy vs lack of involvement

By presenting and listening to cases with the questions posed by the group leaders, I began to better see that patients have complex lives and relationships outside of the doctor's room – which is highly relevant to their care. It has also made me appreciate possible motives or underlying explanations for perhaps “unusual behaviour” and why I may be feeling the emotions which I did at the time. This supports literature which states that these group sessions aid students to recognise and understand the emotions which they encounter with the patient⁽¹⁾. However, I felt that during this rotation although I did see many patients and did feel emotion the patient encounters which I had were relatively limited to what I hope to experience once qualified. I felt that due to having short rotations and limited time with patients (no more than an hour on most occasions) I couldn't fully explore their social and psychological background and found it hard to appreciate the complexity of their situations. This understanding was hindered further by any additional distortions of reality which the patients may have been experiencing. However, I do not personally feel this is a problem as if we get used to developing these skills, there will be a time where we will be a lot more involved in the care of patients, making it useful for our later careers. This is supported by Parker et al (2014) who stated that students felt they did not have complex roles or relationships with patients. However, this process will help them to navigate support when required enabling them to cope with their training⁽⁶⁾.

Parker et al (2014) suggested that students struggled to remain focused on empathic reflection on the student-patient relationship as students instead talked about the diagnosis and pathophysiology of the condition⁽⁶⁾. I felt that during our sessions this was not a problem, people did not discuss anything biomedical, however this lack of biomedical discussion may have been due to the silent nature of the group.

I felt that the conduction of the Balint group sessions were quite disruptive, we often had to rush back from placement to make the session and we felt very pressed for time, often not having time for a lunch break, similarly to many other medical student groups⁽¹⁾. I feel that a better way of integrating these sessions would be to incorporate them into modules such as sociology and psychology where a group discussion talking about a patient would help us to appreciate these aspects in a clinical context, this will potentially enable their introduction a lot earlier within our medical curriculum and they could be conducted throughout the 5 years.

Overall, I feel quite neutral towards my Balint group experience – however, I can see the potential for them to be very useful, especially when we gain more responsibility and have more patient involvement. I feel that in a supportive and open-minded group they could have provided a lot of benefit in helping us to appreciate the complex psychosocial dynamics of our patients lives through a collaborative conversation and to consolidate our emotions and motives. However, I think with large group sizes, worries about confidentiality and little education about the purpose of these groups, their efficacy in medical education will be hindered.

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Balint Memorial Lecture 2019

Dr Peter Toon

It is both an honour and a pleasure to be invited to give the Balint Memorial Lecture, particularly in this anniversary year. I plan to use this opportunity to try to bring together two areas I consider to be of great importance for health care – the ideas of Michael and Enid Balint, their co-workers and successors, and the approach to ethics based on the concepts of virtue and *eudaemonia*, the flourishing life.

Part 1- Balint and Virtue ethics

My life and Balint

Balint met me as soon as I started GP training in 1981. When I arrived at my training practice in Well Street Hackney I felt I had come home – a completely different experience from the alienation I had experienced in hospitals, except for six months I had spent working in a tiny hospital with a warm atmosphere in Caithness in the far north of Scotland. There I was the only junior doctor working for a person-centred consultant physician who constantly advised me “not to become too chromium plated” and the total staff was only about 20 people; in other words it was very like a general practice, only for in-patients.

My trainers Mal Salkind and Paul Julian were both strongly influenced by, and contributors to the Balint movement. The other two partners, Gabby Tobias and Nick Hutt, both of whom sadly have now died, and Lesley Southgate, the academic GP based there shared their values. How much the atmosphere of the practice was due to this involvement of the partners in the Balint movement I cannot tell, but I suspect it played a major part. Certainly I have since worked in much less congenial practices, but none of them has been what you might call a “Balint” practice, whilst I have always found the Balint-inspired practices I have worked in warm and welcoming, to a locum as well as to patients.

The course-organiser (now called programme director) for the GP training scheme in Hackney was Heather Suckling, a former Treasurer and President of the Society, and throughout my three years of training the second part of the half-day release was a Balint group. I’m sure this significant amount of time spent on Balint work changed me both as a doctor and as a person.

An introduction to virtue ethics

My interest in virtue ethics came later. My intercalated degree in psychology, had made me grapple with philosophical problems - the nature of knowledge and how the brain and the mind fit together. This led to an interest in the concept of disease, particularly inspired by some very dodgy arguments for considering homosexuality as a disease, and my first academic publications were on that subject. These interests led me to take the Society of Apothecaries Diploma in philosophy of medicine which naturally included ethics as well as epistemology and ontology.

Later I met the medical ethicist Len Doyal, and we spent many happy evenings over curry in the Whitechapel Road. At one of these he recommended Alistair MacIntyre’s book “*After Virtue*” and though it is not an easy read I became convinced that virtue ethics in general and MacIntyre’s ideas in particular were important for health care.

Unlike rules-based or consequentialist ethical theories, virtue ethics focusses on agents rather than on acts, and not only considers rational thinking about what is right -

it also considers how we train the will and the emotions to do so willingly and easily – something which I would suggest is at the heart of what we do in the Balint groups. Most importantly the fundamental question of virtue ethics is not “what should we do?” but “how should we live if we are to flourish” – in Greek *eudaemonia*.

Aristotle suggests that the route to *eudaemonia* is not through taking part in the cut and thrust of politics or the pursuit of fame or pleasure but via a life of contemplation (by which I think he meant not only the quiet meditation we understand by that word but also the search for knowledge and understanding of the world to which he devoted much of his life) and of friendship. Aristotle had in mind the limited male friendships available to an educated free Greek citizen, but I think we can expand that to human relationships in general.

To live a flourishing life – to achieve our end or *telos* – we need to cultivate certain personal qualities which he calls *arête* – usually translated as virtues but some suggest “excellences” or “good personal qualities” are a more appropriate translation. St Thomas Aquinas suggests that virtues are habits or dispositions to act rightly, according to reason; Marta Nussbaum and Amarita Sen point out that they are the qualities we need to overcome the challenges which we face as we go through life.

Macintyre’s theory of virtue

Macintyre’s theory can be divided into two parts. The first is the hypothesis that a coherent moral tradition existed before the Enlightenment (when virtue was central to ethical thinking) but this has been lost, so that we live in a fragmented moral universe – “*After Virtue*”. He suggests that “*a partial solution*” to this problem is to return to an ethic focussed on cultivating the virtues by engaging in what he calls “*practices*”.

He defines a practice as “*any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.*”

He explains this rather legalistic definition subsequently, and further defines his idiosyncratic use of some words. A practice is “*never just a set of technical skills*” although “*every practice does require the exercise of technical skills*”. Rather, through participation in practices “*conceptions of the relevant goods and ends which the technical skills serve ...are transformed and enriched by these extensions of human powers and by that regard for its own internal goods.*”

He tells us that a practice “*involves standards of excellence and obedience to rules as well as the achievement of goods*”. Although “*the standards are not themselves immune from criticism*” and “*practices never have a goal or goals fixed for all time*” since “*the goals themselves are transmuted by the history of the activity ... we cannot be initiated into a practice without accepting the authority of the best standards realised so far.*” although established practitioners may challenge and reformulate those rules.

A practice has an identifiable history, and “*to enter into a practice is to enter into a relationship not only with its contemporary practitioners, but also with those who have preceded us in the practice, particularly those whose achievements extended the reach of the practice to its present point.*” It was the opportunity which I had to do this at Well Street and on the Hackney Vocational Training scheme which made that such a positive experience.

The difference between internal and external goods in two important ways is crucial to MacIntyre's theory. Firstly *"it is characteristic of external goods that when achieved they are always some individuals property and possession"* and *"characteristically they are such that the more someone has of them the less there is for other people"*. They are *"characteristically objects of competition"* in which there must be losers as well as winners. They are "zero sum" This is obviously true of material goods such as money and other possessions, but this also applies to some non-material goods such as fame and power.

In contrast, although internal goods are *"the outcome of competition to excel"*, it is characteristic of them that *"their achievement is a good for the whole community who participate in the practice"* and the possession of them by one person does not take them away from others, but enriches them. They are "win-win" goods. MacIntyre's examples are Turner's transformation of the seascape in painting and W.G. Grace's advancement of the art of batting in cricket. Knowledge and skill are internal goods of this type.

MacIntyre points out that external goods can be achieved through a practice irrespective of how one participates in it, whilst internal goods can only be achieved through a sincere attempt to achieve excellence according to the rules (explicit or implicit) of the practice. MacIntyre uses the example of a child bribed by the promise of sweets if she wins to play chess. The sweets are external goods, whilst the pleasure that derives from playing chess well - *"the achievement of a certain highly particular kind of analytic skill, strategic imagination and competitive intensity"* - is a good internal to the practice. So long as the child only plays to get the sweets, it does not matter to her whether she cheats or not, so long as she wins. Cheating however renders unattainable the internal goods of chess - that satisfaction uniquely obtained through the pursuit.

MacIntyre defines a virtue as *"an acquired human quality, the possession and exercise of which tends to enable us to achieve those goods which are internal to practices, and the lack of which effectively prevents us from achieving any such goods."* - a definition which complements rather than competes with those I mentioned above.

Healthcare as a MacIntyrean practice

Healthcare has many of the characteristics MacIntyre attributes to a practice - indeed there are few MacIntyrean *"practices"* of which the words practice, practise and practitioner are so widely used. It is a socially established human activity and is complex (*ars longa vita brevis*). Its history in Western culture stretches back to Hippocrates, in both its practical knowledge and its ethical standards. It is not just a technical skill, although it involves the exercise of many such skills. It has standards and both explicit and implicit rules, although some of these lack clarity, especially at the borders. It is cooperative, and is taught and endlessly discussed, argued about and developed amongst its practitioners. The training of a doctor is still basically an apprenticeship, in which the would-be practitioner enters into a relationship with contemporary practitioners, as I did in Caithness and at Well Street. There are clear goods internal to medicine - medical knowledge and skill and their fruits in the improved health of the community.

Balint speaks of *"the small but significant change in personality"* which comes from participation in the Balint group and which enables the doctor to see and relate to the patient and the illness differently. This sounds to me very like another way of talking about cultivation of the virtues needed to flourish in the practice of healthcare, which also involves small changes in our personality –developing tolerance, temperance and patience by recognising our prejudices, learning to be aware of our emotional reactions and to use them positively rather than letting them get in the way of a healing relationship.

Medicine has no doubt been deformed by overemphasis on technology and our love

affair with the biomechanical model, and more recently with the values and apparatus of management – a distortion often referred to as “*managerialism*”.

Balint as a development of the practice

It was the shortcomings of the first of these distortions which led general practitioners in the 1950s to and 1960s to attend those first seminars run by Michael and Enid Balint, at which they sought a better understanding of the doctor-patient relationship than their biomedical hospital-based training had given them. They were experienced practitioners challenging and reformulating the rule of the practice of healthcare as it was carried out in general practice – in this case the overemphasis on the explanatory power of that biomedical model which emerged out of the Enlightenment (or perhaps rediscovering and re-expressing rules which had been lost as part of the moral fragmentation resulting from that Enlightenment). Since then the Balint movement has been an important way in which established practitioners have challenged and reformulated the rules of clinical practice in ways which affect many who have never been near a Balint group – for example by its influence on *The Future General Practitioner* and on the criteria by which candidates for the MRCGP examination are assessed in the CSA simulated surgery

For those early participants in Balint groups as for many of us since, those groups gave us the tools to overcome the challenges we face in general practice and to flourish despite, or even because of them. I think these groups develop habits which help us to act rightly in the consultation, and although much of our attention in groups is focussed on our feelings, the reasoned search for understanding of “*why the patient has come now, with this particular problem*” is also part of the group process. The healing the patient receives when the consultation goes well and the satisfaction the practitioner experiences from her successful treatment are both, in MacIntyrean terms, internal goods.

So it seems to me that there is a good case for seeing Balint work as part of the process of cultivation of virtue and the search for *eudaemonia* for both clinician and patient, and for talking about this within a MacIntyrean framework. The “internal goods” which Balint insights into general practice and no doubt other professional relationships) offer are not only these virtues but also things like the satisfaction the practitioner gets from “the flash” and the sense of connectedness which comes from Balint-inspired practice. An increased ability “*to bear what has to be borne*” for the patient is another example of an internal good which comes from Balint inspired practice, but Mal Salkind, my first trainer, once said to me that Balint had been his salvation as a GP. Perhaps it’s not just for patients that Balint helps to bear what has to be borne? This is an insight which those responsible for planning a primary care service with problems of recruitment and retention might do well to pay more attention to.

Part 2 – What Balint teaches us about virtuous practice

I think I have shown that Balint work and thinking have played an important part in supporting the flourishing practice of healthcare which I discussed in my book published a few years ago. In the rest of this lecture I will try to explore a little about what the Balint corpus of work has to tell us about the virtues we need to flourish as health professionals (and also to flourish as patients) drawing on some of the publications of Balint research groups and thinkers over the last 60 years, and from time to time on my own experience. I will also raise some questions on the particular contribution that involvement in a Balint group makes to the cultivation of the virtues needed to flourish as clinician.

Virtues and vices in “The Doctor, his patient and the illness”

The starting place must be the foundational text of the Balint movement *The Doctor, His Patient and the Illness*. Words like “virtue” and “flourishing” don’t actually appear there - hardly surprising, since the renaissance of virtue ethics had barely started - Elisabeth Anscombe’s essay “*Modern Moral Philosophy*”, often seen as its starting point was published in 1958, one year after *The Doctor His Patient and the Illness*. Perhaps both works arose out of the same Zeitgeist? But nevertheless I think several phrases Balint uses in this book tell us something about the virtues – and vices –important in clinical practice.

The most obvious one, because it does use an explicit virtue term is “*the courage of our own stupidity*”. I’ve always thought courage to be a particularly interesting virtue; not least because perhaps more than any other virtue it gets to places which other ethical systems cannot reach. It exemplifies particularly well the combination of reason, emotion and will needed to be truly virtuous.

Courage is clearly important in clinical practice. Occasionally (as for example in the early days of the AIDS epidemic, more recently during the Liberian outbreak of Lassa fever; or when treating trauma victims in war-zones or disaster areas) clinicians require physical courage to face a risk to their life and health in their work – a type of courage very similar to that of the soldier in battle.

More often however they need moral courage- the courage to break bad news gently but honestly; the courage not to walk past the bed of the dying patient for whom curative medicine can do nothing. I’m sure the reflection on difficult situations with patients which we do in Balint groups can help develop this type of courage.

But the courage of our stupidity is another aspect of clinical courage – the ability of the clinician to feel “*free to be himself with his patient – to use all his past experience and skill without much inhibition.*” It takes courage to not follow guidelines or fall in with patient expectations, or feel obliged to do things you were taught were right at medical school when these seem wrong in a particular situation. The last is a vice which Balint refers to as “*the persistent teacher-pupil relationship*”. But this type of courage is a crucial part of becoming a fuller human being and a better doctor; flourishing as a clinician gaining the internal goods of the practice of healthcare.

Balint also discusses the importance of timing, which he says means “*not being in a hurry*” - in other words the virtue of patience. He speaks of this in connection with the change in the doctor in the Balint group, but as so often what happens in a Balint group mirrors clinical practice. A clinician is often aware of something the patient needs to recognise in order to flourish, but has to avoid pushing them too hard to do so– if she doesn’t wait until the time is right the patient’s defences may spring into action and progress may be put back for months – sometimes for ever.

One chapter of *The Doctor His Patient and the Illness* is entitled “*When to stop*”. This chapter also partly deals with patience, knowing when the best thing to do is nothing, and with strategies – symptomatic treatments, further investigations – which keep the patient engaged until the time is right for psychotherapeutic intervention. Yet it also involves the virtue of temperance; the acceptance that there are limits to the doctor’s powers and capacities. It may be right to stop because partial improvement in the patient is the most that can be achieved; or because the patient (or the doctor) cannot bear to go further on the journey inwards just now. Stopping may involve doing nothing, maintaining a watching brief, or sometimes recognising that the doctor has reached the limit of what she can do and must hand the problem on to someone with different skills – another aspect of temperance.

Balint defines important vices of clinicians, too – although again he doesn't call them that. One example is the "*Collusion of Anonymity*" – this may be simply the vice we know in everyday life as "passing the buck" or it may be more complex. All clinicians will have come across patients who spend a lot of their life and NHS resources being sent from one specialist to another – often in the fruitless search for a physical illness to explain symptoms which are in fact an expression of a deep-seated unhappiness with their lives. Courage, honesty and firmness are the virtues needed to end this cycle of despair – virtues often lacking both in individual clinicians and in the institutional structures of healthcare.

An important hypothesis in virtue ethics is the unity of the virtues. The idea is that to flourish you need all the virtues, because they are interdependent – and to the extent that you lack one your whole flourishing is impaired. Being super courageous (even in your stupidity) can't make up for being impatient, for example – indeed because "Discretion is the better part of valour" impatience may make you take risks which converts courage into foolhardiness. For this reason although I have focussed in these comments on specific virtues like courage, patience and temperance, in fact as you read the cases in *The Doctor, His Patient and the Illness* and subsequent books you will see all these virtues and others intertwined when the doctor and patient are flourishing.

The personal and the professional

One of Macintyre's criticisms of modernity in *After Virtue* is that it partitions life into segments; separating public from private life, and accepting different moral standards in business relationships from those we expect in personal relationships.

It has always been one of the ground rules of Balint groups that the focus is professional, not personal, and must remain centred on the doctor-patient relationship. There are practical reasons for this boundary - a Balint group could be mistaken by the uninformed for a psychotherapy group, and this rule prevents the former slipping into the latter. But it can also be criticised in buying into this portioning of life into segments.

The boundary between the doctor-patient relationship and the personhood of the doctor is somewhat artificial. The "*small but significant changes in personality*" produced in the Balint group are likely to have consequences outside the doctor-patient relationship - generally for the good. Someone used to examining her own emotional reactions in the consultation and trying to understand those of her patients is likely to apply the same approach to her colleagues, family and friends, thus improving personal and professional relationships to the benefit of all involved. I'd like to give you one example of how I observed this happening.

I was working on a development project in Eastern Europe where the atmosphere was tense; there were ethnic and political divisions in the country, and although we were funded by a prestigious international development agency, the local group promoting the project was a small manipulative minority of a medical profession where power lay in the hands of reactionary (and sometimes corrupt) doctors with vested interests in the *status quo*.

Near the end of the project a UK health service manager, another English GP and I had to write up what we had done and suggest proposals for primary care development in the country, and we went into conclave to plan this report. The problem was complicated and at one point our discussion became heated. The other GP and I immediately stopped the conversation and analysed out loud how our small group was reflecting the tensions in the society around us - addressing our situation like a case in a Balint group. The manager had never come across this approach before and was startled and impressed by it.

Virtuous defences

The second work in the Balint tradition I want to look at is “*What are you feeling doctor?*”. This focused on the doctor’s defences, thus acknowledging more explicitly the need for change in the doctor as a person than Balint’s slightly coy reference to “*small but significant changes in personality*”. Those working in the group which produced this work explored what happened when a family doctor is unable to cope with the empathic sharing of a patient’s emotions and withdraws to a safe distance – how his or her defences work.

The account of how to use defences appropriately in this book follows the Aristotelian principle that virtue lies between the two vices of being inadequately defended and being over defended. They acknowledge that some defences are needed (“*humankind cannot bear very much reality*” as TS Eliot reminded us) but that sometimes they make us roll into a tight ball like a hedgehog, which is unhelpful. Conversely if we get sucked into the patient’s emotions – their sense of helplessness or their anger – the consultation can become dysfunctional. We need defences against this, as well as against caring about a patient in a way that prevents us functioning in the rest of our lives. But coolness and contempt for patients, a refusal to engage with their emotions at all isn’t a virtuous way to do this – it isn’t good professionalism, it is the vice of being over defended.

The authors list predisposing factors that may lead to inappropriate use of defences and warning signs to look out for when we are at risk of losing the balance. This is an example of *phronesis* – practical wisdom or reasoned insights into how to behave in a particular situation, an ability which most virtue ethicists see as central to the good life. Holding the virtuous mean with regard to our defences involves these rational insights into one’s own emotions and those of the patient – developing the habit in Paul Julian’s Memorable phrase of “*being there*”, emotionally involved in the consultation, and at the same time being a rational external observer – a habit Roger Neighbour describes as consulting with two heads.

Balint says that “*the small but significant change in personality*” which is the aim of Balint work is partly about facing the fact that one’s behaviour is sometimes quite different from one’s intentions and beliefs – a phenomenon referred to in virtue ethics as *akrasia* or weakness of will. Of course acknowledging this is the first step to overcoming it.

Is the Balint group the only way forwards?

He points out that this depends not on intellectual teaching but on “*an emotionally free and friendly atmosphere*” – perhaps another way of stating the fact fundamental to virtue ethics that right action depends not just on reason but on emotions and motivation.

