

# Journal of the Balint Society



**2017**

# JOURNAL OF THE BALINT SOCIETY

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Editor:  
Tom McAnea

**Cover image:** *“The physician’s verdict”*. Oil painting by Emile Carolus Leclercq,  
1857.



## **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 2017-2018

The events calendar is continually being updated on our website, so for current information see <http://balint.co.uk/category/events/>

Events listed up to the time of publication:

## **Balint Weekends (all include leadership training groups)**

Kenwood Hall, Sheffield: 24th to 26th November 2017

Whalley Abbey, Lancashire: 16th to 18th March 2018

Newcastle: Summer 2018

Oxford: 14-16 September

Belfast: November 2018

## **One day events**

Friday 13th October 2017: Leadership training day, Manchester

Friday 1st December 2017: Balint Day, including leadership training, Bristol

Saturday 2nd December 2017: Lecture by Dr Gearoid Fitzgerald (rescheduled from last year). *The Use of the Group Leader's Countertransference in Balint groups*

Friday 9th February 2018: Annual Dinner and Study Day at the Medical Society of London

## **Group leaders' peer supervision groups**

These are open to anyone running a Balint group and offer an opportunity to discuss your group and related matters. To add your name to the circulation list for a regional group or for more details, contact the organiser indicated below. Meetings take place three or four times a year. Dates are posted on the website: <http://balint.co.uk/category/events/>

**London:** Contact David Watt ([david.watt7@nhs.net](mailto:david.watt7@nhs.net)) Meets at the Tavistock Clinic, 120 Belsize Lane, London NW3 5BA. All meetings begin at 8pm, usually a Thursday. Dates: 7/11/17, 8/2/18 & 8/5/18.

**Newcastle upon Tyne:** Contact Jane Dammers ([jane.dammers@newcastle.ac.uk](mailto:jane.dammers@newcastle.ac.uk)) Meetings are held from 4pm to 6pm on a Wednesday at Benfield House, Walkergate Park, Benfield Road, Newcastle NE6 4QD Tel: 0191 287 6130.

**North West:** Contact Ceri Dornan ([ceri.dornan@gmail.com](mailto:ceri.dornan@gmail.com)) Meetings are held in Manchester on a Saturday morning.

**Midlands:** Contact Shake Seigel ([shake.seigel@btinternet.com](mailto:shake.seigel@btinternet.com))

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### **International meetings**

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

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

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

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

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

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

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

Options for submission:

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

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

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

### **Guidance for contributors**

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

# Editorial

The 2017 Journal marks a special year for the UK Balint Society. This year the Society hosts the IBF annual conference at Keble College in Oxford. We welcome Balint colleagues from countries across the world to share our passion and enthusiasm for the work started by Michael Balint over 60 years ago.

In recognition of this, we publish Michael Balint's original paper published in the BMJ in 1954. What strikes me on reading this again is how relevant it remains to the emotional challenges I face as a family doctor in 2017.

The principles of Balint work remain alive and well for many colleagues across different professions as reflected in our contributions this year. From those at the beginning of their career, such as our Essay Prize winner, through to those experienced colleagues still practising after long careers, such as Dr Pate Tate in 'Rules', the nature of the consultation and our emotional lives with our patients are as complex and challenging as ever.

The essence of the Balint group and the nature of Leadership are addressed across 3 contributions this year. Vladimir Vinokur and Henry Jablonski write about the group dynamic and the necessity of this work at a time when doctors seem to be suffering increasing stress and distress in many countries. Not only are some of our patients in crisis, it seems some of our colleagues also face their own time of crisis as many seek to work part-time or leave altogether. Dr Andrew Elder, former President of the Society and Balint Group Leader of some decades writes about the nature and challenges of being a Group Leader. It reminds us how important a role this is in keeping members feeling 'safe' yet also being prepared to take risks.

The rewards of group work could apply to many professions, not just doctors or psychotherapists, as shown in the paper by Belinda Moller and Michael Redmond. It describes working with Headteachers and the impact Balint group work had on their emotional well-being. It's interesting to note there are other professional groups joining Balint groups such as nurses and dentists.

Finally, I wish to take the opportunity to welcome all our colleagues to Oxford this year and look forward to a successful conference.

**Tom McAnea**  
**Editor**  
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with grateful acknowledgement to the Editor.*

# **Training General Practitioners in Psychotherapy**

by Michael Balint

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## **Present Situation Regarding Psychotherapy in General Practice**

It is generally agreed that at least one-quarter of the work of the general practitioner consists of psychotherapy pure and simple. Some investigators put the figure at 50%, or even higher; but, whatever the figure may be, the fact remains that the present medical training does not properly equip the practitioner for at least one-quarter of the work he will have to do.