He was talking about Balint groups, but is this the only way in which this psychological resonance can be learnt? Through the work of trainers and writers influenced by Balint’s thought (for example Roger Neighbour) the insights of the Balint movement have permeated general practice and are now taught to trainees who have never been near a Balint group. Does this matter?

Although education changes people, it is hard to show that a particular educational activity does so. If a doctor spends two hours a week in a Balint group, good psychometry with pre and post testing may show that she has undergone “*a small but significant change in personality*” after some years, but it is almost impossible to attribute this to those two hours. The noise generated by what happens in the other 166 hours of the week is just too great.

An early attempt to evaluate the outcomes of Balint work *A study of Doctors*, published in 1966, demonstrates some of the difficulties of the task. If someone leaves a group after a few weeks does it reflect a failure of the experience; conversely if they continue to attend for years does it indicate “*dependent failure*” as this book seems to imply? Do people leave because they fail to see the need for the qualities they lack, or because they already have them?

Asking people for their views on an educational experience is a popular way of “evaluating” it, but transformative experiences are not always enjoyable, and we aren’t always the best judge of how we are changed. There is some truth in the joke about the behaviourist making love who asked his partner “it was good for you – how was it for me”?

In the words of the authors of “*What are you feeling doctor*” probably “*all one can say if that those who have joined a group and stayed the course for three of four years will generally say it opened their eyes and gave them a way of feeling about the interplay of feelings in the consulting room which have been of lasting value*”.

They suggest that a Balint group is only one possible option; reflecting on the emotional content of our consultations and those encounters which have gone wrong or failed to achieve their potential with colleagues, a partner, tutor or mentor can help us learn to recognise the warning signs and gradually increase our insight into our own reactions.

Modelling (finding a virtuous person and then trying to become like her), reflection on experiences, good and bad, alone and in groups, and what I call the “South Pacific approach” - pretending to be virtuous when we don’t feel like it until eventually we do – are all ways which virtue ethics suggest we can cultivate the virtues.

One example of a particular gift from the Balint group

The piece on silence by Linda Mary Edwards in the last Balint Journal reminded me of a virtue essential to clinical practice which I think the Balint group may be particularly well placed to cultivate. If patients are struggling to verbalise their problems – or struggling for the courage to share them even if they know what they are – there is often a period of silence. Inexperienced clinicians are tempted to jump in with a question or comment, but if you can only have the patience to wait in silence then the rewards for patient and clinician alike are often considerable.

There is often silence in Balint groups – particularly but not only following the opening question “Who has a case?” - and I have observed seasoned leaders let the silence run, both modelling the ability to tolerate silence and also giving participants the experience of shared silence which you need if you are to understand its value. Are Balint groups the best place to learn to tolerate silence? This is perhaps something which could be evaluated empirically, even if not with an RCT.

An alternative to “The Faith of the Managers”

Increasingly over the last decade or two the belief has grown up that the best way to ensure high standards (not just in healthcare but also in education, social work and many other areas of life) is by regulation. Guidelines, appraisals, e-portfolios, league-tables, structured performance reviews are seen as the tools to ensure excellence. A belief system, not particularly well grounded in evidence, which Stephen Pattison refers to as “the faith of the managers”

Michael and Enid Balint and those who have followed them have shown us that life is rather more complicated (and a lot less rational) than that faith suggests. I would also

argue that virtue ethics provides a better framework within which to understand the qualities doctors need to flourish as professionals and to help their patients to flourish as well, and to establish the best way to cultivate them.

Alisdair MacIntyre has shown us that the way to make things better is not through regulation but through a commitment to become better people which at the same time will make us more fulfilled human beings, and the Balints have made a major contribution to a clearer understanding of what that means and how to achieve it. To Michael and Enid Balint!

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Some relaxation at Whalley Abbey.

Listening and Reflecting: Keynote address for Oxford Balint Weekend 2018

John Salinsky

I would like start by mentioning a famous doctor who had a great connection with Oxford.

I am thinking of the great physician, William Osler, who was born in Canada in 1849. He rose to become Professor of Medicine at McGill University in Montreal and in 1905 was appointed as Regius Professor of medicine at this University. He held that post here in Oxford until his death – in Oxford – in 1919: nearly 100 years ago. Osler is remembered for many wise sayings of which the best known is:

‘Listen to your patient: he is telling you the diagnosis’

Another one was: *Medicine is learned at the bedside, not in the classroom.* To which we might add: ‘medicine is learned in the consulting room – and in the Balint group.’ But the bedside is where student doctors first meet patients. I vividly remember my own first day on the ward. I was one of a bunch of about 10 students and we were each allocated a patient of our own, at whose bedside we would be privileged to sit and take down their history.

Our consultant memorably said to us: ‘Sit down at your patient’s bedside and let him (or her) tell their story in their own words.’ I thought: this is great; at last I am doing proper medicine. Sitting at the bedside, listening to real people telling me their stories. And, in Osler’s words, telling me the diagnosis. Before I sat down with my patient I was also handed a list of detailed *questions* which covered two pages. You know: chest pain questions: what was the quality of the pain? Was it gripping or crushing in nature? Where did it radiate? Was it related to food or exertion?

It was hard to concentrate on the story when I was anxious about missing out a question or not having time to get them all in. I soon realised that there is a big difference between ‘listening to the patient’s story’ and ‘taking a medical history’. Of course, both are important but we need to remember, as Michael Balint said: *if the doctor asks questions in the manner of medical history-taking, he will always get answers –but hardly anything more* (chapter XI).

So Michael Balint says in his book that we need to learn to listen to our patients in a way which is different from taking a history. This is difficult because it requires a limited though considerable change in personality. Limited though considerable. What did he mean by that?

Well, obviously we should listen with our full attention. Another clue is that he also says that in the group, *‘perhaps the most important factor is the behaviour of the leader. If he finds the right attitude he will teach more by his example than by everything else combined’.*

In the Balint group, we are listened to attentively without interruption at least till we have finished presenting our case. By experiencing this in the group we learn a kind of listening that we can then practice with our patients. So we listen carefully. But what kind of listening is it? This is where that personality change comes in. First of all we need to listen to *what the patient is feeling about himself.*

There are important clues, while we are listening, in taking notice of the words your patient chooses to use, and his tone of voice. Not just listening but **observing** him

visually as well; what he **looks** like; his expression and posture. The way he is **dressed**: smart or scruffy? The visible signs of emotion.

I think it's a shame that many cases are presented nowadays without a description of the patient. I am also very curious to know what presenter and patient talked about at their last encounter. I love to hear the actual words that the patient has used.

Here is a case:

A female patient confesses to her GP that she has made fraudulent benefit claims over a period years amounting to thousands of pounds. She can now afford to pay the money back. She feels very guilty about what she has done and would like to confess. But she has heard that courts come down heavily on you for this sort of thing. She could be prosecuted and might be sent to prison.

She says to the doctor: *What would you do?*

Not what *should* I do? What would you do?

This seems to imply that it could happen to you, the doctor, just as easily as it happened to me. The doctor has been asked to join her as co-conspirator. How does that feel to the doctor?

We must also pay the same attention to our own feelings. Oh really? I thought doctors were supposed to ignore their own feelings. Is this part of the *considerable personality change*? Well, I'm glad it's only limited.

So how has this patient's feelings affected me? Am I ready to experience a few feelings about a patient? This will bring us to empathy. Empathy and Compassion. It can be very difficult to feel empathy with a stroppy patient - or a smelly one.

THE FOX

Let us consider the Urban Fox. Have you ever had a fox in your garden? Do you like foxes? I don't. I think they are horrible creatures with slavering jaws and a wicked expression. They are not afraid of us. They seem to think they have a right to come into our gardens. The cheek of it. They think they are entitled. Also they are a bit frightening when they get close.

So a fox is a bit like certain patients we have experienced.

A few weeks ago, I saw a fox lying down in the middle of my back garden. It was in the very hot weather last summer. He seemed to be completely motionless. I watch him through the window and I think: He is very still. Is he dead? What should I do? Get a big plastic bag? Dig a grave? Phone the council?

Then he gets up, gracefully, and I can see that he is a very young fox, not a cub any more but still an adolescent. My attitude softens. Poor thing. He's exhausted. When did he last eat or drink? Can I give him some water? Empathy and compassion have crept up and stolen my heart. Empathy. What does it mean? How does it differ from sympathy? It's like the offside rule in football. Everyone knows what it means until they try and explain it to someone else.

Let's just say that when you experience empathy, you put yourself in the other person's shoes and you know, or at least you imagine, how he feels.

But it can happen the other way round. Not in his shoes but in your head. He seems to have invaded your space like the fox in my garden. It may not be a pleasant experience if your patient is angry, or self-pitying or clinging or demanding. If we can empathise, that's good; but we must avoid being trapped: in the patient's shoes or in our own head. We need to be able to step back, shake our heads free and say to ourselves: what's going on here?

Do these feelings really belong to me – or to my patient? If they are his – why has he given them to me? And what am I supposed to do about them?

This reminds me of Donald Schön's concepts of Reflection in Action and Reflection on Action. Schön was a philosopher and writer on learning. His ideas were taken up by academic GPs and some GP trainers because they are relevant. In the doctor-patient context:

reflection *in* action means you think about what you have experienced while you and the patient are still in the room; in the thick of it. This can be very hard to do.

Here is another case from a group. This was a male patient with extreme right-wing views. The presenter was an experienced psychiatrist who had seen him weekly for a month and knew he was a struggling to succeed as a journalist. On the fifth appointment the patient came out with some toxic racist views and the presenter felt horrified and paralysed.

He felt that he couldn't possibly continue to treat this man. The group all agreed. Fear of this horrible patient spread to all of us. As a group leader I wondered what to say. I looked at my co-leader but he was looking at the floor with a glum expression.

My thought was: is this like a war situation? An army medic has to treat a wounded enemy. Perhaps a prisoner? Do you say: he's a Fascist or even a Nazi? There's no way I can be his doctor. And yet he needs help. He's a human being.

So we discussed this idea for a while. I have to say no one was very keen to explore the enemy's wounds. But at least the conflict of feelings was exposed. And it is an example of Schön's second kind of reflection which he called Reflection on action. This is where you find yourself thinking about your action (and your feelings) afterwards when you go home.

Lucky you, if you have a Balint group to take it to because the Balint group may be just what you need: a space in which it is safe to share reflections and make sense of them.

Then there is the patient who gives to you a *feeling of her own that she wants to get rid of*. Here – you have this instead of me. See how you like feeling miserable and angry, or in the wrong. Trainee doctors, more often unsure of themselves, can often become victims of this sort of thing. They can be made to feel useless and incompetent, and treated with scorn.

The patient says: 'You don't really know what's the matter with me do you? Are you a student? Oh, you've been qualified for two years. Well, can I see someone with a bit more experience?'

This doctor has been ambushed. An emotion has been telegraphed instantly from his unconscious to hers. There was no time to reflect. The doctor feels badly abused (and incompetent) and pours it all out to the group. Everyone sympathises. Or do I mean empathises? Anyway, the trainee feels better. But maybe it was the patient who was feeling helpless or abused or incompetent. She was just dumping it on the doctor.

As GPs we are often advised to find out the real purpose, the real reason why the patient has come. This time, it's not for a prescription or a referral or because of a fear of cancer. The purpose of the consultation is to leave the doctor feeling useless.

So do we interpret this to the patient? No way. That would be like handing the explosive package back to her. No, we just accept the unwanted 'present': and feel crushed. And cross. But the group, helped by the leader, may realise what is happening. The doctor has shown that he can survive being made to feel useless. The patient may return and next time be more trusting. The patient may be helped to survive also.

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Whalley Abbey celebrations!

Iranian Balint Groups – an update

Ray Brown

In last year's journal (Volume 46, 2018), there were four contributions on the development of Balint Group work in Iran. Dr Mahdieh Moin, Head of the Psychotherapy Department, Roozbeh Psychiatric Hospital, Tehran, wrote about the formal structures for Balint Group training set up within the National Iranian Psychiatric Association (page 30). Dr Mozghan Amini, recently accredited as an Iranian Balint Group Leader, in her article (the PDF version of the journal) and an anonymous Attendee both described their experiences of attending Iranian Balint workshops. I wrote an article (page 17), titled "Culture, Context and Development" in which I described my experience of Balint Group work in Tehran.

Since then, there have been further developments in the arrangements for training and accreditation of Iranian Balint Leaders. This is overseen by a committee, the "Iranian Balint Group", within the Psychotherapy Committee of the National Iranian Psychiatric Association. The Chair of the Iranian Balint Group is Dr Mahdieh Moin, and Dr Mozghan Amini is the Secretary. A Steering Committee has been formed comprising the accredited individuals for Iranian Balint Group leadership, individuals particularly interested in the development of Balint Group work, and myself as an honorary member. The Iranian Balint Group oversees the training and development of Balint Group work in Iran.

Further Iranian Balint Workshops have been held in Tehran. In Roozbeh Hospital workshops were held on 7th and 8th October 2018, and on 14th April 2019. There was a workshop held in Razei Hospital on 9th October 2018. In addition to these, Mehrnaz, my wife, and I flew to the ancient desert city of Kerman for a workshop on 11th October 2018. Kerman has a population of 3 million and is the provincial capital of Kerman province, in the southeast of Iran. Then on 24th April 2019, we travelled by car from Tehran over the Alborz Mountains for a workshop in Sari the next day. The ancient city of Sari is the provincial capital and the most populous city of Mazandaran province, located between the northern slopes of the Alborz Mountains and the Southern coast of the Caspian Sea.

The workshop in Kerman, I co-led with Dr Navid Khalili, the Director of the Kerman Branch of the Iranian Psychiatric Association, who also holds the responsibility for training. Dr Khalili has recently become an accredited Iranian Balint Leader. Nearly 50 people attended the workshop including many senior psychiatrists, physicians and surgeons from a wide range of specialities. Cases were presented by a senior psychiatrist, a professor of renal medicine, and a senior cardiologist. For me, this was an extremely moving workshop, not only because of the richness of cases and discussions, but because of the effects that the arbitrary and extra-territorially imposed US sanctions (illegal under international law) have had on the provision of necessary medical supplies and the consequences this has had on patient care. Dr Khalili has arranged another workshop for the 27th July 2019 which he will co-lead with Dr Nabi Bannazadeh, a senior psychiatrist, who is near accreditation for Balint leadership. Mehrnaz and I will attend the workshop via Skype. Dr Khalili has written accounts of the workshop in October 2018 and hopes to publish these in an Iranian Journal and also present a paper in a symposium on Balint Group work in the 35th Annual Conference of the National Iranian Psychiatric Association in October 2019. Balint groups are now part of the recognised training for psychiatric residents in Kerman and are held on an ongoing basis.

In Sari, I co-led a workshop with Dr Faezeh Sheikh-Moonesi, who, like Dr Khalili, is a Fellow in Psychodynamic Psychotherapy and a senior psychiatrist. Dr Moonesi was



Delegates at the Sari Workshop.

also accredited recently as an Iranian Balint Group Leader. About 20 people attended the workshop. There was a mixture of psychiatric residents and senior psychiatrists, including Dr Mahdi Pourasgar, who is the Chair of the Psychiatric Committee of the province of Mazandaran, and has a major responsibility for the training of psychiatrists and a very strong interest in the development of Iranian Balint Group work. Dr Moonesi is in the process of writing a paper on the workshop and on the Iranian Balint Group which she has been co-leading with Dr Mozghan Amini for psychiatric residents in Sari, for the last year. This group for residents is being evaluated by Dr Taha Yahyavi, Professor of Psychiatry and the Director of Roozbeh Psychiatric Hospital, Tehran. Dr Moonesi, Dr Amini and Dr Yahyavi are intending to publish their work in an Iranian Journal or internationally, in addition to presenting work at the forthcoming symposium on Balint Group work in October 2019. Dr Moonesi has continued to run Iranian Balint Groups for residents in psychiatry at Zare'e Hospital, and this has become an ongoing part of the training for psychiatric residents in Sari. In addition, she is starting a Balint Group for psychologists and also planning to set up and co-lead a Balint Group within the Gynaecology Department of a General Hospital in Sari.

In Tehran, Dr Mozghan Amini is investigating the possibility of running an Iranian Balint Group in a cardiovascular hospital – the Tehran Heart Centre Hospital, one of Tehran University Medical Science centres of cardiovascular education. Dr Homa Rezaee, a senior counsellor and teacher at the University of Social Welfare and Rehabilitation in Tehran, has also started an Iranian Balint Group for trained counsellors.

Mehrnaz, acting as the linguistic and cultural translator, and myself have continued to work with Dr Mamak Tahmasebi, the Consultant in Palliative Care on an individual basis, with the aim of establishing an Iranian Balint Group for Oncology and Palliative Care in Tehran. Dr Tahmasebi is in the process of completing a paper titled, “She is still alive, please do something doc!”.

Reflections

I have used the term Iranian Balint Group to stress the particular context in which this work is being developed. Though I have some familiarity with Iranian culture and have visited Iran over the last 24 years, I am still learning about the sophistication and complexity of Iranian culture. An article in the New Scientist, evaluating different

cultures, described Iranian cultural reality as “jelly like” by which, I think, is meant, that there are movements, shifts and flexibility. In my view, this is the product of an ancient multi-ethnic nation with a linguistic sophistication and complex codes and protocols for interpersonal communication. The love of poetry seems to be ubiquitous and this is coupled with strong use of metaphor in every day speech. For example, an individual in one Balint Group described an emotional situation as being like “the sparks from Espand” (a herbaceous plant dried and burnt as part of a purification ritual) (Ref 1), or another individual said, “If your tears could speak, what would they say to you?”.



Delegates at the Kerman Workshop in October 2018.

Both Mehrnaz and I have been treated with such kindness, gentleness and hospitality everywhere, it feels almost impossible to reciprocate such graciousness. This experience is very common and many travellers to Iran report the same type of experience. In Kerman, we visited the desert of the Dasht-e-Loot, with Dr Khalili and his family, to stay there overnight in the silence of the desert to view the stars. In Sari, we were booked into a beautiful hotel, Salar Darreh, surrounded by forest. During dinner there with Dr Moonesi and Dr Pourasgar, Dr Moonesi said that her husband, Madjid, sent his apologies for not being able to be with us but invited us to go paragliding with him the next day. I have a dislike of heights amounting to a fear. At first I said I would think about it and then the thought of the courage it takes for Iranians doctors to attend a Balint Group (or for that matter, anyone attending a Balint Group anywhere) when it is completely unfamiliar, entered my mind. I then found myself saying that I would go. The next day, when I was near a thousand feet above the rice fields in Tajan Valley near Sari, I thought of the wings of the paraglider as the metaphor for the unconscious mind from which, as it were, we are suspended. Tangles there from the wind and weather definitely impair the capacity for free flight! I suppose every time someone presents a case in a Balint Group, they do take off for a flight and a view of the fields in the valley below (Ref 2).

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1. https://en.wikipedia.org/wiki/Peganum_harmala
2. *Psychoanalysis and Dreams, Bion, the Field and the Viscera of the Mind*, Antonino Ferro, 2019, Routledge.

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Balint group: an experience of cohesion after a serious fragmentation in psychiatric residents group

Fatemeh Sheikh Moonesi, Psychotherapist, Head of Psychotherapy
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I have been the head of the Psychiatric Group's Scientific Committee at the Zare'e Hospital for the past 12 years. The hospital is located at the heart of a forest in the city of Sari in the northern province of Mazandaran. This is also the hospital in which I did my psychiatric training and carry very fond memories from my period of psychiatric residency there. At the time the residents worked like a team, everyone helped each other even in cases beyond the call of duty. The deep bonds of friendships that formed during that period stay strong. I loved this cohesive group and was very happy to belong to it.

In recent years, however, I have noticed the absence of that old style of friendship and solidarity amongst the residents. The increase in the number of residents has reduced the volume of work but because of the inner group conflicts the level of complaints about the pressure of work has increased.

In 2017, this group which I consider like my family, experience something bad. One of the first year psychiatric residents committed suicide totally unexpectedly. Later there were many investigations into the reasons and circumstances of this very painful and horrific event and the measures which could be employed to prevent a recurrence. The suicide however had a very negative impact on the residents group and as if a bomb had gone off, it led to the fragmentation of the group. The members of the group were no longer in solidarity with each other and continuously were in rancour and complained about each other. Years 1 and 2 viewed themselves as separate from the years above them. One or two supportive sessions were held to enable the residents to talk about their feelings about the dead colleague, but the intensity of anger was such that some of the residents stopped participating because they did not feel the atmosphere as safe. I know that in some countries there are T-groups where the residents are given the opportunity to discuss their feelings and conflicts in groups held for this purpose, but we did not have such groups.

It was during this time that I came across Balint Groups held by Dr Ray Brown in Tehran and found it a suitable opportunity that may enable the residents to sit together once more, come close, and understand each other better. When I talked about the Balint Group to the residents I noticed that for some the thought of "being together" was not a comfortable consideration. They came up with various proposals, such as holding separate Balint groups, one for residents years one and two, and the other for years above. Gradually we began our journey. In monthly Balint groups, all the residents sat together in one group. In some sessions there were as many as 14 residents in attendance. In these Balint Groups, the residents talked about their patients and their feelings towards them, but at the beginning, the cases were predominantly about patients who had committed suicide and the free associations were linked to the dead resident. In Persian, there is an expression saying, "Say it to the door, so that the wall can hear", and this was what was happening in the Psychiatric residents' Balint group. For the first 6 months, Dr Mozghan Amini who is a psychiatrist, psychotherapist and the Secretary of Iranian Balint Group and myself co-led the group. Every session, Dr Amini and her husband Dr Yahyavi,

travelled 270 kilometres from Tehran to Sari which was a clear indication of how important they felt this group was. It has been a year now since we started the Balint Group in Zare'e Hospital. The sense of security in the group has increased. The group members talk about their feelings with more ease and there is more empathy between the lower and higher years residents. The group has come together again and found its cohesion.

Dr Pourasghar and myself are co-leading monthly Balint Group for psychiatric residents and are hoping to introduce and hold Balint groups for the residents of other medical specialities.

I am deeply grateful to Dr Ray Brown who provided on-line supervision for all the sessions, and also to Mrs Mehrnaz Shahabi, his wife, for the very difficult task of impromptu translation and cultural interpretation of all the supervision sessions. On 25 April 2019, Dr Brown and Mrs Shahabi held a Balint workshop in Sari for the psychiatric lecturers and residents. Dr Brown continues to monitor our Balint Groups and provide support and guidance.



Relaxing at Whalley.

As trainee psychiatrists, what are we learning as Balint Leaders and how is this influencing our psychiatric practice? – a personal reflection on my work as a co-leader of a Balint Group for Psychiatry Higher Trainees and Staff Grade Doctors

Dr Jonathan Olds

As a co-leader of a Balint group for higher trainees and staff grade doctors, I find myself on a steep learning curve in terms of not only Balint leadership, but also of skills in thinking about my patients, my colleagues and the system in which I am training. As a core trainee in psychiatry, I attend a local Balint group for trainees and through my training in group leadership, I have developed a greater sense of security within the Balint group that I attend. This has fostered a greater sense of safety; allowing me to present and think about cases that make me feel more vulnerable and to explore cases that leave me feeling less potent and skilled as a psychiatrist at my stage of training.

I have always considered myself to be a good communicator with colleagues and feedback from my colleagues has validated this. However, I have recently become more aware of the importance of listening as a way not only to elucidate facts, but also to allow the thoughts of others to be considered and to shape my thinking about patients. Balint leadership has certainly fostered this different way of listening. Through leading a group and encouraging the group to listen and work with the material provided; not only by the presenter of the case but also the material provided from the minds of the group members; I feel that this is a skill that I am developing and am able to begin to make use of with my psychiatry patients and colleagues through truly respecting the mind of self and other and allowing thoughts to emerge. It is not simply a case of learning to value listening more effectively and appreciating the other perspective, it is more about the way my role as co-leader requires me to wonder, when the other speaks, what this might mean relative to me as a co-leader, what it might mean within the group or what it might mean in relation to the case. Dr Gearoid Fitzgerald provided an introduction to a Balint day in London (February 2016) which is also available as a podcast (it was recorded) on the Balint website, entitled 'Nurturing the Roots of Psychoanalysis in Balint Groups'¹. Dr Fitzgerald described how in his opinion psychoanalytic roots are fundamental to the way that the leader listens to the presenter and the group and the way the group comes to listen to itself.

A particular role I feel I embody through leading a Balint group is facilitating the sharing of minds, as well as providing the group with stable and safe leadership. Furthermore, after each session, my co-leader and I spend 30 minutes thinking and talking about the group and clarifying themes and interventions; as well as reflecting on frustrations. Being able to share thoughts and feelings arising from leading the group as well as the responsibilities that leadership brings allows a further level of clarity and understanding of not only the group dynamics and processes, but also of the thoughts and feelings that leadership evokes within us as leaders. It is also important to consider the development of understanding through such discussions of what may also have been left with us as leaders from the group discussion about the cases.

As leaders, we are hoping to provide a safe setting for the group that enables discussion and consideration of often difficult feelings about their patients and themselves. A well-recognised role of Balint group leaders is to protect the presenter who may find themselves in a vulnerable position in relation to the group; especially whilst 'sitting-back' and allowing the group to work with the case. This particular role of the group leader is, for me, a profound one that requires monitoring of the group and careful consideration of the group work. In my role as co-leader I am becoming more aware of the importance of this which seems to be permeating into my psychiatric clinical practice, affording me a greater sensitivity to understanding through the way in which I listen to patients and their support networks as well as to my colleagues. An example of this can be nicely illustrated by a patient I saw in the community, during my training. When I met this particular patient for the first time, I found myself feeling anger towards them, as well as feeling intimidated and exhausted. In fact, I felt so disturbed by the patient, that without thinking, I lied to them about having previously taken the same medication that they were prescribed - as a way to try to relate and to diffuse my feeling of intimidation by them. I was surprised and disturbed by my feelings and my extreme response, especially as my team colleagues who had met this patient previously had described them as "warm", "calm" and "low in mood". I felt disturbed by my emotional response to this patient but I think that my growing experience of maintaining the safety of the Balint group that I co-lead had nurtured a sense of internal safety in me; permitting these feelings and noticing, valuing and staying with these feelings and offering them to my colleagues during our team handover in a way that made me feel vulnerable but authentic. Perhaps the sense of authenticity stems from my becoming more used to noting and working with countertransference within my practice. This position promoted discussion amongst colleagues and reconsideration of the patient's formulation. To quote Dr Fitzgerald: "one shouldn't underestimate that for most doctors the idea of having feelings in a doctor / patient relationship is initially seen as unprofessional. A by-product of a group is less persecutory guilt and shame if they can find a use for difficult feelings in the service of the patient and a chance to metabolise them rather than the feelings as an indigestible lump."¹ Perhaps unsurprisingly, I also presented this case to the trainee Balint Group the next day.

Through Balint leadership, I feel I am gaining a greater capacity to think about countertransference responses, as well as thinking about feelings related to the group dynamics in addition to the cases presented. Dr Fitzgerald recognises that Balint groups are guided by simple and elegant concepts, and he quotes Michael Balint to illustrate this point: "this 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. If these feelings do not seem to belong to the patient but to the doctor it helps to know that too, to be a participant in a relationship and its observer is fraught with difficulties and potential bias. The aim is to study this (bias) carefully. As a consequence, the doctors can take the feelings that arise from their work seriously and pay attention to much that would otherwise be disregarded"¹.

Dr Fitzgerald explains, with caution, that when doctors use their own feelings as a means to understand the patient's inner world, they make themselves vulnerable to errors "to which any instrument is prone"¹. Dr Fitzgerald also describes a concept that I conceptualise as 'noise' which may obscure our understanding of the patient's difficulties. This 'noise' is described as arising from either within the doctor-patient interaction itself or it may be extraneous. I find this a particularly interesting concept. I have found, through co-leading a Balint group for doctors in training, that extraneous factors are often

present. The dilemmas facing working with patients and working to understand the doctor-patient relationship within a case are often subject to influences that may be described as inherent within the training system. Often, we have been faced with the challenge, as leaders, to enable the group members to feel safe enough to think about their relationships with patients who have very difficult histories, often bringing disturbing material. It has been interesting to note how the presenters tend to externalise the cases in a way that almost invites exploration of the 'service-patient relationship', as opposed to the doctor-patient relationship, which is often perpetuated within the group's work whilst the presenter 'sits-back'. It is also important to consider, in addition to the organisational challenges to Balint work and to the thinking about the emotional impact of psychiatric work in particular, the extent to which the Balint group members value the work of the group. One may consider whether an apparent externalisation of a case to the 'service-patient relationship' is in fact a way of communicating little motivation to truly engage with the Balint method or perhaps to avoid difficult feelings stirred by the case.

Another important aspect of training in Balint leadership is the ability to reflect and learn from supervision. It is through supervision that I am becoming more aware of my own impact on the group as well as the origin of my frustrations and fantasies as to how I feel the group *should* run. Through exploration of the cases and the group discussion in supervision as well as examining my interventions and my unconscious motivation behind the interventions, I have become more aware of the power of 'sitting-back' more and allowing the group to work with the case in a perhaps more organic fashion; as opposed to acting on my anxieties regarding how I feel the group *should* be working with the case. I am learning about the role of containment as a Balint leader, in terms of containing the thinking and feeling within the group.

Through supervision, I have been encouraged to think about my own responses in relation to the cases being presented and to perhaps take on more of a containing role for my anxieties as a group leader. I have also been thinking more about how the group really works with the case as opposed to (to use my own word) "shove" the group towards working more towards my fantasy of how the group *should* be working.

With regard to the patient material that is presented in the group, I have been thinking about both countertransference and acting out in the countertransference, in my roles as both group leader and as trainee psychiatrist. This, especially for me, is often linked to the difficulty of staying with and tolerating complex feelings being projected by my patients. I have been thinking about this in terms of my psychiatric training and how this may relate to my patients. There is often a 'pull' for a doctor to categorise a patient to a pre-determined formulation or diagnosis which is often counterproductive. On a personal level, I do not consider myself to be particularly rigid in terms of my patient formulations; however, as Balint describes, the doctor adopts an apostolic function, incorporating beliefs of how a doctor ought to behave. This may lead to a doctor tending to avoid examining their own behaviour and so a fixed style may develop. To quote Dr Fitzgerald: "in a subtly indirect way Balint groups pay attention to the unconscious hidden aspects of the doctor-patient relationship without theorising them in the group. One could say they are about the derivatives of the unconscious expressed in countertransference and transference in the doctor-patient relationship and the resistances to them. But more they are about exploring this in ordinary English."¹ I particularly relate to Dr Fitzgerald's self-reflection on his leadership style. He says: "As a leader I talk more in these groups and feel very embarrassed and un-balint when I compare myself to my quieter colleagues. This could be my personal garrulousness as well as a response to these younger groups where one has to sometimes suggest or describe the coded communications they send

round to each other. I note I talk much less as the group goes on and they talk more and bring more. How active should one be?"¹

A particularly significant aspect of Balint leadership, as I have discovered, is the ability to 'weather the storms'. After a period of two months where the Balint group was unable to meet for a number of logistical reasons, the group attendance upon re-grouping was very poor for four sessions. There were two instances when we needed to cancel the group as only one member turned up, owing to other work taking priority for other members. In addition, during the sessions in which we did run a group, both we leaders were subject to unusual challenges from the group, including mocking and overt and acknowledged pushing of boundaries ("I know we only are allowed to ask *three* questions, but that one only counts as a half."). I find this a particularly challenging aspect of my practice, and I find myself thinking about a patient who came for her first session of psychodynamic psychotherapy with me, but has not come to three subsequent consecutive sessions. Again, through reflection in supervision, I have developed an appreciation for the fact that as human beings, group members, whether they truly want a Balint group or not, will attack the group. Through supervision, I have been encouraged to 'weather the storm', thinking about how the group prioritises their time. Whilst in Balint groups we may not necessarily verbalise our thoughts around this, it is important that as leaders, we think about them. As leaders, with an investment of time and travel in the group, we started to feel somewhat disheartened. An interesting observation was made in supervision: an analogy to the psychodynamic psychotherapy patient who will say: "I don't know why I keep coming". With such a patient, we keep in mind that they probably *do* want to keep coming, so in terms of the group not coming together for two weeks in a row, we were encouraged to not hold too tightly to it, but also not to hold too lightly to it. As my supervisor said, "Weathering the storm requires putting on your wellies." During one particular session, the group looked a little pre-occupied at the start and asked whether they could use some time, either within that group, or perhaps another group, to think about their concerns with the group, particularly how safe they felt to truly open-up and think about their patients. We acknowledged that it felt important to think about this and invited the group to explore what had been going on. The group acknowledged that they had found it hard to prioritise their time for the group and furthermore they explained that they felt somewhat unsafe owing to the fact that they had difficult experiences with a rigid structure in the past and also they had wondered about how safe they were to talk about cases on a deeper and more personal level with a leader who was a junior trainee. The group explained that they felt somewhat uncomfortable "laying themselves open" with a leader who may eventually enter the higher training pathway and may even end up becoming *their* trainee. I felt it was important to reiterate and re-orientate the group to the fact that the Balint group is not a therapeutic endeavour and that the role of the group was to explore the interpersonal factors (i.e. the doctor-patient relationship) and how this may help us to reach more of an understanding about the patient and perhaps ways to think about what may be helpful. I also felt it important (rightly or wrongly) to reassure the group that I had no intention of becoming a higher trainee; pointing-out that their dilemma was a fantasy. What was clear though was that there was an issue with group members feeling comfortable enough with the leadership. On further reflection and consideration, I think it may have not been helpful to allay the group's fears that I may one day become a higher trainee and that it may have been more useful to keep in-mind, to tolerate and potentially come to understand the feelings of uncertainty around my ability to lead the group.

One of the benefits of co-leading a group that meets every two weeks is that there is time to reflect on the group between sessions. I found myself thinking about my own stance as a group leader and reflected further on Dr Fitzgerald's self-observations; questioning "am I 'balint' enough?"¹ I realised that I was perhaps trying to act as I fantasised a group leader *should* act; almost adopting a role as the cold, detached and somewhat knowing *therapist*. Perhaps, therefore, I was also playing into the fantasy that the group had around the essence of our work being more than Balint, leaving them feeling vulnerable and the work insufficiently boundaried. For a while, in my role as co-leader, I did not feel genuine and I reflected on that both personally and within supervision. Interestingly, the session following me becoming conscious of this seemed fraught with logistical difficulties (the room had been rearranged at the last minute) and I found myself almost stumbling into the session, rather discombobulated. The group seemed to respond warmly to my humility. Furthermore, as I was closing the door to the room, a peer of mine put his head around the door and asked what was going on in the room. I felt protective of the group and calmly explained that I was running a Balint group for staff-grade and higher-training doctors and politely informed him that the session was due to start and that I would need to close the door. This seemed to enable the group to work particularly well with the presented case, opening themselves up and empathising with both the patient and the doctor, in a way that we had not seen before. Perhaps then, the group observed the leader be a leader and hold the boundary and frame for the group which helped.

Having learnt so much from co-leading a Balint Group during my psychiatric training and with themes developing through time and experience, it is difficult to summarise and conclude this reflective piece. Perhaps it is adequate simply to reflect on the way that the experience of Balint leadership has afforded me a greater understanding and capacity to hold in mind the thoughts of others, be they thoughts of patients or of colleagues. Furthermore, the ability to tolerate and come to understand my own insecurities in my role as co-leader has afforded me a greater depth of insight not only in terms of myself as a trainee psychiatrist, but also a greater depth of insight into the countertransference from my patients. Having been involved with the leadership of Balint Groups for medical students and having attended Balint Groups myself, I had an existing working knowledge of Balint Groups but it is through the experience of leadership that I feel my understanding of the purpose and clinical usefulness of Balint has been significantly enhanced.

References:

- 1) Fitzgerald, G. Nurturing the roots of psychoanalytic thinking in Balint groups. This talk was given as an introduction to a Balint Society Leadership Study Day held on 5th February 2016 at the Medical Society of London. Recording available at: <https://balint.co.uk/our-podcasts/nurturing-the-roots-of-psychoanalytic-thinking-in-balint-groups-dr-gearoid-fitzgerald/>.
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Shared celebrations: from Budapest to London

Papp-Zipernovszky Orsolya, Esti Rimmer and Ceri Dornan

In May 2019, some members of the UK Balint Society were fortunate enough to visit two notable buildings where Michael Balint worked and lived. This was a poignant reminder of his journey as a refugee, though a celebration and renewal of the friendship between the UK and Hungarian Balint Societies and our shared roots.

Budapest

During the Hungarian Balint Society weekend conference in Budapest at the end of May 2019, participants at the conference were invited to visit Meszaros street 12. The first Psychoanalytic Institute, the Polyclinic, that was founded by Sandor Ferenczi in 1931 was at Meszaros street 12, Budapest. He, together with his follower, Mihaly Balint and other psychoanalysts worked there. It was devoted to provide psychoanalytic treatment to the poor free of charge. The Polyclinic was also a place for professional education as well as for popular lectures on psychoanalysis. Michael (Mihaly) Balint had taken over its leadership after Ferenczi's death and had lived and worked here before he left Hungary.

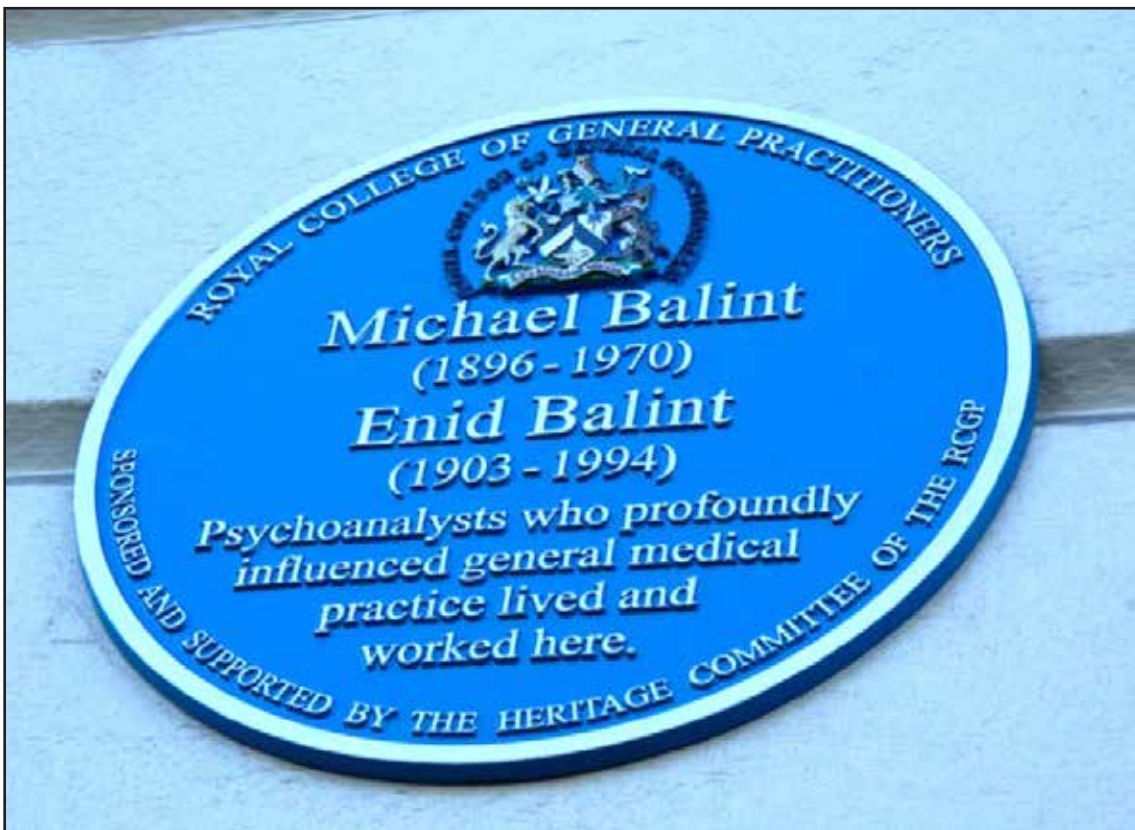
We sat in a small shaded square on the opposite side of the street and heard about the clinic and history from Agela Juhasz, Training and supervising psychoanalyst of Hungarian Psychoanalytic Society and Member of the Sándor Ferenczi Society. Orsolya, Papp-Zipernovszky, Associate Professor, Department of Psychology, Department of Personality, Clinical and Health Psychology, translated the talk into English for those of us who did not speak Hungarian. Kati Dóbó, President of the Hungarian Balint Society and Don Nease, President of the International Balint Federation, also spoke then placed celebratory flowers on the wall beneath the plaque.





Orsolya, Papp-Zipernovszky, Agela Juhasz, Kati Dóbó and Don Nease.

London



In London the UK Balint Society, celebrating its 50th anniversary, had joined forces with the Royal College of General Practitioners' Heritage Committee to place a plaque on the house of Enid and Michael Balint in 7 Park Square West near Regents Park. The commemoration plaque was unveiled by the President of the RCGP, Dr Mayur Lakhani, the Lady Mayor of Westminster Council, Ruth Bush and the President of the UK Balint Society, Dr Caroline Palmer (see photo). They were joined by four of Enid's granddaughters and two young medical students. Following a few short and moving speeches, we were fortunate to be invited inside by the current family living in the house to see Michael Balint's study and to enjoy their generous hospitality.



Susan Lawler (above) one of Enid's granddaughters, spoke at a Balint conference in London in 2018 about her childhood memories visiting her grandparents' home and brought to life some of the family traditions such as meal times where some of the Central European flavours still lingered. The late Michael Courtenay spoke very movingly in his talk at a Balint conference some years back in Northumberland of his memories of the house on 7 Park Square West while arriving to attend the early Balint groups, of the warm welcome and the atmosphere of benign curiosity he encountered.