Although the need for a better understanding of psychological problems and for more therapeutic skill is keenly felt by many practitioners, they are reluctant to accept professional responsibility in this direction. The most frequent reason advanced is that they have too much to do and it is quite impossible for them to sit down and talk with one patient for an hour at a time, week after week. Impressive as it sounds, this argument is not, in fact, firmly based. It is true that establishing and maintaining a proper therapeutic relation needs much more time than prescribing a bottle of medicine. In the long run, however, it can lead in many cases to a considerable saving of time both for the doctor and for his patient (and for the National Health Service).

What actually happens at present in most of the so-called psychological cases of general practice is an almost mechanical prescribing of phenobarbitone if the patient is not depressed, and of some "tonic" if he is. If this fails, various specialists are consulted, usually resulting in "reassuring" reports that nothing organically wrong has been found. Eventually a psychiatrist is also consulted, often not so much as a deliberate policy as *faute de mieux*. This situation, however, is created as much by the difficulties of the psychiatrist as by those confronting the general practitioner. It is common knowledge that the psychiatric services are pathetically unequal to the ever increasing demand; they are flooded with patients, and consequently the psychiatrist must pick and choose. If a patient is picked he is put on the waiting-list, eventually taken on for treatment, and, more often than not, lost completely to the practitioner. If the patient is not picked the report sent to the doctor hardly ever helps him in his psychotherapeutic task except advising him to give sedatives or tonic.

Thrown back on his own resources, the doctor, often shamefacedly, prescribes some placebo or gives a "reassuring" pep talk. (It is a common joke to ask, "Reassuring — but to whom?") Then there are the advocates of common-sense psychology who advise the patient to have a holiday, to change his job, to pull himself together, to leave home, to get married, to have a child or not to have any more children but use some contraceptives, etc. None of these recommendations is necessarily wrong, but the fallacy behind them is the belief that an experienced doctor has acquired enough well-proved "common-sense" psychology to enable him to deal with the psychological problems of his patients. But minor surgery, for instance, does not mean that a doctor can pick up a well-proved carving-knife or a common-sense carpentry tool and perform minor operations. On the contrary, he has to observe very carefully the rules of antisepsis and asepsis, he must know

in considerable detail the technique of local and general anaesthesia, and must have acquired reliable skill in using scalpel, forceps, and needle, the tools of the professional surgeon. Exactly the same is true of psychotherapy in general practice. The uses of empirical methods acquired from everyday life are as limited in professional psychotherapy as are carving-knife and screw-driver in surgery.

### **Experiences in Teaching Psychotherapy to General Practitioners**

In the past twenty-five years or so, psychiatrists in many countries have run courses for general practitioners, courses which were often arranged because of the pressing and ever-increasing demand for them.

The results of these courses have been generally disappointing. This is a surprising outcome, for the general practitioner of some years' standing is a very good trainee. He has had time to assess the value and limitations of what he has learnt at his medical school and hospital, he has also had a fair amount of frustration and success in his practice, and he has seen enough of human suffering to make him sensitive. (Seen from this angle general practitioners are much better material for training in psychotherapy than young medical students.) The reason for the failure of these courses would appear to be that theoretical lectures, even when based on, or illustrated by, case histories or clinical demonstrations, hardly give more to the general practitioner than what he can get from reading books. Strongly influenced by the traditional medical training based on lectures and clinical demonstrations, both practitioners and psychiatrists forget, in a mutually attractive teacher-pupil relation, that psychotherapy means acquiring a new skill and not learning some more theories and facts. Nothing is easier or more satisfying for a psychiatrist than to take a patient's case and deliver a lecture about the theoretical implications, the unconscious dynamisms, and the likely diagnosis of the patient. Moreover, such teaching is gratifying indeed to both. The specialist can shine, and the practitioner feels enriched and reassured. But this gratifying collusion is disappointing in the long run because in reality it is too facile and does not give the means of effecting therapeutic changes.

Instead of allowing this teaching-being-taught atmosphere to develop, the aim of such a course should be to help the practitioner to acquire a new skill. This means a considerable, though limited, change in the personality of the doctor. The doctor has to discover in himself an ability to listen to things in his patients that are barely said, and, in consequence, he will start listening to the same kind of language in himself. This fairly difficult change of attitude is not needed if the doctor does not have to do the listening himself, but is taught and told what other people have found out about the "human mind" – namely, the theories of psychodynamics, of personality development, of transference patterns, and so on. In the same way as a new physical skill can be learnt only in the actual situation while dealing with the problems in it, so is it with the acquisition of a psychological skill. This is why concentrated full-time courses lasting for some weeks have proved to be of very limited value. The general practitioner must use his own current experience as a basis for learning the new skill. Past experiences are unsatisfactory for this purpose, since the memory of an emotional involvement is always less alive, less vivid, than the actual experience itself.