Both houses in Budapest and in London represent the early and the later phases of Michael's journey. Both were family homes and places of work all in one but with clear boundaries between the private and the professional aspect of life. Both full of warmth, creativity, curiosity and interest in people and their relationships and in their humanities. Interestingly, both houses face a square and a garden. The Hungarian one a modest inner-city square lined with benches and shrubs, with children and dogs playing. The English one facing an exclusive private square, but both connected with the outside world, with people, with beauty, with nature. Good places for reflection and inspiration.



Before Enid was Enid: The Birth of Couple Psychoanalysis

by Professor Brett Kahr

Enid Balint, a landmark figure not only in the history of psychoanalysis, but also within the field of general medical practice, will be well known to health care professionals as a highly popular Training Analyst at the Institute of Psychoanalysis in London, as a theoretician of the psychoanalytical process and, moreover, as an internationally renowned consultant to family physicians. Together with her husband, Dr Michael Balint, she created what have become known universally as “Balint groups”, designed to provide deeper psychological understanding and support for medical practitioners. Mrs Balint documented this pioneering work in several sterling, co-authored book-length publications, including *Psychotherapeutic Techniques in Medicine* (Balint and Balint, 1961); *A Study of Doctors: Mutual Selection and the Evaluation of Results in a Training Programme for Family Doctors* (Balint, Balint, Gosling, and Hildebrand, 1966); *Focal Psychotherapy: An Example of Applied Psychoanalysis* (Balint, Ornstein, and Balint, 1972); *Six Minutes for the Patient: Interactions in General Practice Consultation* (Balint and Norell, 1973); and, finally, *The Doctor, the Patient and the Group: Balint Revisited* (Balint, Courtenay, Elder, Hull, and Julian, 1993). As someone who applied the fruits of psychoanalytical knowledge to medical practice, Enid Balint received the rare award of an honorary fellowship from the Royal College of General Practitioners.

Shortly before Mrs. Balint’s death in 1994, Professor Juliet Mitchell and Dr. Michael Parsons edited a collection of her essays, *Before I Was I: Psychoanalysis and the Imagination* (Balint, 1993). Inspired by this compelling book title, I wish to remind us that, although we remember Enid Balint as a great psychoanalyst and as a consultant to physicians, she made perhaps an even greater contribution to world health care, although one that has become increasingly marginalised with the passage of time. Indeed, long before she married Michael Balint, this free-thinking woman, then known as Enid Eichholz, pioneered the development of marital psychotherapy in Great Britain and lay the very foundations of one of the most impactful movements within contemporary mental health. In the pages that follow, I shall attempt to provide a brief overview of the early achievements of this forward-thinking, creative, and bold woman. Drawing upon unpublished archival data, I shall endeavour to explore her professional contributions throughout the 1940s and the early 1950s, during a period of her life that we may describe as “Before Enid Was Enid”.

In 1914, not long after the outbreak of the Great War, German Zeppelins began to drop bombs on British soil, in such locations as Great Yarmouth, Hull, and Tyneside, far from the nation’s capital. Quite strikingly, many privileged Londoners worried very little about these air raids, confident that Kaiser Wilhelm II, a grandson of Queen Victoria and a first cousin to King George V, would never dare to attack Buckingham Palace and the surrounding lands which he had known intimately since early childhood. Indeed, Lady Cynthia Asquith (1915, p.13), daughter-in-law of the incumbent Prime Minister, Herbert Asquith, took great pleasure in reporting that, “the only reason why there has been no Zeppelin raid on London is that the Kaiser absolutely refuses to countenance it on account of all his relations there.” In similar vein, the noted English novelist, David Herbert Lawrence (1915, p.253), writing from his home in Hampstead’s Vale of Health, described

the German airships as quite entrancing; indeed, he enthused to Lady Ottoline Morrell, “I cannot get over it, that the moon is not queen of the sky by night, and the stars the lesser lights. It seems the Zeppelin is in the zenith of the night, golden like the moon, having taken control of the sky; and the bursting shells are the lesser lights.” Many Britons considered their homeland to be quite safe – even somewhat romantic – imagining the real war to be far, far away, on the battlefields of Belgium and France.

In spite of the arguably naïve attitudes of Lady Cynthia Asquith and D.H. Lawrence, Londoners did, of course, experience horrific devastation during the Great War. But decades later, during the Second World War, the British capital city suffered far more extensively. Unlike the gentlemanly Kaiser Wilhelm, the German dictator Adolf Hitler bore no relation to the British Royal Family and hence did not hesitate to authorise the bombing of central London, including Buckingham Palace itself, which endured no fewer than nine direct hits. This time round, even the blue bloods could not escape destruction; indeed, the war against the Nazis claimed the life of many grandees, such as the twenty-six-year-old William Cavendish, the Marquess of Hartington, heir to the dukedom of Devonshire, killed in action while serving in the Coldstream Guards, not to mention the thirty-nine-year-old Prince George, The Duke of Kent – an Air Commodore in the Royal Air Force and, also, Patron of the Tavistock Clinic – whose flying boat crashed while on a mission to Iceland.

Londoners suffered numerous bombings throughout the *Blitzkrieg* and stood in horror as such stalwart buildings as Lambeth Palace, St Paul’s Cathedral, the Tower of London, and Westminster Abbey all endured extensive structural damage (Richards, 1942, 1947). During these terrifying attacks, which could last between eight and ten hours (Stansky, 2007), many spent their nights either in the bowels of London’s underground or in primitive, cramped Anderson shelters – dank and dark huts made of corrugated steel, only six and a half feet long by four and a half feet wide (Stansky, 2007). The German air raids created such untold chaos that, after the first two weeks of the Blitz of 1940 alone, approximately 1,800 London roads became congested with some 3,000,000 tonnes of rubble (Woolven, 2013).

In terms of family life, husbands and fathers disappeared to fight overseas and many lost their lives. At home, mothers and their children suffered from profound malnutrition due to wartime rationing. Many young boys and girls endured prolonged evacuations to the countryside or to foreign lands; and even babies had to be fitted with special infant gas masks and transported in gas-proof perambulators (Grayzel, 2012). The fabric of daily life must have felt very frightening indeed.

Writing about the First World War, the noted historian Professor Jerry White (2014, p. 131) opined that, “The Zeppelin raids, though leaving many people badly shaken, seem to have done little by themselves to dent Londoners’ morale.” One certainly could not make a similar assessment of the Second World War, which resulted in considerably greater trauma on the Home Front. The German Luftwaffe produced not only physical wreckage but much emotional devastation as well, and before long, the medical press began to heave with accounts about the psychological consequences of the war.

Psychiatrists in particular noted the impact of the fighting upon civilians having observed such symptoms as tremors, tics, diarrhoea, palpitations, excessive sweating, increased micturition, asthma, and disturbances of sleep. These nervous reactions arose for the most understandable of reasons. For instance, Dr. Elizabeth Rosenberg and Dr. Eric Guttmann (1940, p. 95), in their report on “acute panic reactions”, described the case of a woman with a gammy leg who worried that she might not be able to reach the air raid shelter in time. Other people began to display signs of the newly-christened ‘ “shelter

neurosis” ’ (Mackintosh, 1944, p 29) – an unreasonable neurotic urge to seek refuge underground at every available opportunity. *The Lancet* even published the case of a woman who reported the onset of pains in her vulva each time the air raid sirens began to blare (Bodman, 1940).

Physicians struggled to find remedies not only for those soldiers wounded while fighting overseas but, also, for these traumatised civilians, some of whom had survived the horror of being machine-gunned from the air (Fairbairn, 1943). Dr William Sargant and Dr Eliot Slater (1940), two of the most prominent British psychiatrists at the time, recommended rest, diet, narcosis, barbiturates and, even, hypnosis as potential remedies for those suffering from acute war neuroses. Few psychological professionals, however, promoted the so-called talking therapies as a treatment for war-ravaged Britons.

With enormous numbers of men posted overseas and children evacuated, the British family had truly disintegrated. Strikingly, virtually all of the psychiatrists who wrote about the war neuroses among civilians focused almost exclusively on the anxiety symptoms and hysterical manifestations of individual patients. Very few considered the effect of the war on marriage. Quite singularly, Dr Ronald Fairbairn (1943), the venerable Scottish psychoanalyst, commented quite presciently on the role of loss among soldiers, noting that a sergeant major cannot substitute for a wife! Thus, with broken attachments aplenty and with the threat of death at any moment, Londoners became quite desperate.

In an effort to provide financial relief, Lieutenant-Colonel John Dawson Laurie, who served as Lord Mayor in 1941, established the Lord Mayor’s Air Raid Distress Fund. But the victims of air raids needed more than money. U.M. Cormack (1942, pp. 178-179), a social worker, described the survivors of bombings thus: “Their minds are dazed, their spirits apathetic; their symbols of security have been swept away in a night and they are left part of a wave of helpless humanity eddying to and fro in a sea of misfortune.” Cormack (1942, p. 179) thus urged fellow social workers to offer each victim “individual attention”.

However, in spite of this worthy *cri de coeur* to arrange support for those devastated by the Blitz, the British social work profession, though rather good at providing practical assistance, had not yet developed any significant degree of psychological understanding. The aforementioned U.M. Cormack (1942, p. 183) advised that, when confronted with a client who weeps a great deal, one should “Take no notice.” Cormack (1942, p. 183) recommended that, when encountering a reticent client, “Don’t ask questions; talk about yourself.” And as for obstreperous clients, this well-intentioned social worker advised that one should “encourage them politely to write to the Prime Minister if they want to.” (Cormack, 1942, p. 183). In fact, at that time, most social workers offered simply little more than fifteen-minute interviews in which survivors of the Blitz could fill out claim forms (Cormack, 1942).

Many Britons visited the local citizens advice bureaux, first established in 1939, which endeavoured to provide a range of practical support. For instance, these bureaux would help civilians – mostly women – trace missing relatives or communicate with prisoners of war by sending Red Cross Postal Messages (Samson, 1941). In 1942, the Ministry of Information released a public service film, *Ask C.A.B.*, advertising the work of the citizens advice bureaux, and emphasising that these fledgling organisations could help members of the public to obtain clothing coupons and rations for eggs and soap or to arrange an appointment with a “poor man’s lawyer”. One of the elderly widows portrayed in the film, seeking financial assistance, received kindly advice from a bureau worker who recommended that she contact the Soldiers, Sailors, Airmen and Families Association. Grateful for this information, the needy woman responded, “It’s such a relief to talk to

someone about these matters.” But although the kindly female staff members at the citizens advice bureaux offered practical solutions to everyday problems, they offered no formal emotional sustenance; indeed, one of the workers in this film described herself as little more than a “quiz machine”, answering question upon question about administrative minutiae.

Amid the carnage of war, one of the more enlightened citizens advice bureau workers – a British woman by the name of Enid Eichholz – decided that she wished to be more than just a “quiz machine” and aspired to offer greater comfort for families in psychological distress. Born in 1903, Enid Flora Albu eventually matriculated to the London School of Economics and Political Science in the University of London and obtained a bachelor’s degree in economics and then, subsequently, created a special school for German refugee children (Kahr, 2016). Shortly after the outbreak of World War II, Mrs. Eichholz volunteered for the Family Welfare Association and helped local citizens with practical anxieties. She recalled that some housewives shared their concerns that, if they lent a bowl of sugar to a neighbour in need, the bowl might never be returned (Kahr, 2016). Mrs. Eichholz tried to help families to apply for benefits under the War Damages Act 1943, but she soon came to realise that many of her clients wished to speak to her, not about monetary matters but, rather, about their own personal traumata and losses (Rudnytsky, 2000) and that, perhaps, the anxiety of a sugar bowl becoming lost may well have reflected the deeper fear of a British woman losing a husband or a son. Mrs. Eichholz resolved that she would endeavour to provide something more substantial than mere paperwork solutions.

After the war ended and the surviving soldiers returned to Great Britain, families had to struggle with the long-term effects of separation, infidelity, and terror. Alas, at that time, few physicians or social workers, let alone the tiny cadre of Freudian psychoanalysts, had developed much interest or expertise in working with troubled marriages and families. In 1934, Baron Horder [Thomas Horder] and a group of distinguished fellow physicians, including Dr. John Rawlings Rees, the medical director of the Tavistock Clinic, lamented the lack of professional provision for couples and families in distress and noted, “More scientific handling of the factor of matrimonial discord would very considerably strengthen our attack on the kindred social problems of divorce and child delinquency.” (Horder, Rees, Moodie, Glover, and Hadfield, 1934, p. 12). Those who did offer counselling and support to couples in distress at that time – such as the Reverend Herbert Gray and the physician Dr. Edward Fyfe Griffith – tended to dispense advice of a predominantly contraceptive nature (Griffith, 1981).

Fortified by her experiences of having helped refugee children and, moreover, disillusioned by the limitations of providing practical assistance to sufferers, Enid Eichholz boldly embarked upon a plan to care for the emotional needs of troubled, war-torn British couples and families. By 1945, Eichholz proposed the creation of a series of specialist marriage guidance centres in London which would offer psychological intervention to couples. By early 1946, the General Secretary of the Family Welfare Association, Benjamin Astbury, spurred by Eichholz’s request, agreed to the creation of a specialist Marriage Guidance Council.

At 11.00 am on 22nd January 1946, Mrs. Eichholz convened the first meeting of this newly formed organisation, under the auspices of the Family Welfare Association, in which she and a small group of colleagues discussed how female workers – then known as “secretaries” – could offer diagnostic assessments of marital troubles (Marriage Guidance Council, 1946). By February 1946 the seemingly indefatigable Mrs Eichholz inaugurated a plan to launch centres in many of London’s most impoverished

communities such as Bethnal Green, Lewisham, North Islington, Shoreditch and Wandsworth (Marriage Guidance Council, 1946); and by December, 1946, the newly-opened centre in Lewisham had already offered special secretarial appointments for six cases, while that in Shoreditch had provided help for three cases, and the centre in Wandsworth had assisted an additional four cases (*Marriage Guidance Centres Committee: Monday, December 9th, 1946*, 1946).

Although many historians of the Tavistock marital psychotherapy tradition have identified 1948 as the year of our foundation (Gray, 1970; Clulow, 1990; Woodhouse, 1990), the archival data suggests that 1946 may be a more historically accurate date.

But in spite of her tremendous efficacy and organisational savvy, Enid Eichholz admitted that she suffered, nevertheless, from a “lack of knowledge about human relations” (Quoted in Rudnytsky, 2000, p. 2); and thus, with tremendous open-mindedness and with a strong wish to collaborate, she approached Dr. Archibald Thomson Macbeth Wilson – known to his comrades as “Tommy” – an immensely forward-thinking psychiatrist at London’s Tavistock Clinic, for support and guidance. A much-neglected figure in the history of psychoanalysis, Tommy Wilson had already undertaken significant research on psychosomatic medicine (Davies and Wilson, 1937; Wilson, 1939; Wittkower, Rodger, and Wilson, 1941; Wilson, 1949) and, during the war, had served in both the Directorate of Army Psychiatry and the Directorate of Biological Research (Wilson, 1949), prior to the commencement of his training at the Institute of Psychoanalysis. Unlike some of the more insular psychoanalysts of this period who worked only with fellow Freudians, Tommy Wilson had already developed a broad range of professional interests and appetites, having enjoyed a close association with Dr Millais Culpin, an early medical psychotherapist who embraced not only the teachings of Sigmund Freud but, also, those of Carl Gustav Jung and Alfred Adler, and who maintained a longstanding interest in the application of psychology to industry (Culpin, 1929). Thus, Tommy Wilson had already developed a more outward-facing approach to psychology and he welcomed Enid Eichholz warmly and provided immense support for her fledgling marital project.

Wilson had already embarked upon creative collaborations with colleagues from other disciplines, such as the anthropologist Adam Curle and the psychologist Eric Trist in order to help former prisoners of war return to civilian life (Curle, 1947; Curle and Trist, 1947; cp. Dicks, 1970). Hence, Wilson had no difficulty working with Eichholz, an essentially untrained social worker and untrained marital therapist, who considered herself quite “lucky” (Quoted in Rudnytsky, 2000, p. 3) to have forged such a professional marital alliance. Wilson invited Eichholz to attend meetings at the Tavistock Clinic and he encouraged her to read the writings of Sigmund Freud (Rudnytsky, 2000). He also arranged for her to speak with his Tavistock Clinic colleague, Dr John Bowlby, and also to receive supervision from a warm-hearted social worker, Miss Noël Hunnybun, who became an important and much-cherished mentor. Spurred by this immersion into the world of depth psychology, Mrs. Eichholz eventually embarked upon her own personal psychoanalysis with one of Sigmund Freud’s former analysands, Dr John Rickman, and she ultimately began to train as a psychoanalyst in her own right.

The alliance between Tommy Wilson of both the Tavistock Clinic and its associated organisational body, the Tavistock Institute of Human Relations, and Enid Eichholz of the Family Welfare Association, proved rich and fertile. Yet it would be not only inaccurate but also unfair to describe the alliance between Wilson and Eichholz as hierarchical and patrician, in which a male physician offered benefaction to a female do-gooder. The arrival of Eichholz into the Tavistock family resonated perfectly with the clinic’s newly-

constructed post-war project, known as ‘Operation Phoenix’ (Dicks, 1970, p. 121), designed to transform the organisation from a psychiatric clinic into one that promoted “Sociatry” (Dicks, 1970, p. 127) – the antithesis of psychiatry – in order to reach into the wider community. By collaborating with Eichholz and the Family Welfare Association, the Tavistock Clinic would thus be able to exert an impact beyond its headquarters on Beaumont Street, in Central London – at that point the clinic’s sole physical premises – and would be able to penetrate some of the poorer parts of the capital.

Throughout 1946 and 1947 Enid Eichholz’s Marriage Guidance Council developed apace and eventually changed its name to the Marriage Guidance Committee and subsequently, to the Marriage Guidance Centres Committee (Marriage Guidance Council, 1946). In 1948, the organisation altered its identity once again and became more formalised as the Marriage Welfare Committee, with Eichholz as Secretary and soon thereafter became rebranded as the Marriage Welfare Sub-Committee. And ultimately, in 1948, this grouping adopted yet another name – its sixth one in just over two years – and restyled itself as the Family Discussion Bureaux, with an impressive board of patrons in place.

In the immediate post-war period, Eichholz had enlisted support not only from the staff of the Tavistock Clinic and the Tavistock Institute of Human Relations but also from Dr Thomas Main of the Cassel Hospital for Functional Nervous Disorders, as well as Dr Colman Kenton from the North West Metropolitan Regional Hospital Board, and from Dr Roger Tredgold of the South East Metropolitan Regional Hospital Board, and others besides (General Secretary, 1948), and hosted meetings at the Tavistock Clinic headquarters. With support from these physicians, as well as from the aforementioned Dr Tommy Wilson and Dr John Bowlby, Eichholz perfected her model of collaboration and never operated as an isolate.

With numerous advisers and institutional partners in place, Enid Eichholz’s Family Discussion Bureaux grew in size and scope and began to offer an increasing amount of psychological support to couples and families in distress and did so with increasing psychoanalytical sophistication. Indeed, when in 1951 Noël Hunnybun – Mrs. Eichholz’s clinical supervisor – organised a year-long “Advanced Course for Post-Graduate Case Workers” in the Child Guidance Department of the Tavistock Clinic, Eichholz sent some of her new employees to participate as students (Hunnybun, 1951).

Not only did Enid Eichholz promote clinical work for couples, as well as training for her members of staff, she also began to create research projects with social scientists in order to investigate the nature of family breakdown (Eichholz, 1949a); and she sought independent funding from organisations such as the Nuffield Foundation (Eichholz, 1949c, 1950b), long before such activities had become standard practice within mental health institutions. The Family Discussion Bureaux flourished so considerably that when, in 1950, Tommy Wilson suggested that Enid Eichholz might offer assistance to his psychiatric colleague Dr Alfred Torrie, who hoped to establish a therapeutic group for expectant mothers, Eichholz (1950a) boasted that she and her team had *already* done so, both at the Fulham Maternity Hospital and at the Maternity and Child Welfare Clinic in Hendon, North London.

Amid this period of tremendous professional growth and creativity, Mrs. Eichholz became estranged from her long-standing husband, Robert Eichholz, and began a flirtation with a Hungarian-born psychoanalyst, Dr Michael Balint, who worked at the Tavistock Clinic and who offered seminars on the psychology of sexuality for Eichholz’s (1949b) staff. Mrs. Eichholz and Dr Balint eventually married in 1953, by which point Eichholz had yielded the directorship of the organisation, now known as the Family

Discussion Bureau (without an “x”), to her deputy, the German-born Mrs. Lily Pincus, who expanded this small department even more extensively. In 1955, Lily Pincus, in conjunction with several colleagues, produced a book under the imprint of Tavistock Publications, entitled *Social Casework in Marital Problems: The Development of a Psychodynamic Approach. A Study by a Group of Caseworkers* (Bannister, Lyons, Pincus, Robb, Shooter, and Stephens, 1955) – a landmark text and, moreover, the first full-length volume produced by Enid Eichholz’s *protégés*.

In 1956, the organisation changed its name, yet again, to the Institute of Marital Studies, and then, to the Tavistock Institute of Marital Studies and, subsequently, to the Tavistock Marital Studies Institute, and then, penultimately, to the Tavistock Centre for Couple Relationships, before selecting a far more concise and, also, punchy name, Tavistock Relationships, in 2016. And over the last seventy years, this prescient, forward-thinking institution has done more to pioneer the field of couple and family mental health than any other in the United Kingdom and, some might argue, in the world.

Across eight decades, our leaders have undertaken inspiring work. Mrs. Enid Eichholz established the institution, and the first generation of her successors, Mrs. Lily Pincus, Mrs. Janet Mattinson, and Mr. Douglas Woodhouse, consolidated the clinical services and contributed to the development of a growing body of theory, while our more recent directors, Dr. Christopher Clulow and Mrs. Susanna Abse, and our current Chief Executive Officer, Mr. Andrew Balfour, have collectively transformed the fledgling organisation into a powerhouse institution which offers tens of thousands of couple psychotherapy sessions per annum, hosts several impressive clinical trainings, commissions and conducts ground-breaking research, sponsors publications and public outreach aplenty, and collaborates with members of government in order to share our near-century of knowledge of couple psychology, in the hope of contributing to the prevention of relational breakdown and its costly sequelae.

One might argue that the discipline of psychotherapy owes much of its growing success to the work of Sigmund Freud, but he cannot claim credit for the application of psychoanalytical psychology to the marital arena. Although Freud certainly psychoanalysed husbands and wives, he did so in quite a segmented fashion, and never treated both members of a couple in the same room at the same time. To the best of our knowledge, only one of the early Viennese psychoanalysts, Dr. Siegfried Bernfeld, ever welcomed a husband and a wife into his consulting room simultaneously when in 1922 an English clergyman visited Vienna in order to undertake psychoanalysis. This man of the cloth insisted that as he had no secrets from his wife he would welcome her presence in the sessions, while he free-associated upon the couch. Dr Bernfeld agreed to this most unusual suggestion and even provided a second couch for the spouse! But as the Englishman’s psychoanalysis progressed, he eventually asked for more privacy in order to discuss certain matters that could not be shared in front of his partner (Boyer, 1991).

Thus, Enid Eichholz inaugurated a process whereby both wife and husband could seek help in the same room and at the same time, and this represented a huge paradigm shift in depth psychological treatment. And in doing so, she and her pioneering colleagues had to endure a great deal of resistance from traditional Freudian psychoanalysts who operated exclusively from a one-on-one model of intervention. The suspicion towards marital psychoanalysis lasted for many decades. Indeed, Dr. Arturo Varchevker (2014, p. 92), a London-based psychoanalyst, recalled that during the 1970s, “If you did group psychotherapy or marital therapy you had to keep them out of sight and not mention it.”

Fortunately, many generations of workers at Tavistock Relationships have successfully questioned the more traditional model of individual psychoanalysis while

remaining loyal to its extensive contributions about the role of childhood traumata and unconscious processes in the development of couple distress. And this never would have happened without the blue-sky thinking of an essentially untrained and clinically inexperienced woman with a vision.

Back in 1941, the British writer and cultural commentator, Ritchie Calder (1941, p. 126), author of *The Lesson of London*, a much-forgotten book about life during the Second World War, wrote that, “The women after this war are not going to be political amateurs with a feminist inferiority complex, such as the women’s franchise produced at the end of the last war, but seasoned campaigners.” Although we have no evidence that Ritchie Calder ever met Enid Eichholz, his description of bold women unencumbered by “a feminist inferiority complex” and able to become “seasoned campaigners” applies perfectly to the future Mrs. Balint, whose legacy we remember and celebrate today, and who provided us with the creative foundations upon which subsequent generations have built with profundity in an effort to bring relief to individuals, couples, and families in anguish.

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A Balint group at work.

Opening Others' Eyes to Balint Work: What is our Story?

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Abstract

This paper explores how Balint group members and leaders of varying experience and from different health professions explain Balint to people who know nothing about it. Using social media, we made recordings of a verbal description of Balint, imagined to be to a person of the participant's choosing. The 23 resulting recordings were transcribed and we applied a process of thematic analysis. We considered the style of descriptions and paid close attention to language and content before settling on themes and sub-themes. These appeared to be the best way to represent the depth of importance of Balint to the participants themselves and to their work. This applied across levels of experience and profession. Direct quotes and language used are included with theme descriptions to try to bring the participants' descriptions to life. The interpretation is offered as a way of assisting each of us to tell the Balint story in our own way, not to create a perfect script. We also speculate about the meaning of the word Balint in present day usage.

How can we encourage people to open their eyes to look at medicine the Balint way? There are very accessible written descriptions of the Balint method (Salinsky) but what if Balint comes up in conversation and we are asked to explain? I (CD) am often unsure where to begin and how to tell the Balint story in a way that fosters curiosity. I wondered what others say in this situation and decided to ask.

Collecting stories

Data were collected verbally to approximate to a conversation. Twenty nine people involved in Balint work received an email inviting them to a Skype or Face Time video call with me. They would be asked to imagine explaining Balint to someone who didn't know anything about it, in a short, over coffee conversation. My contribution was kept to a minimum. I obtained signed consent to record calls and use unattributed quotes when writing. Recordings lasted between 3 and 7 minutes. I transcribed the recordings and gave each a number. Only I know the identity of participants. I asked for some background facts as shown in Table 1 (see end of paper).

I used an opportunity sample of people on my personal email list to avoid Data Protection problems. Participants were group members or leaders with varying experience. 23 of 29 people contacted took part.

The analysis

I used a thematic analysis method (King and Horrocks), which involves becoming thoroughly familiar with the scripts before looking for themes, whilst keeping the study question in mind. I progressed to the highly technical approach of the Very Large Dining Table method, involving paper and scissors, and putting text into groups under headings. Final themes should be distinct from each other and relate to a significant minority of scripts.

Louise Ivinson, co-author of this paper, read 8 of the transcripts in full, selected for contrast of participant background and experience, and content. We compared notes and discussed themes until we reached an agreement. We continued to discuss data and interpretation until this paper was completed.

Our findings

We present the findings under the following themes. These are not facts; they are our thoughts, so as in a Balint case discussion, open to wondering and speculation. Words and phrases from stories are included in theme descriptions as well as full quotes.

Themes

Style

- Developmental
- Cerebral
- Personal

Content

- Purpose
- Credibility
 - o History
 - o Method
 - o Living
 - o Widely applied
- It's a group thing
 - o Nurturing
 - o Accepting
 - o Liberating
- Connects to what matters
 - o Being human
 - o Vocation
 - o My working world
 - o Survival

Style

We found three main ways of telling the story.

Developmental

Michael Balint and his work with GPs is the basis of the story. This style is a feature of leaders rather than members.

Cerebral

Descriptions were delivered in a steady and considered style, at a slight distance from personal experience. This seems to relate to individuals rather than profession or experience.

Personal

Descriptions where there is extensive use of the first person or reference to the listener. The person's own experience of Balint is predominant. The content is less ordered and more spontaneous.

Content

Purpose

What is the aim of Balint? The professional-patient relationship and emotions are always represented. People add their own clarifiers, possibly to help our understanding.

“It's a way of helping a clinician to gain some understanding as to what may be going on in a puzzling or difficult doctor-patient encounter or relationship.” (P1)

“To explore the emotional aspects of what is going on in the consultation rather than the strictly medical or factual.” (P2)

“It's an opportunity and time for us to think more deeply on things than we normally do, in particular the relationship between ourselves and our women and families.” (P5)

It's about both sides of the relationship.

“The hope is that there would be a lot of thought about the relationship, really from the two sides of it, so that's why you'll talk about the patient story.” (P13)

Credibility

The Editor of the first Journal of the Balint Society (1971) expressed concern about placing the Society and the Balint method open to scrutiny. Another concern has been the use of the eponym 'Balint' and whether this places too much historical emphasis on the method, so perceived as old fashioned. Although not voiced, anxieties about being taken seriously are there. We know we are in a minority.

History

Six descriptions mention that Michael Balint started this group method and when. The method came from somewhere and someone. Another person includes the longevity of the method. For the other 16 people, history was not a necessary part of their description. The Balint eponym appears to be accepted and used to cover everything about the method and groups.

“Balint is a place you can speak about patients you have been thinking about or patients that have played on your mind a little bit.” (P15)

“Balint is a group of clinicians...”(P11)

Method

Some emphasise a method or structure. It is not just any old group.

“And there is a tried and tested method which helps us.” (P1)

“But not through a didactic method, but through a method which I like to think of as being absolutely founded now in our ideas about education.” (P17)

Living

“I want to emphasise that it is still going.” (P7)

“They were quite popular to start with then there was a bit of a lull, but they are now being revived and featuring in doctors’ trainings, and the movement is growing again, thriving.” (P8)

Widely applied

Several descriptions mention use of the Balint method beyond its origins in general practice. This is not an exclusive club.

“GPs have used it a lot but so have other doctors, nurses, psychologists, all sorts of other people including teachers, care workers, pretty well anyone who works with people can find it useful.” (P2)

“I think there was even a dentist at one point.” (P21)

It’s a group thing

“Balint is a group thing and it being a group is very, very important in so many different ways”. (P10)

The notion of a group of people coming together is widely present and emphasised in almost half of stories.

Nurturing

Regular contact with others in a group reduces loneliness and shares a burden. The words ‘enriching’ and ‘rich’ appear often. It nourishes. It provides opportunity, permission and space to think in an otherwise very busy day.

“And so then we have got some time to think about it and the group can then pick up the gauntlet and carry on with our case while we have a bit of a rest and look at it from an outside view. It’s like a golden opportunity to take a breather and look at things with fresh eyes” (P5)

“It can be quite lonely in some ways even if you are in a group practice, because a lot of the work we do, we don’t have time to discuss our patients, those who are troubling us, those who have stayed in our minds long after we have left the workplace.” (P12)

Accepting

The culture of Balint is to be non-judgemental and give permission, in a safe space, for difficult things to be said without shame. We can share our weaknesses. Other people have had similar experiences. What a relief.

“It provides a unique opportunity of stepping aside a bit from the from the ordinary professional sort of interaction and the things that guide and govern it to allow yourself to speak freely in a confidential space where there is no right and wrong.” (P22)

“And it was a real revelation when I joined a group as a trainee to be able to talk about patients with whom I’d had real difficulty, people who I really disliked in a way.” And “It was very helpful to be able to talk about it. It’s difficult not to feel ashamed of having feelings like that.” (P1)

Liberating

Group discussions can free us from a rut, lift our blinkers and illuminate. We can take a fresh view and be curious about our patients. We can talk about anything that comes to mind. We can be creative. We are not seeking a solution or trying to fix things. We can use our feelings to help people.

“...the remarkable thing is that this whole process can transform the way that a clinician is feeling about a patient.” (P7)

Connection to what matters

Being human

This applies to both the professional and the patient. We can see the patient as a person again and open ourselves up to their perspectives. We feel human again and reconnect our human and professional selves. We are helped to reflect about our own attitudes in a supportive way.

“That brings me to the idea of presentation. The idea is to put the patient right in the room in front of you as a real person, a real individual, as far away from the idea you may have noticed in something like a medical grand round where it is the disease which is the centre of attention.” (P17)

“I don’t want to leave half myself behind as I become a doctor, so what enriches my practice is being able to stand in myself whilst being a doctor, so I shouldn’t be losing anything.” (P18)

Vocation

We can be the professional we want to be. Balint takes us back to thinking about individuals and families and not only the disease. The relationship lies at the centre of our work. We can use the relationship with our patients in a helpful way.

“I know there is a place for cardiology updates but this keeps you sensitive to patient-centred medicine really. And there isn’t very much in professional development that keeps that element going, so I think it is a central balance to everything else.” (P4)

“I find its really interesting and I find it really helps me back to looking at what’s really, really, vital in consultation technique and also what’s really good about general practice, in that it is a lot about the dynamics between the doctor and the patient.” (P14)

Our working world

Balint acknowledges the reality of our working world, which is full of puzzling feelings that don't make sense. We can apply what we take away from the group to our everyday work whether we present a case or listen to others' cases.

“It is good to hear other people's views and thoughts on consultations, things that I possibly hadn't thought of and it gives me space to think how those interactions with patients work. It makes a difference not only to the patients but to us as well.” (P19)

“But I think it enriches your practice generally, not just with that person, but allows an enriching space to reflect about the experience as a professional with different people you are working with.” (P22)

Survival

This applies to more recent and long-standing members.

“There's a recognition that the work that people do whether it is physical healthcare or as a GP or a mental health professional that there is an emotional impact of that work.” (P13)

“So that's what keeps me coming really, after all these years. I always go away feeling quite uplifted and feeling more positive about being a doctor as well.” (P4)

“Help me understand what was going on and recognise it, and become interested again instead of, Oh God, I want to run away from this problem, actually what I can do to improve it, make more tolerable, make it better, make it more therapeutic.” (P1)

“I call it like my therapy, like I'm not anxious or depressed or anything but it's like a kind of protective system, like a buffer, some kind of resilience training.” (P16)

“The reason I do Balint is to prevent me burning out, because I do get quite involved with patients sometimes mentally and I think it really helps me to distance myself and work out why I'm feeling close to that patient and try to understand myself a bit more.” (P23)

Risks and fears

Anxieties about being in a Balint group are openly expressed or more hidden. Intensity of emotions that can be experienced may be too much for some.

“But I'd say to people that it's not for everyone, it's for people that are quite willing to engage with the process and talk about the way that things really made them feel. And it is definitely for people who are able to look at their own emotions and emotions of other people and so if they are not able to do that or they don't want to then it really wouldn't be for them.” (P16)

Sometimes group members say things that are a bit weird. You don't always hear what you want to hear.

“I can see that for some practitioners and maybe for myself when I was starting out, the idea of doing such a thing might be a little bit scary because I might think people

are going to judge me, I've said the wrong thing or done it wrong, I'm rubbish or should have done it differently or....." (P18)

But:

"The whole culture of Balint is to get away from that and say, you know, look, we're all human beings, we bring that." (P18)

Anxiety is anticipated. Leaders are there to make the space safe and protect us from unwanted personal exposure.

"I would also say that it is important that the people in the group feel safe and protected and that it is not a form of therapy for group members and therefore the personal information that a presenter or group members may wish to speak about in the group should only be something that they feel comfortable speaking about.."
(P20)

Discussion

There is not a singular or perfect Balint story, but naming themes in people's contributions can help us think about our own way of telling it.

It is hard to do justice to all the material in these interviews. There was nothing that we didn't recognise as Balint in its essence. We can only speculate about the effect our participants' versions would have on someone hearing about Balint for the first time. The interview method seemed to make some contributors a little hesitant, perhaps feeling exposed in front of me. What was notable was the depth of commitment and belief in the value of Balint groups to leaders and members alike. Language used was often powerful and colourful. There was mention about feeling human again and of parts of the self being reconnected. These are deep feelings and moving to hear. What might a new listener think and feel? Is passion welcome or is there a risk of being over zealous? Is this reflective practice or a religion?

The link between the Balint way of thinking and benefit to the working world was very engaging. This was mainly from GPs of all levels of experience. These are voluntary group attenders rather than mandatory. Their face-to-face and ongoing contact with patients continues, rather than reduces as may happen with seniority in psychiatry. Four of the six GP members inferred a contribution to their professional survival. Maybe these group members would make good ambassadors?

We wonder about what the word Balint has come to mean. We imagine all participants know who Michael Balint was. In current use, Balint appears to be shorthand for the group, the method and aims all rolled together. Not consigned to history, but evolved into something tangible, valued and applicable.

We have not offered much comparison across the professions or leader / member categories, because the numbers don't merit it and because the general impression is that variation comes with individuals, being themselves, using their own style. Balint encourages that in our consultations and we think the same goes for our stories. Let's keep talking about Balint.

Acknowledgements:

We would like to thank all the people who took part in this study and gave their time, often during a busy working day or after work and when they were weary.

I would also like to thank Professor Tim Dornan, for his support and encouragement during times of self-doubt.

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TABLE 1 Participant	Male/ Female	Role GP= General Practitioner CAMHS=Child & Adolescent Mental Health Service	Experience of Balint	L leader M member	Who they imagined speaking to
1	F	GP	++	L	GP
2	F	GP	++	L	GP
3	F	Consultant Psychiatrist & Psychoanalyst	++	L	Junior Doctor
4	F	GP	++	M	GP
5	F	Consultant Midwife	+	L,M	Midwife
6	F	Psychoanalyst	+	L	Colleague
7	F	GP	+	L	GP
8	F	Group Analyst	+	L,M	GP/teacher
9	M	GP	++	L,M	GP
10	M	Consultant Psychiatrist	++	L,M	Non mental health professional
11	F	Psychotherapist	++	L	Medical students
12	F	GP	+	L	GP, nurse, receptionist
13	M	Consultant Psychiatrist & Psychotherapist	++	L	Non medical team member
14	F	GP	+	M	GP
15	M	GP in training	+	M	GP in training
16	F	GP	+	M	GP
17	M	GP	++	L	GP
18	M	CAMHS Associate Specialist, Group Analyst	+	L	Work colleague
19	F	GP	++	M	GP
20	F	Psychotherapist	++	L	Psychiatrist
21	F	Consultant Psychiatrist	++	L	Colleague in psychiatry team
22	F	CAMHS Consultant	+	L	CAMHS professional
23	M	GP	+	M	GP in locum group

Collusion of Anonymity: The Manager, his Players and the Team

Observed relationship between International Balint Federation (IBF) membership and success at this year's FIFA World Cup

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What might Michael and Enid Balint's concept of the "collusion of anonymity"⁽¹⁾ which relates to the relative roles of general practitioners and consultants have to do with modern football? In the Balint community we could not help but notice the predictive power of a nation's Balint activity, evidenced by its membership of the International Balint Federation (IBF), and their World Cup success.

There is an entertaining history of attempted prognostications in the run up to (and during) the FIFA World Cup, some based on computerized algorithms (eg. <https://talksport.com/football/357478/world-cup-2018-super-computer-predicts-winners-russia/>) and others on the supposed exceptional predictive talents of animals. In 2010 Paul the octopus gained global recognition by correctly predicting the outcome of all Germany's world cup matches only to die shortly after Spain's triumph over Germany in the semi-final in Durban. In Brazil in 2014 a plethora of animal clairvoyants did not come close to Paul's predictive prowess. And in Russia this year, Baidianr, a cat in Beijing's Forbidden City, died during the group stages after correctly predicting Argentina's victory over Nigeria; whilst Marcus, a pig from England, managed to predict only one of this year's four semi-finalists, correctly choosing Belgium, alongside the ill-fated Uruguay, Argentina and Nigeria. Could there be a predictive system that takes into account slightly deeper socio-psychological factors?

Table 1: International Balint Federation Member Societies and Their Countries

Australia and New Zealand	Italy
Austria	Netherlands
Belgium	Poland
China	Portugal
Croatia	Romania
Denmark	Russia
Finland	Serbia
France	Sweden
Germany	Switzerland
Hungary	United Kingdom
Israel	United States of America

Michael and Enid Balint at the Tavistock Clinic in the 1950s pioneered Balint Groups with the goal of improving and deepening communication between clinicians and patients whilst, at the same time, enhancing teamwork and professional collaboration.(2) Since 1975 the IBF has existed to support and promote the spread of Balint groups and their study internationally. Currently there are 23 societies across 26 different nations (Table 1) affiliated to IBF. Insert Table 1 about here

Balint groups, the practice of medicine, and playing football are all team activities. A well-led Balint group must find the courage to confront the emotional dilemmas brought by its members from the complex reality of clinical practice. Each individual group member plays an important role by contributing from their own experience and perspective on the case, thus enabling the presenting clinician to work more effectively with the patient. When a sense of shared responsibility for a complex patient is lacking in a medical team or between GP and specialist, the patient’s care suffers. Given the hypothesis that a similar sense of shared responsibility, cultivated by a skilled manager contributes immensely to the success of a football team, could it be that a correlation exists between countries with Balint Societies and their success in the World Cup? We report our observational study and findings from the 2018 FIFA World Cup competition.

Methods

Data sources were the official IBF website (www.balintinternational.com) and the 2018 FIFA World Cup website (www.fifa.com/worldcup). We report observed associations/percentiles and comparisons using t-test statistics of wins.

Results

Of the 206 FIFA member national football associations, only 26 countries have IBF-affiliated Balint societies, whereas 180 do not. 14/26 (53.85%) of IBF affiliated Member

Countries (affiliates) qualified for the finals in Russia as opposed to 18/180 (10%) of non-affiliated countries. This appears to constitute preliminary evidence of an association. In the competition itself the association appears to strengthen. 9/14 (64.3%) of affiliated countries qualified for the knockout stages as opposed to only 7/18 (38.9%) of the non-affiliates. Of the 48 group stage matches there were 27 involving affiliates vs non-affiliates. In these matches, Balint-affiliated countries prevailed on 16 occasions, losing only seven, with four ending in a draw. A simple comparison of mean number of wins in the group stage, ignoring draws, shows a significant advantage for Balint-affiliated countries (1 vs. 1.54, $p = 0.04$).