So far, so good; but the skill to be acquired involves understanding and guiding the development of the two-person (patient-doctor) relation, and the presence of a third person would fundamentally change this situation. This condition automatically excludes the presence of the tutor. Therefore the material on which the whole training has to be based is the doctor's report of what happened in the interview situation between him and

his patient. This necessary condition implies a number of uncertainties. The doctor has not yet learnt what to look for and he is somewhat selfconscious and apprehensive because of his lack of skill and understanding; like everyone else, he too is apprehensive of criticism, and, consciously or unconsciously, tries to make his activities appear in the best light and to minimize his shortcomings and mistakes. On the other hand, in order to train him, his blind spots, shortcomings, and mistakes have to be brought out quite clearly and discussed as frankly as possible. It is difficult enough to do this in any sphere of physical activity which is near to the core of the personality — say, for instance, in dancing, social behaviour, or table manners — but it is still more difficult in the psychological sphere, where the whole personality is always involved. Moreover, any such personality change needs time, and it is impossible to hurry it. The only training which systematically caters for those difficulties is the psycho-analytic training, which provides for a personal analysis lasting for many years and amounting to several hundred hours.

Experience at the Tavistock Clinic, where courses in psychotherapy for general practitioners have been given for more than twenty years, has confirmed the limited value of “teaching” psychotherapy. Consequently in the last few years a new approach has been tried — namely, to shift the emphasis from “teaching” to training, using group methods to achieve to a certain extent, although admittedly not completely, the necessary changes in personal attitudes. At first the aim was a very modest one, amounting only to the awakening of an awareness of psychological factors, enabling the practitioners to give a better and deeper assessment of their patients’ problems and illnesses. According to the doctors’ reports, the result has been a great saving of their time, much less need for complicated hospital examinations (hence a considerable saving for the National Health Service), and, last but not least, some help to the patients. Admittedly all this amounted only to something of a better diagnostic skill. But, having achieved a better diagnostic skill, the practitioners then wished to know how to treat the patients. This demand was not unexpected, as, with a greater awareness of the problems, the practitioners’ desire to do something to alleviate them was bound to follow. To answer this demand a two-year course in psychotherapy was organized. I now report briefly on the principles and methods used in this course. My main reason for doing so at this stage is that I believe similar courses may be contemplated elsewhere, and I felt that the approach developed may be of value to others and an exchange of ideas about the problems involved would improve the quality of the work.

### **Training in Psychotherapeutic Skill: (a) First Attempts**

We started by advertising “introductory courses in psychotherapy for general practitioners” in the medical press, and every practitioner interested was admitted to one of the courses, each taking in, on an average, 8 to 12 doctors. Each course lasted for a term and consisted of weekly case conferences of two hours each. No systematic theory was given. The practitioners were asked from the start to describe any recent “psychological case” they had had to treat, and the discussion was kept so far as possible concrete — that is dealing with the individual problems of the patients in question. For some doctors this was enough; one or two dropped out during, and a few more at the end of, the first term. The remainder were the ones — mentioned above — who asked for more. To provide this further training, the weekly case conferences were continued, but each conference session was now followed by a tutorial meeting on the general outlines of psychodynamics, based mainly on psychoanalytic concepts. Both events took place on the same afternoon, and lasted from 2 to 5 or 5.30. This arrangement continued for two terms,

and as the demand for still more training persisted it was decided to institute a two-year course.\*

The method used in our training scheme was developed and tested to a fair degree jointly by Enid Balint and myself while training for the Family Discussion Bureaux a group of social case-workers who were trying to help people with marital problems. The human problems facing these workers were roughly the same as, although in some relevant points simpler than, those of the general practitioners. Some of the similarities were the starting situation — namely, a patient in trouble coming for help and a professional offering understanding, the developing patient-doctor or patient-worker relation, especially the need for controlling the doctor's or worker's subjective involvement in this relation, and so on. What was different was the usual presence of illness, often physical, in the doctor's material, and the all-important fact that the general practitioner cannot "pass the buck". Unlike general practitioners, social workers and, for that matter, specialists may say — and as is well known they often do say — this or that patient is not "my cup of tea"; "I am not interested in this kind of illness"; "I cannot find any justification for his complaints"; "the illness is so slight, or so severe, or so progressed, that it is a waste of my time to treat the man"; "give him some reassurance and 1/2 gr. phenobarbitone thrice daily and leave me alone"; etc. The general practitioner, come what may, *must* see his patient through, sometimes even to the bitter end: he cannot "refer him back" with an easy and empty cliché.