In the round of 16 there were five matches that involved Balint affiliates vs non-affiliates. 4/5 (80%) were won by affiliated countries with only Portugal losing to Uruguay preventing a remarkable clean sweep.

Table 2: Round of 16 matches between IBF affiliate and non-affiliate nations

<u>IBF affiliate</u>	<u>Non affiliate</u>
FRANCE 4	ARGENTINA 3
RUSSIA 1 *	SPAIN 1
ENGLAND 1 *	COLUMBIA 1
CROATIA 1 *	DENMARK 1
PORTUGAL 1	URUGUAY 2

*Victory on penalty shoot out

In the quarter finals there were two such matches with the IBF affiliate triumphant on both occasions with Belgium ousting Brazil and France triumphant over Uruguay. By the semi-finals, four IBF affiliated nations were left in the race for glory and it came as no surprise that the only country with two IBF affiliated societies lifted the coveted trophy. Vive La France! Here again, a comparison of the mean number of wins shows an advantage for IBF affiliates (0.29 vs. 1.45 wins, $p=0.02$).

Discussion

Coincidence or significant association? What can explain our findings? Perhaps the answer lies in the similarities between Balint group work and the team culture created by modern day football managers.

In *The Doctor, his Patient and the Illness* published in 1957, (1) Michael Balint devotes a chapter to what he describes as “the collusion of anonymity”. He describes how patients with vague or non-organic symptoms, hence with unclear diagnoses, are often seen by a variety of different consultants each of whom rules out a condition related to their own specialty. The poor patient and his or her GP are left with a number of consultation reports without anyone taking responsibility for the true cause of the suffering.

In world cup matches a collusion of anonymity reflects a team attribute. In an article in the *New York Times* immediately after France’s victory Andrew Das writes “Didier Deschamps’ 2018 team will not be remembered as the most elegant champions,

or the most creative. Instead, it will be remembered for what it was: a team of exceptional talent and ruthless efficiency, a group in which every player knew his job and performed it flawlessly.”(3) And the same can be said for many of the other teams that reached the latter stages of competition. Teams that were over-reliant on (or colluded with) a single superstar for success tended to fail. Contrarily, England’s Harry Kane was rested for the group stage match against Belgium despite his being a strong contender for the golden boot award. Yet in a tournament where David so often conquered Goliath, Kane proved he was clearly ‘able’ and indeed went on to win the coveted award, heading the official FIFA list of the leading goal scorers followed by Antoine Griezmann of France and Romelu Lukaku of Belgium. Amazingly the top ten players on this list all represent Balint affiliated nations and of the 169 goals scored 95 (56.2%) were by players from affiliated nations. <https://www.fifa.com/worldcup/statistics/players/goal-scored>

For The Balint journal readers we must of course mention England who came so close to reaching the final against all odds. Fleet Street’s positive response to England’s semi-final loss against Croatia was fascinating. The Daily Telegraph posted a banner headline “Thanks for the Fairytale” and in an article entitled “Gareth Southgate, the understated manager, has transformed the nation's relationship with its football team” the Telegraph’s Jeremy Wilson describes the importance of the manager in England’s success, “because of the benefit of someone who listens and so then learns, of someone who analyses and is prepared to self-critically challenge themselves in the search for ongoing improvement”.(4) He could so easily be describing a Balint group leader or participant.

Footballers and doctors both carry a heavy burden for error and failure- recurring topics in Balint groups internationally.

In Brian Goldman’s TED lecture “Doctors make mistakes can we talk about that”,(5) he starts by comparing doctors’ performances to those of baseball players, describing a player with a batting average of 300 (meaning that he hit safely three times out of 10 when batting) as “Good, really good, maybe an all-star” and with an average of 400 (four times out of ten) as “legendary”. He then provocatively asks “Suppose you have appendicitis and you’re referred to a surgeon who’s batting 400 on appendicectomies”.

GPs have for many years been referred to as gatekeepers. Sometimes we may feel more like goalkeepers on a rather uneven playing field with patients lining up on a daily basis for a never ending penalty shoot out. Patients increasingly expect to have every kick saved without a single ball crossing the goal line. Or, as Brian Goldman might say, we physicians need to bat with an average of 1000 on headache, dizziness, chest pain, weight loss and anything else that is kicked or thrown our way! But are we really that good? Good enough to win the medical World Cup year in year out for careers that span 35 years or more? All this is part of an ever-increasing quest for patients to get access to extra time and if possible to avoid injury.

But like all humans in all fields we do make mistakes. When a patient’s creatinine level soars into the top corner of our professional net following our adding a diuretic to his or her hypertensive regimen, instead of admitting an ‘own goal’ we employ euphemisms such as ‘iatrogenic’ in the hope that it won’t be realized that we have erred. Feelings of guilt and inadequacy are never far away. Or as Brian Goldman puts it, we can quickly feel “alone, ashamed and unsupported”. It takes a good group or team manager to absorb the feelings of failure and reframe our thinking so that we can confront the next appointment/match with positive feelings.

In conclusion, recall the images of Gareth Southgate consoling his players after that cruel (if you are an English supporter) late Croatian goal. They depict a Balint-like culture

where disappointment, guilt and pain are accepted; perfection and triumph not expected and things do not always go according to plan. Like a one man Balint group he addresses his players' torment giving them an empathetic hug of support and encouragement.

“We'll be back in 2022”, he says.

But a word of warning - Brazil have applied for membership of the IBF.

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Whalley Abbey weekend.

Obituary: Professor Marshall Marinker (1930-2019)

Marshall Marinker died peacefully on June 10th 2019. Three weeks earlier he had spoken with his usual elegance and wit at a ceremony honouring Michael and Enid Balint with the unveiling of a blue plaque on their former house.

Marshall was a leading academic general practitioner who made an enormous contribution to the development of the discipline and to its teaching. Born in Stepney, East London, to Polish Jewish immigrants, Marshall qualified from the Middlesex Hospital Medical School in 1956. Typically for that period he went straight into general practice after his house jobs. As a GP assistant in Debden, Essex, he soon had 24-hour responsibility for 4000 patients, many of whom had multiple health and social problems. After a short period as a junior partner in a Nuffield Health Centre in Harlow, Marshall moved to Grays where he soon had the opportunity to set up his own practice.



Marshall Marinker

In 1965 Marshall applied for a place in one of Michael Balint's seminars. He attended for an hour long interview and recalled in his speech at the plaque unveiling that Balint accepted him, telling him: 'You will love the work. After all, you're a little bit crazy'. Marshall was in groups led by Michael and Enid for several years. One of his lasting contributions was as a co-author of the book *Treatment or Diagnosis – a study of repeat prescriptions in general practice*, published just before Michael Balint's death in 1970. The book explored the relationship of 'repeat prescription' patients with their doctor, showing that such patients did all they could to keep the doctor at bay for fear that otherwise their 'magic' treatment would be stopped. The book also explores the concept of the drug 'doctor' reminding us that it can be seen as a drug of abuse with all that entails for the doctor-patient relationship.

At around this time Marshall became an active member of the Royal College of General Practitioners, first in his local faculty and then nationally, where he served on Council for 15 years. He gained a Jephcott fellowship giving him the opportunity to review Balint seminars and their possible use in medical education. This led to his membership of the working party that produced the seminal work *The Future General Practitioner, Learning and Teaching* published in 1972. Most of Marshall's distinguished colleagues on the working party had also been participants in Balint seminars; the result was a book that gave great prominence to Balint work in the education of future general practitioners and in the policy of the Royal College.

After a short spell as Senior Lecturer at St. Mary's Medical School, Marshall was appointed Foundation Professor of Community Health at the new medical school in Leicester in 1974. This gave him the opportunity to influence the curriculum and ensure that general practice had a central place in it, a model for future developments in academic general practice. Marshall was warmly open to visitors to his department including both

distinguished colleagues from around the world and younger doctors keen to learn from him. As a trainer struggling to introduce group work into the half-day release course, sitting in on Marshall's seminars gave me a model for such work, grounded in Balint but also giving an emphasis to clinical rigour.

After eight years in Leicester, Marshall returned to London as director of the MSD Foundation. The Foundation was there to promote postgraduate medical education and included a series of successful leadership courses. Marshall was initially a member of, and then continued to support, a Balint research group led by Enid and held at the MSD offices. He later also became visiting professor at Guy's and St Thomas's Medical School.

Throughout his career Marshall produced papers and books on a range of topics, all written with great flare and stylistic brilliance. In the background was his claim that: 'I write not to tell you what I know but to find out what I think'. In conversation he was similarly lively, engaging, witty and erudite.

Although Balint did not feature much in Marshall's later work it always remained of central importance to him. At the unveiling ceremony he was much moved by the visit to what had been Balint's study and where his first groups (and that dreaded interview) had been held. All of us who were there were touched that this turned out to be his last 'public' appearance.

Paul Sackin

I am grateful to Sharon Messenger, archivist at the Royal College of General Practitioners, for supplying information about Marshall's life.



Dr Marshall Marinker, Professor Mayur Lakhani and Dr Caroline Palmer at the RCGP Blue Plaque event.

President's Report 2019

Looking back over the last year, the second and middle year of my presidency, I can see that we have managed to make progress in some areas, accomplish some of what we had hoped, but alas not all just yet! However it has certainly been eventful. After all it has been our 50th anniversary year!

To help me take stock, I find it useful to list the events through the year and it may therefore be helpful to our membership and readership too to realise just how busy the Society has been. We have held well-attended Balint study days in Birmingham, Bristol, Cardiff, London (2) and Manchester, as well as a pan-London student study day. We've also run popular two day events at Oxford, Belfast, Whalley Abbey in Lancashire and Newcastle.

Many of these have had a strong element of leadership training and the leadership team continues to work hard to encourage suitably motivated and experienced candidates to apply for leadership accreditation in the hope that this will help equip the Society with more leaders, to help set up more groups and thus grow the Society in the future. Of course, we also recently held our 'Balint@50' anniversary study day, celebration and event too, of which there is more in a separate piece elsewhere in the journal.

We've actively contributed to events organised by others as well, including presenting posters and a session on Balint, with a fishbowl at the RCGP annual conference in Glasgow last October; the RCPsych student psychotherapy and Balint scheme conference in London in January; the Northern Irish GP appraisers' conference this June; and the Institute of Psychoanalysis' 2 day conference on 'The Balints and their World' at the Anna Freud Centre in London last December. Continuing to develop these reciprocal relationships remains very important both for the productive cross-pollination of cultures and ideas but also for the vigour, health and standing of the Society.

We also recently enjoyed the RCGP's hospitality after the unveiling of their latest blue plaque on the house where the Balints lived and worked, so publicly respecting and honouring both Michael and Enid, their psychoanalytical theories and their practical contribution to and influence on General Practice. We were delighted that the ceremony and occasion brought the College and the Society closer together and it felt especially significant and auspicious during our 50th Anniversary year. So we have been continuing to pursue our goals, set out in March 2017, to re-engage with our primary parental roots in both General Practice and Psychoanalysis.

Now back to the more mundane, but in many ways more fundamental core work of ongoing Balint groups at 'the coal face' of our work and practice! The Society is still growing in terms of geographical reach and inter-professional influence and support. There are Balint group experiences for medical students in over half of our medical schools now, which are appreciated by many, and indeed the pan-London medical student Balint Society has recently been established born out of the enthusiasm of current students. We hope that the introduction of Balint work early in their career will help medics retain their empathy for patients and their curiosity, interest and enjoyment in their work, continuing throughout their professional lives.

Throughout the UK, we are aware that there are now over 30 Balint groups for GPs and mixed practitioners meeting regularly and that there are waiting lists developing for those who want to join groups too. From looking at our weekend and study day registrations, there seems to have been a modest but definite upturn in GP interest in Balint work.

All psychiatrists in training, due to RCPsych endorsement, are attending case-based discussion groups almost all of which are now run as classical Balint groups and many of whose leaders are now accredited by the Society. I gather that more senior psychiatrists are also finding that attending Balint groups continues to be helpful throughout their professional lives.

We are now also engaged in tentative early discussions with the RCGP about plans to help establish Balint group work in GP training and education in the first instance, which of course is extremely welcome news to the Society. We are making overtures to the Chair as well as the outgoing and incoming Presidents of the RCGP too, in the hope that Balint work will achieve the recognition and support from the College that we think it deserves.

This is all at a time when the health service feels under siege, when health care staff say that they are facing increasing and intolerable demands from both patients and the government, and all health care professionals feel under extreme duress. This coincides with a slump in the workforce due to problems of junior doctor retention as well as the early retirement of consultants and mature GPs, all because of extreme pressure and low morale. The profession feels overburdened with ever increasing demands and responsibilities, coupled with a loss of professional autonomy and control. Those that are left in the workforce feel under even more intense pressure than ever. About half of GPs now admit to be nearing burnout.

The Practitioner Health Programme is seeing more and more doctors who are feeling burnt out, some to the point of severe depression and even contemplating suicide. As well as seeking therapy and counselling for those seriously affected by this crisis, the PHP want to introduce interventions at an earlier stage so that staff with developing mental health problems can be helped and their emotional and professional lives salvaged. Indeed there are already one or two Balint groups available for 'Doctors in Distress' through the PHP. So the Balint Society may have an important role to play in alleviating some of the distress that Health Care staff are experiencing. By joining our groups, which offer attentive listening by peers about clinical dilemmas and situations in a non-judgemental, supportive and yet unpatronising, rigorous way it is hoped that many more can be helped to retrieve their empathy and enthusiasm for medicine. Further overtures by the Balint Society are being made to the PHP to see if we can collaborate further by offering more groups.

Many of these aspects and applications of our group work were highlighted during our 'Balint@50' event held on May 17th, at the Wellcome Collection in London. During the day, there were contributions from a wealth of speakers talking about their experiences of Balint work, from seasoned old-time GPs such as James Carne, who was a member of one of the very first Balint groups, to an enthusiastic psychiatry trainee Khushi Ghazanfar, as well as some young medical students Inseo Yun from Edinburgh and Scarlett Tankard from Bristol. One of the day's highlights was the 23rd Michael Balint Memorial Lecture delivered by Peter Toon, which was both thought-provoking and inspiring about Balint and Virtue Ethics. The lecture is also printed in its entirety elsewhere in the journal and will, with the other non-confidential proceedings of the day, be available to view on the website www.balint.co.uk soon.

We continue to have a close interest in and ties with the International Balint Federation (IBF) and its work, since Paul Sackin, a UK Society member is their Honorary Secretary and Esti Rimmer is involved with the IBF leadership taskforce. Some of our leadership team attended the IBF leadership conference in Helsinki in late September and others on Council have attended the IBF summer meeting in Budapest when they

were also able to visit the site of Michael and Alice Balint's original consulting and group rooms at the Budapest school of Psychoanalysis where Sandor Ferenczi also worked.

We are now eagerly awaiting the 21st IBF Congress in Porto from 11th to 15th September on the theme of 'Seeing Medicine Through Other Eyes', and where as well as being involved in Balint groups and workshops, we will hear some papers including, I am proud to say, some delivered by UK members Andrew Elder a past President of the Society and Raluca Soreanu, a Wellcome Fellow at Birkbeck University of London and a Psychoanalyst.

On the international front, we are now also hosting an International Leaders' Peer Supervision Group via the internet on Zoom which Sylvia Chudley, a recent recruit to the UK council has set up. There are group leaders from Pakistan, Israel, Iceland and New Zealand involved amongst other countries and so far it has been greatly valued. Ceri Dornan, our past Honorary Secretary, has recently visited Taiwan and lectured about Balint groups to medical educators there, and Shake Seigel, another Council member also speaks to many international colleagues about Balint group work on his frequent travels to Australia and South Africa.

So, for a small society of only 250 or so paid up members we are working tirelessly to spread the word about Balint work and its enlightening, effective and helpful application in many areas of health care. Of course, the more people who join the Society and engage with our work, the more we hope we can influence the culture of health care for the better, for the sake of both practitioners and patients. So I will end with a plea and ask if our members could help recruit their like-minded colleagues to consider joining us and for those reading this who are not yet a member, go and search for us on our website www.balint.co.uk and join now!

Many thanks!

Caroline Palmer

Report for the Journal on the May Events in 2019

This May saw the culmination and fruition of planning for two major Balint-related events in London.

The first, which took place on Thursday afternoon, May 16th, was the unveiling of an RCGP blue plaque on the house in Park Square West, Regents Park, where the Balints had lived, worked and held the first Balint groups in the UK. The impetus for this gesture of recognition of the Balints' contribution to General Practice was instigated by the RCGP heritage committee, led by Bill Reith, with logistical support from Sharon Messenger, their archivist and Chris Timmis, with strong moral support from Professor Marshall Marinker, who had been involved at the very inception of the Society.

Planning for the plaque and unveiling had taken nearly two years, as the RCGP had made overtures to us about their plans in the Summer of 2017, before I was appointed President, and while Ceri Dornan was Honorary Secretary and in discussion with the College about where to house the Balint Society archive. Of course we were delighted at the idea, and suggested that Enid's contribution should also be acknowledged by including her name and dates upon it too. The College Heritage Committee and we worked together further on the design and wording of the plaque, and co-ordinated the date of the unveiling so as to maximise the attendance.

It was a beautiful warm Spring afternoon and the Regency house designed by John Nash looked regal with its outlook over the handsome square. All past officers of the Society as well as current Council members were invited by the RCGP to attend the ceremony. It felt a great honour to be invited to say a few words on the steps of the house under the plaque, alongside Professor Mayur Lakhani, President of the RCGP; Susan Lawlor, Enid Balint's granddaughter and herself a psychotherapist; the Right Worshipful Lord Mayor of Westminster, Councillor Ruth Bush on her first official engagement; and also a young member of the family who currently own and live in the house. The owner had very kindly thrown open her doors and we were afforded a great welcome in the form of champagne and canapes which we enjoyed in the rooms that the Balints had used for consulting and analysis, as well as for accommodating the first Balint groups. Later we repaired along the Euston Road to the RCGP, as the Heritage Committee also lavished hospitality upon us with bubbly and canapés in the Princes Gate Room at the College, where Professor Lakhani and I spoke again, and Prof Marshall Marinker gave a very amusing speech in the presence of Helen Stokes-Lampard, the Chair of the RCGP. It felt a very important gathering and meeting between the College and the Society that we hope will have renewed and strengthened our ties once more.

The following day, Friday 17th May was our 'Balint @50' event which we held at the Wellcome Collection, on Euston Road. It was about 18 months before that I'd been writing a mundane shopping list on a piece of scrap paper when I noticed the words 'Founded in 1969 for the study of the Doctor-Patient Relationship' printed across the top, and it dawned upon me that the 50th anniversary of the founding of the Society would fall during my 3 year Presidency. An idea started to take root in my mind. Surely we should try to look back over and honour the last 50 years, and celebrate the present life of the Society in some way, while entertaining our hopes for the future of the Society too? I gathered a select band of helpers, including Andrew Elder, John Salinsky, David Watt, Ann Evans and Suni Perera. We shared our ideas and discussed how to begin to order them and how we might reflect the life of the Society just in a day. As the day grew nearer, Ceri Dornan kindly offered crucial unstinting practical and logistical support too.

We were keen to invite the elders of the Society, some of whom unfortunately were too ill to attend on the day, as well as Enid's granddaughter Susan Lawlor and her family, members of the RCGP, academic departments, and some 'movers & shakers'.

We wanted to begin by paying homage to the Balints' psychoanalytic legacy so invited Raluca Soreanu, Psychoanalyst and Wellcome Fellow in Medical Humanities at Birkbeck College, who spoke with erudition about the young Michael Balint's life as the son of a GP, and his work with Ferenczi and the Hungarian School; Dr Jennifer Johns, GP and Psychoanalyst, who had been Enid's analysand, and known both Balints in the early days at the Tavistock Clinic, who spoke warmly about her experience of working alongside them and really brought them back to life for us; and then lastly Gearoid Fitzgerald, Consultant Psychiatrist and Psychoanalyst in Leeds, who is very involved with the present day Balint Society, especially leadership training and accreditation as well as being our current Vice-President.

We then heard an entertaining talk and some mischievous recollections from retired GP Dr James Carne, who was a member of one of the earliest Balint Groups, and took part in the transition from the 'Long Case' to the 'Six Minutes for the Patient' group; followed by John Salinsky talking about the foundation of the Balint Society and the contributions made by founders such as Marshall Marinker and especially by Michael Courtenay who remained engaged and active in the Society and Balint research for all his life. I had written to Michael about our plans to celebrate the 50th anniversary, a few weeks before his death in the summer of 2018, and I was very pleased to hear that he was gratified and approved of the idea.

The last session in the morning was devoted to the 23rd Biennial Michael Balint Memorial Lecture, on 'Balint and Virtue Ethics', given by an old friend, GP colleague, Society member and medical ethicist, Peter Toon, whom I've known since I was just 16, and whose path I have kept crossing during the last 50 years! He spoke with great eloquence and passion about the ideas of Michael Balint and Alasdair MacIntyre, which have affected his thinking, how we may flourish in our personal and professional lives by cultivating and practising virtues, and the rewards of generating 'internal goods'. The audience was spell-bound by his lecture, which you can read elsewhere in this journal and which generated a lot of interested questions and enthusiasm for his ideas.

After all the intellectual stimulation of the morning's sessions, we all felt the need for physical sustenance, so enjoyed a very good lunch thanks to the Wellcome Collection's catering team, during which there were many warm and animated conversations going on, as well as the opportunity to peruse the exhibition about the Balints' life and work, organised by Raluca Soreanu and Ewan O'Neill from the Institute of Psychoanalysis.

After lunch, we all participated in a Fishbowl Balint group, with a central group working on a real case, which was led by Andrew Elder a retired GP and therapist, and Doris Blass, a retired GP and Psychoanalyst, with the wider group listening to the proceedings, thoughts and speculations of the inner group. For some this was their first experience of participating in or seeing a Balint group in action, and there was also an opportunity to discuss the group process.

After a tea break, the present day work of the Society was explored, with contributions 'From the Psychiatrist's Chair' reflecting the recent expansion of Balint group work within Psychiatry training at all levels. The talk by Dr James Johnston, Consultant Psychiatrist and Therapist in Leeds, was typically ironically amusing and yet serious, followed by a moving talk by Dr Khushbakht Ghazanfar, a CT3 trainee in Preston, Lancashire on the way that Balint groups had helped her reinterpret her relationship with two patients at either end of life.

The following session focussed on Balint work within General Practice, with contributions from Suni Perera, a GP Trainer and GP Programme Director, about her experience of running GP registrar groups, as well as a pilot project Balint group for Care Home assistants. David Watt informed us that there were actually well over 30 Balint groups running nationwide for GP Principals, and exploded the myth that Balint work was dying out in the GP community. Andrew Elder then spoke with passion and some concern about the state of Balint work, its position vis a vis academic departments and asked provocatively, if we should be pleased to still feel the need to be a separate Society, and whether in fact if we'd been really successful, our ideas would have rather been accepted as mainstream and the norm. Clearly we still have a long way to go!

The final formal session of the day was called 'Into the Future: Student Balint Experiences and Plans', which included an emotional paper delivered by Inseo Yun, a 5th year Medical student from Edinburgh, who had won the Balint Essay prize in 2018 based on her experience of witnessing a consultation on her GP placement, and the subsequent illuminating help she found in a Balint group. This was followed by a paper by Scarlett Tankard, an enthusiastic Balint group member at Bristol medical school, 'From Membership to Leadership', whose devotion to the method has seen her recently take on the role of co-leader. The last contribution to the session was made by Eamonn Marshall, Psychotherapist and Balint Group leader at St.George's, University of London, speaking on behalf of one of his students who was indisposed on the day, and talking about the proposed establishment of the Pan-London Medical Student Balint Society which is currently under way. This is an exciting development instigated by medical students themselves who want to extend their membership of Balint groups beyond the prescribed sessions during their Psychiatry placements, to a more sustaining, continuing experience during their clinical training.

The formal sessions ended on this optimistic note and message about the relevance of Balint work to students, and hopefully its embedding in the medical curriculum in the future, as well as the working lives of individual future doctors, having been exposed to Balint early in their training and careers.

There was a short plenary, in which all the speakers and chairs of the sessions were thanked for their commitment of time and effort on preparation for the day, as well as their spirit of common enquiry that was shared by all the participants too. People said that it had been an important, even quite historic day, gathering and joining up the threads of the beginning of Balint work with those of the present day and hopefully into the fabric of the future. With the crisis in the GP workforce, the high rates of burn-out, the problems of retention of both junior doctors and consultant colleagues and the apparent erosion of clinicians' empathy, it was agreed that we urgently need to embrace Balint work now more than ever. There were calls to increase our outreach especially to nurses, and also to pursue closer relations with the RCGP, in the hope that they might validate the Balint method of group work as a helpful form of reflective practice, in a similar way to the Royal College of Psychiatrists.

After the formal sessions we all enjoyed some fizz and a delicious and stunning cake that Paul Julian, a member and retired GP from Hackney, had made and decorated in the form of the numeral 50. There were beautifully intricate, exact authentic facsimiles of Balint's books rendered in marzipan and icing laid out on the '5' cake, representing the Balint theory. A model Balint group of 8 participants, (Michael Courtenay, Mary Hare and Paul himself being recognisable members of the group!) the figures made of marzipan, sitting on the inner edge of the 'o' cake with their legs dangling into the centre represented the practical aspects of the Balints' work! The cake was such a wonderful

work of art and indeed a labour of love for the Society that I felt that we needed a surgeon with enough sang-froid to make the first incision, but Paul and I together performed the dastardly deed and the cake tasted as delicious as it was beautiful. About 40 pieces of cake were also sent out by post in special 'Balint@50' boxes to those who had regretted not being able to attend.

During the day I was very pleased to see such a meeting of interested, animated and engaged clinicians and therapists, of all ages and from so many different work situations and cultures, from all across the UK and beyond, sharing our enthusiasm for and belief in the relevance and helpfulness of the Balints' ideas. It had been very good to welcome some old friends of the Society to the day too, including Erica Jones, and also Professor Marshall Marinker, who said on leaving that he'd been profoundly moved by the proceedings. It was a sad shock to hear that he died only two weeks later. His obituary appears elsewhere in this journal. Many of the presentations made on the day are, or soon will be, available on our website, www.balint.co.uk and you are all very welcome to view them online so that you can feel connected to the Society and visit or revisit our day of reflection and celebration. Here's to the health, vigour and growth of the Society over the next 50 years!

Caroline Palmer



Delegates at Whalley Abbey relax in the grounds.

Reports of Balint work in the UK and Ireland June 2019

Once again we are reporting on a lot of activity around the regions in the UK and Ireland with many new developments. South Wales held its first study day, attracting more than forty participants; the 'London' annual study day and dinner in February has outgrown the venue and will be in Birmingham in February 2020; there are new groups for medical students, foundation doctors and GPs, a new international peer leadership supervision group co-ordinated by Sylvia Chudley on Zoom and another new peer supervision group in West Yorkshire co-ordinated by Chris Douglas. We now have around one hundred and thirty accredited leaders and more are in training.

Contact details of the local regional representatives have been included in these reports. Do get in touch with them if you are looking to develop some Balint work, join a group or want to know more about what is going on in your area. As always details of our main events are published at least three months in advance on our website; information about leadership training, accreditation and supervision can also be found there and by contacting leadership@balint.co.uk

The reports open with a lovely poem from Ray O'Donnchadha about the first Dublin Symposium, held in June 2018.

Dr Jane Dammers - Member of Council 15 June 2019

Ireland

Dublin Balint Symposium

Junethesixteenthtwothousandandeighteen

Balint Blooms.
In the west Dublin summer air.
From Finns Hotel to Finnstown House,
The Balintees came, their hungry souls aflame
On the promise of
Engagement.
The newness in every meeting;
The openness to every 'wrong'
The vulnerability of knowing.
We had come separately, along diverse paths;
To this together-sharing colloquy of wisdom.
And then dispersed in our new-knowing uncertainty, to look
Forward.

Ray O'Donnchadha
rodonnchadha@gmail.com

Republic of Ireland

Sligo

The development and spread of Balint continues steadily in Ireland. The Sligo Balint Symposium continues to be the main standard bearer in the Republic and is paired with the Belfast gathering on alternate years. We have just celebrated our 4th Symposium which was a great success. The Sligo event places particular emphasis on the multidisciplinary dynamic and this was reflected in the diversity of professionals who attended the event. Feedback supports the view that this range of experience in Balint groups adds depth and richness to the process and experience.

The Sligo area is rich in Balint activity and has three separate Balint groups for GPs in the community. The Sligo GP Training scheme has had Balint groups as part of its training for 15 years now. It is clear that when Balint is embedded within GP training it has traction to continue and thrive in the community for GPs, as a culture of reflective practice has already been established.

Dublin

There is a vibrant and energetic need for Balint in other areas as well. Secondary School principals are now emerging as a distinct group who are using the method within the educational arena. The first Dublin Balint Symposium was held in June 2018. There are several Balint groups emerging in Dublin, which is demonstrative of a new energy in the field. We plan to run a Balint Leaders' day later in the year in Dublin to maintain equilibrium and to address the need for development of the skills required for group leadership and management.

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Northern Ireland

Belfast Balint weekend

The fourth Balint weekend in Belfast was organised by Christine Christie, Marie King and Glenda Mock and was held in the Clayton Hotel from November 16th to 18th 2018. It attracted forty two delegates from across the UK and Ireland. Once again it coincided with the switching on of the Belfast City Christmas lights. The Balint Groups and Leaders Workshops ran in parallel and everyone experienced the Goldfish Bowl session. Dinner on Saturday night was held in Conor restaurant, in the University area. Many people enjoyed the opportunity of unexpectedly dry clear weather to walk the short distance to the venue. To the bemusement of the few other diners, our group effectively took over the restaurant before stepping outside for a '99' or a 'Slider' from Morelli's Ice-Cream Van. The odd passer-by also indulged in the experience! At the end of the weekend a number of participants asked if there was a group they could join, so a waiting list has been started for a second group in private practice.

Balint Groups

Christine and Glenda continue to run their multidisciplinary Balint group, which has been running in Belfast for two years. There appears to be a growing interest in Balint work among general practitioners, with its benefits for workload and stress management being acknowledged.



Delegates enjoying themselves at the Belfast Weekend.

Spreading the word

Christine took an opportunity to promote Balint groups at a conference in Dun Laoghaire in May. Organised by the Irish Psychoanalytic Association, it featured an international panel of speakers presenting papers on the work of Psychoanalyst Sandor Ferenczi and the Budapest School. She spoke on the background of the work of Michael and Enid Balint and their collaboration with doctors in their Training and Research seminars, and then did a brief demonstration with volunteers from the audience. The session appeared to generate interest, with a midwife exclaiming afterwards 'I wish we had those groups!'. Caroline Palmer and Marie King have been invited to run a short introduction to Balint during the Northern Ireland Bi-Annual Appraisal Conference in June 2019. This is a great opportunity to highlight the work to the GP appraisers, who between them have contact with all GPs working in Northern Ireland.

Glenda Mock
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Wales

South Wales

There is excitement about the Balint green shoots (? Leeks), in South Wales. Following the success of the Experiential Balint Study Day held in Chepstow in 2017 and the Leadership Training days held over the border in Bristol, Wales is about to hold its first ever Balint Leadership Training Day at the lovely Insole Court in Cardiff on 10th June. The day is being organised by Dr Neda Mehrpooya and Dr Danika Rafferty, both ST6 doctors in Psychiatry who currently co-lead a Balint group for trainee doctors at the Royal Glamorgan hospital. They have also been involved in running groups for medical students and trainees in Bridgend and are both working towards accreditation. There has also been support from the South Wales peer supervision group that has been running for the past two years, involving amongst others Mary Self, Amelia Lyons, Clare Cribb and Adarsh Shetty. There will be three groups catering for varying levels of Balint experience. The group leaders will be Judy Malone, Amelia Lyons, Shake Seigel, Mary Self, Esti Rimmer and Ann Evans.

North Wales

There are plans to establish a Balint group in Wrexham in the near future, co-led by Dr Ann Evans, GP and Dr Emily Sherley, ST4 in Psychiatry. Linda Mary Edwards, Group Analyst and Ann Evans also co-lead a Balint group for the Dyffryn Clwyd GP VTS from time to time.

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Bristol

Psychiatry Trainee-led Balint group scheme for Medical Students.

The scheme is now completing its sixth year and offered all 3rd year medical students at Bristol University the opportunity to participate in Balint groups this year. The project management team currently comprises Ami Kothari, Clare Trevelyan, Eva Bowditch, Melissa Buckley and myself and we are grateful to Eva who did the bulk of the work

organising group leaders and co-leaders, collecting and collating feedback from medical student and psychiatrist questionnaires and organising the two leadership training days this year. With project sustainability and future developments in mind we are welcoming Rob Dixon, Caroline Guest, Jon Olds and Melanie Woolgar to the team who are all in senior positions and likely to be around for some time and we are pleased that Scarlett Tankard, a medical student who has done several training days and has had experience of co-leading medical student groups for the last two years can also join us. We hope to also attract further trainee psychiatrists on the scheme to join us.

We have no difficulty recruiting trainee psychiatrist leaders and are pleased that our scheme continues to be attractive to both core and advanced trainees. The trainees particularly have enjoyed the opportunity to co-lead groups and attend supervision together. We are hoping to attract more students to take up leadership opportunities. We continue to face ongoing challenges with medical student attendance to some student groups and difficulty in some areas around scheduling regular times and rooms for groups with busy administrative staff and a busy student timetable. We also continue to face the challenge of some psychiatrist leaders not attending regular supervision. Having experimented with offering more supervision opportunities we are aiming to have an initial meeting with all potential group leaders at the start of the academic year to discuss the scheme and leader responsibilities and offer one regular supervision group and the possibility of phone supervision for those outside Bristol.

The scheme continues to receive mostly positive feedback from students and trainees. We struggle to continue to stay in the minds of the busy medical school especially at a time when the medical school is very much caught up in delivering a new curriculum with its benefits and challenges. We hope to be able to fit in with the new year 3 curriculum and deliver our groups to all year 3 medical students during the next academic year despite there being no junior medical and surgery block as previously. We are in the process of discussing delivering groups to year 4 medical students in the care of the elderly placement next year. The current plan is to have trainee psychiatrist leaders co-leading these groups with GP trainees. Other developments from the scheme include psychiatrists leading Balint groups in different settings including a group for core trainees in medicine, in a paediatric department and in a psychosexual service and several psychiatrists leading core trainee and FY1/2 Balint groups.

Louisa Wilson, Hattie Greenstone, Scarlet Tankard and I were pleased to be able to present our work at the Medical Student Psychotherapy and Balint Schemes in the UK 2019 symposium this year and we are proud that Scarlett Tankard could also present at the Balint at 50 Celebration conference.

We are grateful to the Severn deanery for funding the biannual leadership training days for the psychiatry trainee and medical student leaders and we ran two successful days for a total of 48 trainees in September 2018 and March 2019. We were pleased to welcome Alexa Gilbert-Obrart to facilitate the training days with me with her experience of working with medical students. We were able to accommodate so many people on the training days by running a demonstration group in the morning with discussion and two leadership training groups in the afternoon. We continue to be grateful to the Department of Medical Education in the AWP trust for funding additional supervision and attendance at Balint society leadership training events to support doctors and trainees on the accreditation pathway and we now have seven accredited leaders in Bristol and several on the accreditation pathway. Ami Kothari and I continue to be involved in the Balint in medical schools strategy group (BIMS) discussing issues around Balint and supporting medical students with colleagues from the UK, Australia and New Zealand. We also

continue our involvement with the Royal College of Psychiatrists Medical Student Psychotherapy Schemes and Balint groups working group.

Leadership training

The fourth Bristol Balint leadership study day was held in December 2018. The event was very successful and was again attended by a range of clinicians from different disciplines and from the private, voluntary and public sectors. We have a further day booked for December 2019 and plan to keep this as an annual event.

Balint Groups in Bristol and the South West

Balint groups continue to run across the AWP Trust and as mentioned above trainees who have gained experience on the medical student scheme have been involved with leading and co-leading these groups. I now co-lead two GP Balint groups in Bristol with one group specifically for GPs involved in GP health work which has been an interesting development. Both co-leaders, a GP and a group analyst, involved with this private work are senior clinicians in Bristol and are on the Balint leadership accreditation pathway. I am planning to trial co-leading a Balint group for psychodynamic clinical trainees at the Severnside Institute for Psychotherapy in the next academic year which is another interesting development. We continue to make links with people interested in Balint and Balint leadership training in the South West and Wales.

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London and Southern region

The Oxford Weekend

The Oxford Weekend was held at Corpus Christi College 14th – 16th September 2018. The title was ‘Listening and Reflecting’, John Salinsky gave the keynote speech and there were seventy two participants.

London Study Days

The study day in February 2019, which is aimed largely at accredited leaders and those on the accreditation pathway was very successful. Dr Gearoid Fitzgerald gave a very useful talk titled ‘Theoretical reflections on the Leaders: their feelings, their thoughts and their responses to the Group’ getting us to think more about how we feel as leaders and what we do with those feelings. In the early evening there was the presentation of a marvellous dramatisation of ‘A Fortunate Man’ based on the book by John Berger and Jean Mohr, presented by New Perspectives Theatre Company. The two actors and producer engaged in a stimulating and emotional discussion after the play, and were able to stay to the buffet supper and continue various conversations. The Medical Society of London, while lovely, is becoming too small for this annual event which will be transferred to Birmingham University for February 14th 2020. The June London Leadership Training Day led by Helen Sheldon and David Watt attracted fifteen people and is becoming a regular annual event.



London Study Day.

GP Balint groups

GP Balint groups in the South are as before. Brockley, South London - Eamonn Mitchell and Paul Julian; East London - David Watt and Joan Fogel; Wembley - John Salinsky and Tessa Dresser; Brighton - Ann Tyndale and David Watt; Oxfordshire (two groups) - Val Cooper.

Three large GP practices have Balint groups. . A new group based in General Practice will be starting in West London led by Ann Patterson. VTS Groups continue at Hackney, Northwick Park, Tower Hamlets, and the Whittington

Other Balint groups

Physician Health Programme - Andrew Elder and Ann Tyndale; Whittington Hospital Gynaecologists -John Salinsky and Doris Blass; UCLH Foundation Year 1 group, established 2015, meeting weekly during their surgical rotation, co-led by psychiatry trainees and supervised by Helen Sheldon. David Watt and Roberts Klotins are running a group for six months for medical registrars at Whipps Cross Hospital. Its future is uncertain at the moment, though it is certainly proving very interesting for the leaders

The Balint Group Leaders Workshop

The Balint Group Leaders Workshop continues at the Tavistock Centre three times a year, and appears to be much appreciated both by older Balint leaders, and by new leaders wanting to present their new groups for comment and group supervision, particularly those leading groups for psychiatry trainees.

Medical student groups

In January 2019 the RCPsych held a symposium for medical student psychotherapy and Balint group schemes which was well attended by Balint Society members and medical students. Over twenty medical schools around the country now offer Balint groups to their students. During the past 12 months St Georges and UCLH each ran two medical student Balint groups of twelve sessions. At Kings there is a new initiative providing mandatory fortnightly Balint groups for all students during their first clinical year. Barbara Wood is the lead for this initiative and is joined by Paul Julian and Helen Sheldon in supervising these groups on a weekly basis.

A new London initiative, the pan-London Medical Student Balint Society was formed in October 2019 in response to students' request to continue to develop their Balint experience after their medical school groups had ended. There are a dozen students involved, supported by a Facebook page and a Balint group, meeting every three weeks since early this year. Eamonn Marshall, Ross Champion and Helen Sheldon are involved with this project.

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North West Region – Manchester, Merseyside, Cumbria

Balint activity in the North West has continued as before with gratifying growth in some areas too. We had grand ideas of setting up a North West leader peer group supervision group over the last year, but other events have overtaken me and this has failed as yet to

come to fruition. Ceri Dornan and I have however discussed a strategy and think that it might be workable to split the region into a Manchester/Liverpool area, and a Lancashire/Cumbria area, to reduce travelling distances and times. We hope to launch this on a termly basis from the Autumn. The possibility of meeting via Zoom is also being considered if meeting in person proves too difficult to achieve.

Around Manchester

Two Balint groups continue in South Manchester. One is for GPs, mainly younger practitioners, led by Simon Henshall, and Ceri Dornan, practising, and retired GPs respectively, both accredited leaders; attendance has improved a bit. The second group is a mixed GP and psychiatrist group led by Louise Ivinson, a medical psychoanalytic psychotherapist and Ceri Dornan, which seems to be thriving. Simon has continued to provide some Balint sessions into the Salford and Trafford GP VTS, often assisted by Ceri.

Helen Sheldon, psychotherapist and Ceri ran another leadership training workshop in March this year, which attracted people from Manchester, Liverpool and Sheffield. It was quite a small but intensive group. We hope there will soon be a few more accredited leaders in the North West as a result.

Lancashire

The 'Clinicians in Practice' group, based near Burnley, has settled down to quite a stable group of eight regular attendees. This includes a couple of consultant psychiatrists, a Medical Oncologist, an advanced nurse practitioner and four GPs. The group is led by Cheryl Williams, an established Psychoanalytic Psychotherapist, who is now applying for her leadership accreditation and myself, a retired GP. We are keeping a waiting list for other interested recruits and hope that a nucleus of another group may form in time. Sylvia Chudley, an accredited leader and GP who fairly recently moved to South Cumbria hopes to form a group for Cumbrian clinicians which may meet via Zoom if this suits the hilly Lakeland geography.

Groups for Psychiatry trainees working with Lancashire Care Trust continue, with established groups based at Preston and Blackburn now thriving. The slightly more experienced trainee CT3s, who show an interest and aptitude in Psychotherapy are given the opportunity to co-lead with a Consultant Psychotherapist.

Merseyside

There are Balint Groups for junior Psychiatry Trainees, and groups for 5th year medical undergraduates at the Medical School. We do not currently know of any groups for practising GPs or other health professionals in the area.

Cumbria

Andrew Morgan reports there is still a Balint Group operating for Allerdale Community Mental Health Team staff; also a group for Psychiatry and GP trainees and FY doctors run by Cumbria Partnership Trust.

Student Balint Group Activity

Student Balint Group Activity has been quite vigorous in the North West. The Balint Groups for Manchester medical students undertaking their clinical years of study at Preston are well-established. All students attend three 1 hour long groups during their Psychiatry attachment, with the option of then attending an on-going evening Balint group. An enthusiastic doctor Ben Greers, who attended the Whalley Abbey weekend, is

liaising with the University about setting up a Manchester University Student Balint Society, which is a great initiative. Medical student Balint groups 1.5hrs long for five weeks are now up and running at Lancaster University for all students during their psychiatry attachment. These have been led mainly by Sylvia Chudley and Caroline Palmer, with co-leadership from medical education tutors. Liverpool medical students who are undertaking their clinical training in Blackpool attend Balint Groups run by Lancashire Care Trust colleagues, along the same lines as those receiving their clinical training in Merseyside. There are also some Balint Groups running for international medical students and post-graduate Physician Associate students at UCLAN in Preston. Altogether we have seen considerable growth in the provision of student Balint groups in the region, largely due to the commitment and passion for Balint work shown by Simon Belderbos, Consultant Psychiatrist at Lancashire Care NHS Trust. I think that the earlier we can introduce Balint thinking and the method in a medical career the better emotionally equipped the subsequent practitioner may be to deal with the rigours of their work.

Whalley Abbey weekend

Held in the delightful and historic conference centre, near Blackburn, the weekend was again a stimulating but refreshing experience for the thirty eight participants. People came from all over England, as well as from Wales, Scotland, and even Chicago. Over a third of the attendees were GPs, which was encouraging, as well as Psychiatrists, a Psychoanalyst, three nurse or midwife clinical student educators from Preston, a Geriatrician and two medical students. There were enough people wanting to present cases to produce two reasonably sized 'ordinary' Balint groups. A larger group of fourteen who wanted to develop their group leadership skills were able to either observe or co-lead a group session, or the fishbowl. All these opportunities were appreciated. The intense group work was balanced by a free afternoon for local exploration or rest which was aided by pleasant sunny Spring weather, in contrast to the snow of last year. The Abbey staff were as welcoming as ever and the ambience worked its magic on us all. I gather that there may be changes in management at the Abbey conference house during the next year, but we have booked another weekend for March 27th to 29th 2020 due to popular demand.

So, in the North West we can look back on a year of some growth in our work, especially with medical students which we hope we can consolidate, and also plan to collaborate further with Balint colleagues in the wider region in the year ahead.

Dr. Caroline Palmer
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North East Region – Tyneside, Teeside and Northumberland

We have quite a few new initiatives this year with an exciting pilot for all foundation doctors in the Gateshead Trust to attend fortnightly Balint groups as part of their regular educational activities, as well as the start of several other new groups – see below. We have fourteen accredited leaders in the region, most of whom are involved in Balint work. We have always had a close relationship between GP, Psychotherapy and Clinical Psychology leaders, with most groups being co-lead, and the leaders meeting regularly to plan events and developments. We also present our groups at our termly Peer Supervision Group in Newcastle.



**Photographs from
the Newcastle two
day Balint event
2019.**

**Dinner in the Grotto
seafood restaurant at
Marsden Rocks after
an exhilarating dip in
the North Sea
Swimming as the tide
came in on a
beautiful evening
after a day of Balint
work.**



Many of us also contribute to running Balint society events nationally, helping with planning and leading groups; also providing supervision to many of those on the accreditation pathway either face to face or by skype. Esti Rimmer is a member of the IBF Leadership Task Force team and Jane Dammers is on the Council and closely involved with leadership training and accreditation.

Our aspirations are to continue to encourage development of groups for GPs and others; to train more, and younger leaders in the region to continue and expand the work in the future; to embed the pilot foundation year scheme in the Trust so that it continues in the future; and to reintroduce Balint into the Northumberland GP Vocational Training Scheme where it once thrived very successfully but now seems to be squeezed out. We are also promoting links with colleagues in Scotland, encouraging them to come to our training days and two day events, and plan to help them with a training day in Glasgow or Edinburgh in the Autumn.

GP and Mixed Groups

We continue to have a quite a few groups for GPs in the region. Most of these are mixed groups with a range of other professionals which is stimulating. There is a new group in Durham led by two local GPs Kate Hodges and Purnima Adla. Two groups in Newcastle are led by Esti Rimmer, Dave Morgan and Jane Mulholland and one in Gateshead by Claire Appleton and Jane Dammers. Amanda Smith and Zara Samad ran a GP group on Teeside last year with funding from the PHP programme and people came from as far away as York to join.

Foundation Doctor Groups

Dr Prathibha Rao, Foundation Programme Director for the Northern Foundation School, has obtained funding for all year 1 and year 2 Foundation doctors to be in a fortnightly Balint group for a year long Pilot in the Gateshead Trust. Dr Chris Brogan has liaised closely with her to set up the groups and this exciting development will start in September. The groups will be part of the junior doctors' weekly education session, so we hope will be well attended and will be co-led by experienced accredited local Balint leaders partnered by doctors in the Trust who will be in training as leaders. North and South Tyneside Foundation Doctor groups in the Psychiatry rotation have continued, led by Chris Brogan, Lucy Buckley and David Catterall. Attendance has been a bit erratic and there is a feeling of some lack of support from the Trust to make it possible for doctors to come.

Medical student groups

Kate Hodges, GP, led a medical student group for two years during her time as a teaching fellow. Dr Frauke Boddy initiated a pilot scheme for medical students in their psychiatry rotation, due to start shortly. Unfortunately the Newcastle Medical School has not shown any proper commitment to Balint groups and so these are sporadic individual initiatives. Professor Scott Wilkes, Dean of the new Medical School in Sunderland, also a GP, has expressed an interest in introducing Balint groups to the students in the third clinical year.

Clinical Psychology Groups

Zara Samad ran a group for clinical psychologists on Teeside over the last year; she is now on maternity leave. Claire Appleton and Annette Hughes run a monthly group for clinical psychologists on Tyneside which is going well. Many of the clinical psychologists have previous experience of being in a Balint group in their training.

Consultant Psychiatrist Group

Consultant Psychiatrist Group has recently started led by Richard Duggins and Chris Brogan and already has seven members.

Higher Psychiatry trainee Groups

A new group will be starting in NTW NHS Trust in September co-ordinated by Lucy Buckley. Phil Osborne runs a weekly core trainee psychiatry group in Darlington and a fortnightly higher trainee psychiatry group in Stockton on Tees, co-led by Tony Aston, group analyst. After their experience of Balint as core trainees, many want to continue in a Balint group.

Newcastle Two day weekday event June 2018 and 2019

Last year we piloted a two day event, very similar in structure to a Balint weekend but on Thursday and Friday. This was in response to some, mostly younger, people saying that it was hard to come to weekend events because of family commitments, or just too much after a full working week. Also their trusts are more likely to give them time off and pay for them to come during the working week. The two day event was very well attended with more than thirty people so we have decided to repeat it this year with leadership groups, a Balint group and a Balint Psychodrama group as we did last year. We anticipate about forty people and are just now looking forward to what the two days will bring. There will be a chance to relax at Marsden Rocks, a beautiful sandy cove, surrounded by rocks full of nesting sea birds with an extraordinary Victorian Grotto and Fish restaurant built into the cliff. A good time will no doubt be had by all.

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Yorkshire and Derbyshire – Leeds, Sheffield, Derby

Sheffield

Balint groups

There are four groups for core trainees in Psychiatry, one lead by Alex Pavlovic in Sheffield which also has GP trainees; a second in Rotherham lead by Dr Warren. Joanne Carley leads groups in Chesterfield with Amy Herford, and in Derby. Both are mixed groups with foundation doctors and GP trainees alongside the core trainees. Harriet Fletcher leads a group for Foundation year doctors in Sheffield. Joanne also supervises a clinical psychologist who is leading a multidisciplinary Balint group for members of one of the community mental health teams in Derby.

A monthly Balint Group has been running in central Sheffield for the past two years led by Steve Delaney and Libby Kerr. Steve is a group analyst and Libby a psychotherapist and clinical supervisor. Both have worked for over twenty years with complex clients in various settings in health, education and the third sector. The membership of this multidisciplinary group includes GPs, Clinical Psychologists, Counsellors and Psychotherapists. The group has received positive feedback from members who have found the different professional points of view particularly helpful and interesting. The group is recommencing in September for a new series of monthly sessions and there are one or two places still available for new members. If you are interested please contact the leaders sheffieldbalintgroups@gmail.com

Medical Students Michael Milmore and Dasl Abayaratne lead medical student groups for six sessions, three or four times a year. Joanne Carley was previously involved with Sheffield medical student masterclasses in 2017 and 2018 which included Balint. Unfortunately there was a reduction in the number of masterclasses this year and Balint was not given as an option.

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West Yorkshire

Peer supervision group for Balint group leaders

Peer supervision group for Balint group leaders co-ordinated by Chris Douglas is held bimonthly on the third Friday of the month 2 – 3.30pm. It is usually held in Bradford and has also met in Halifax and Leeds. For more information contact Chris Douglas Chris.Douglas@swyt.nhs.uk

Balint groups

Chris Douglas co-facilitates a mixed Balint Group for Core Trainees/GPSTs/FYs with Dr Mark Radcliffe, associate specialist, and with monthly co-facilitation from Dr Katherine Redwood, higher trainee. Chris also run a monthly Consultant Balint Group with Leonie Hilliard, Group Analyst.

Leeds

Medical student groups

Dr James Johnston, Consultant Psychiatrist in Medical Psychotherapy runs fourth year medical student Balint groups in psychiatry every week, alongside Turlough Mills, Consultant Child and Adolescent Psychiatrist and a higher trainee Dr Mathew Harrison.

Foundation Year Doctor groups

Dr Vikram Luthra (Consultant Psychiatrist in Medical Psychotherapy) leads a weekly Foundation Year doctor Balint group with a higher trainee co-leader, Dr Mathew Harrison.

Core Trainee groups

Dr Vikram Luthra leads a weekly Core Trainee in Psychiatry Balint group with a higher trainee co-leader, Dr Mohammed Qadri.

Higher trainee in Psychiatry groups

Dr Vikram Luthra leads two higher trainee in Psychiatry Balint groups.

Bradford

Dr Jeani Lingham, Consultant Psychiatrist in Medical psychotherapy runs a Core Trainee/GPST Balint group with Emily Clavering, Consultant Child and Adolescent Psychiatrist. Jeani also runs a Foundation Year group with Joy Billingham. Dr Emily Clavering runs a medical student Balint group with Dr Tolis Bardis Consultant in General Adult Psychiatry.

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Midlands – Birmingham, Nottingham and environs

Leadership

There is ongoing interest across the region in Balint work. More people are proceeding to accreditation for Balint Group Leadership. Following a leadership day held in Birmingham in 2018, an international supervision group has developed. This group is being facilitated by the Balint Society using the Zoom internet platform. This platform could also become available for supervision within the UK as well. Watch this space.

The annual Balint Society Study Day for accredited leaders and those on the pathway is being held in Birmingham in 2020 instead of London, **February 14th 2020**. This is an attempt to provide a central location for the increasing number of attendees at this study day. Check the website for details closer to the time.

Balint Supervision group

A Balint Supervision group continues to meet in Birmingham at the Edgbaston Golf Club. This group is currently meeting every two months on a Thursday evening and has a potential membership of 18 members. The group supports accredited leaders as well as those on the pathway to accreditation or considering applying. There are clear signs of growing interest in Balint in the region.

Balint groups

The Telford group is now well into its fifth year and well supported. This mixed group of GPs, Palliative Care consultants and psychiatrists meets monthly. Facilitation is led by Dr Chris Brown who is now an accredited leader. The venue is Severn Hospice and meets monthly on the second Monday of the month. This group could possibly accept new members.

Burton-Lichfield-Tamworth group

The longstanding Burton-Lichfield-Tamworth group still meets regularly after 35 years. Facilitation is done in rotation by members in private homes. Another long standing group in Hereford continues to run and support local GPs and GP trainees, currently facilitated by Kate Gathercole.

Birmingham

Three groups continue to meet regularly. One in Central Birmingham being facilitated by Debbie Williams; a second in the south of Birmingham facilitated on a rotating basis by members. A third mixed membership group, mainly drawing from the West Midlands Institute of Psychotherapy (WMiP) membership, has been meeting monthly at the Friends Meeting House in Edgbaston for the past four years, facilitated by Shake Seigel and Sandra Harrison.

Nottingham

A new group in Nottingham, facilitated by Jane Monger, is open to new members. A GP VTS trainee in Nottingham has run a research project on the potential benefits of being in a Balint group. Watch this space.

Palliative Care group

A Palliative Care group for specialist trainees is running on the regional training days. This is being led by Dr Miling Arolker.

Medical students

Birmingham University Medical School has introduced a pilot project for final year students. The facilitators are being supported and supervised by Isabelle Akinojo and Helen Campbell as well as Specialist registrars in training.

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Whalley Abbey delegates.

“The Inner World of Medical Students Listening to their Voices in Poetry”

By Johanna Shapiro, Oxford: Radcliffe Publishing. 2009

Poetry has been described as an inquiry into meanings (Campo R., 2003). Poems can also be a vehicle for exploring emotions. In this remarkable book, Johanna Shapiro, a clinical psychologist and Director of Medical Humanities at the University of California Irvine School of Medicine analyses 576 poems written by 386 medical students from their first through to their final year of studies at 15 medical schools in the USA and Qatar. Her study is much more than a clear and fascinating presentation and analysis of the thoughts of these students. It is, as its title states, an exploration of the inner worlds of these and other medical students.

Since the 1980s there has been an increasing emphasis on using clinical narrative, poetry and visual art as ways of helping students to be more aware of the patient as a person. The intent of this 10 year study of students’ poems was not merely to be descriptive, but also to be prescriptive, so as to provide indications of what kinds of issues medical education should address differently and better. Shapiro presents many of the poems she has received and carefully considers each poem, organising its content and insights into thematic categories that emerge from a grounded theory analysis. These themes, arranged as chapters, are students’ reactions to studying anatomy, the idea of becoming a physician, the idea of becoming a patient, the Doctor-Patient relationship, the Student-Patient relationship, the intersection of medicine and social justice, dealing with death and dying and finally, reflections on love and life. She ingeniously divides these poems into sub-categories according to whether they represent a cry for help by the emotionally overwhelmed student (referred to as “chaos” poems), or restitution stories that help repair the student’s uncertainty, or journey stories that describe the student’s journey of self-discovery, or witnessing stories in which a student bears witness to a situation or more directly to the patient’s suffering, or transcendence stories in which the student is able to overcome a problem. One student, Michael Doo, movingly wrote in his poem “Metamorphosis”, referring to his relationship with his patient,

“Let us take flight!.....

.....

Hopeful, you and me together”

Many of the poems quoted are deeply meaningful and beautifully written and reflect on the enormous idealism of medical students. The text that precedes them in each chapter is very relevant, especially in its thorough review of the relevant literature and consideration of the issues raised by the poems. Shapiro speaks from over 20 years of personal experience of teaching medical students using the humanities to counter the “hidden curriculum” (Hafferty 1998) that may encourage students to become emotionally detached: the student, Michael Doo wrote,

“Deny me the temptation to
interpret you as a process, reduce you
to a treatment plan.
Let me in on the irrelevant, the
maybe-not-so-insubstantial.”

The medical student's journey through medical school can be seen as a rite of passage, in which the student's sense of identity is gradually transformed so as to include a medical identity. Shapiro argues that medical education can easily overemphasise the acquisition of measurable skills at the expense of linguistic, empathic and interpretative ones. Students often fear that in this process they will lose their own identity and can feel confused about their role, having more knowledge than their patients but not nearly enough to be a physician. Medical education expects the student to learn to be in control and to develop a capacity to make accurate diagnoses, but sometimes in this process it devalues the student's sense of identity and discounts his or her personal experiences. Gradually students are encouraged to develop a distance between themselves and the patient. One student, Andrew Sledd, wrote in his poem "Sand and Stone",

"We're the same
but in different circumstances,
from the same earth
but worn differently
by the body of time.

Can we tell
the difference
between sand and stone?"

In this poem he sees himself as the sand and the patient as the stone.

Shapiro points out that in telling stories through their poetry students use their stories to make sense of the new world in which they find themselves and of the relationships they must navigate. However she also points out that only some students write poems. Many medical students struggle to express their complex and often conflicting feelings and are not as articulate as those students quoted in this book. They need support to be able to find words for their feelings, as we learn from our work with students in Balint groups.

I strongly recommend this sensitive and highly original study to all who are interested in better understanding medical students or are involved in teaching them.

References:

Campo, R. (2003) *The healing art- A doctor's black bag of poetry*. New York: W.W. Norton & Co.
Hafferty, F.W.(1998) Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine*, 73 403-7.

Peter Shoenberg

A Fortunate Man

a play by Michael Pinchbeck

based on the book by John Berger

performed for the Balint Society

after the London Leadership Study Day February 8th 2019

We were very privileged to have the New Perspectives Theatre Company come and perform 'A Fortunate Man' by Michael Pinchbeck for us after the Balint Leadership Study day in February 2019. The play is based on the book of the same name by John Berger with photographs by Jean Mohr. Published in 1967 it is a study of one month in the life of the GP John Sassall who worked in the Forest of Dean. He was a practical and an emotional doctor, deeply sensitive to the needs of his patients and his community. The book captured something noble about General Practice and GPs around the world were proud to identify with him.

The play was delivered in the form of a lecture by two doctors played beautifully by Hayley Doherty and Matthew Brown. They reveal and reflect on Sassall's life and work using readings and projected images from the book. The final photograph of Sassall striding up the hill to his house 'flipped round so he appears to be walking out of the book' remains the defining image of the work which is profoundly elegiac, recalling a vanishing world.

From the outset the play spreads its wings beyond the book. A modern perspective on General Practice is introduced with a brilliantly delivered testimony by contemporary GPs. Less romantic but nevertheless entirely believable it captures the difficulty of preserving a sense of self as a good and caring doctor in the current NHS. The writing is witty with knowing nods to 'Ways of Seeing', another influential work by Berger, and the direction is inventive and entertaining.

Of course the irony of the title 'A Fortunate Man' is that Sassall eventually committed suicide. This is revealed very early in the play and certainly lent pathos to many of the scenes. Voices from his family later in the play helped us to move beyond the good doctor of the book and to understand Sassall as a much more complicated and real human being.

It was extraordinary to see the emotional effect this play had on the very mixed audience of GPs, psychiatrists, psychotherapists and analysts, nurses, counsellors and others who attended the study day. We had been immersed in Balint work, exploring our own relationships with patients and acknowledging the burden that we often carry. We had talked about the emotional challenges of providing care and the need for practitioner supervision. Sassall's son said his father had always suffered with his mental health and Berger wrote 'he cured others to cure himself.' The play allowed many of us to see something of ourselves in his life and feel the sadness of his death. We were deeply moved.

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New Perspectives Theatre Company www.newperspectives.co.uk

John Berger and Jean Mohr *A Fortunate Man: the Story of a Country Doctor* 1967 Allen Lane The Penguin Press

John Berger *Ways of Seeing* 1972 Penguin and BBC



The Blue Plaque commemorating Michael and Enid Balint, Park Square West, London.

The Balint Society
(Founded 1969)
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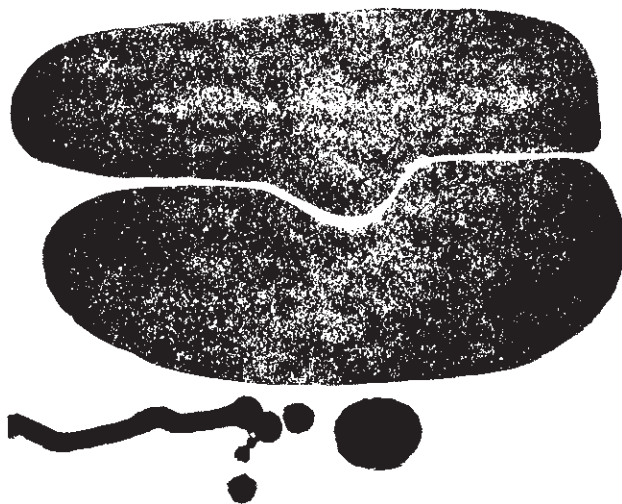
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All manuscripts for publication in the Journal should be submitted to the Editor, Dr Tom McAnea by email as an attached word file. The address is tomcmc@doctors.org.uk

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

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



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