Before describing our scheme I wish to discuss at some length the implications for training of this factor, as its realization profoundly influenced our attitude.

### **(b) Practitioners and Their Relation to Specialists**

The first of these implications is that the general practitioner must remain in his practice during his whole training. This rightly emphasizes the mutual roles of the psychiatrists on the one hand and the practitioners on the other. Both of them are doing their jobs, neither of them is so important that for his sake the other must make sacrifices; their jobs and their roles are those of peers. A further consequence is that the general practitioner remains in full and unrestricted control of his patients, he is the one who is running the show; the psychiatrist accepts the fact that his own role is that of an expert assistant, not that of a manager, and still less of a superior mentor or teacher.

Although this approach preserves, even enhances, the practitioner's dignity, it is only with great difficulty that it can be accepted by him. One reason is the burden of responsibility, sometimes really severe, that it involves. It is so much easier to farm out responsibility, to say, "I have asked all the important specialists and none of them could say anything of importance; I really need not be better than the bigwigs." No such escape is permitted in our course. Although the opinions of specialists are asked for and listened to, they are not accepted as final or binding; they are criticized for what they are worth, and then the doctor in charge is asked to decide what is to be done with the patient and to accept undivided and unmitigated responsibility for his decision. Often the decision influences the patient's whole future. This fact too must be borne in mind.

No wonder that the practitioners, as often as not, do not like to shoulder this heavy burden. What is more surprising is the willingness of the psychiatrists (in fact of all specialists) to enter into a collusion with the general practitioner in order that this responsibility may be dissipated, if I may say so, into thin air. The patient with psychological complications is often seen by several "eminent" people, each of whom gives

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\* In fact, our total intake was 36 doctors. Of these, seven were irregular attenders right from the start. Of the regulars nine left after their first and a further five after their second term, leaving 15 who are doing the present two-year course.

his opinion about one or other part of the problem, but the final responsible decision is seldom explicitly stated even if it has to be taken. If possible, no decision is taken; things are left hanging until fateful events supervene and make the decision anonymously, allowing everybody to feel that after all it was not his word that counted. On the other hand, if things turn out well everybody concerned may feel that his contribution was highly important, if not the decisive one.

One feature of our scheme was to unmask this anonymity by making the practitioner accept that he is and must remain in charge of his patient. If the doctor needed more help than the course could give him he was free to refer his patient to the clinic for consultation only. The patient was then tested by a psychologist and interviewed by a psychiatrist (usually the leader of the course), but only if the doctor was willing to continue the treatment. The results of the tests and of the psychiatric interview were then brought up in our conferences and mercilessly scrutinized. The final test of their value, which kept psychologist and psychiatrist equally on their toes, was the standard question of how much help in his further treatment of the patient did the doctor get from their reports.

This is a severe test indeed, as I can testify from first-hand experience. Neither I nor the psychologists who took part in this scheme found it easy to accept that some of our reports were merely nice phrases, repeating in a different form the facts known only too well to the doctor, and giving him hardly any help in his difficult task. This sobering realization of the shortcomings of our work is only one of the many lessons that general practitioners can teach us specialists.

The “collusion” and anonymity mentioned above is an excellent way out of this often very trying self-criticism. The specialist need not see the futility of his reports, and may rest perched on his “eminent” pedestal; the doctor may grumble and feel justified in his contemptuous opinion of the useless and pretentious specialist, and no one need do anything. Our scheme, by bringing face to face as equals specialists and practitioners, has made this escape impossible. Admittedly we, as everyone else, have had cases in which very little or nothing could be done; this fact then had to be accepted explicitly and in full and open responsibility.

I have already mentioned another kind of escape, the establishment of a teaching-being-taught atmosphere. This temptation, although very attractive to both practitioners and psychiatrists, should in most cases be resisted. When listening to a case an experienced psychiatrist can almost always without any great effort make a “clever” diagnosis and even foretell with reasonable accuracy what will happen in the doctor-patient relation for the next period. If he indulges in such a “conjuring trick” he severely interferes with the doctor-patient relation and inhibits the doctor’s powers of observation and ease of handling the case. The doctor will then try either to confirm the psychiatrist’s prophecy or to prove it to be incorrect, according to the actual relation between them. In any case the individual doctor and the group are deprived of the opportunity of finding out for themselves the advantages or disadvantages of one or the other ways of handling the problem.

### **(c) Present Training Scheme**

The weekly case conferences are the mainstay of our scheme. About 10-12 are held in each of the three terms. To secure intensive participation and, on the other hand, to obtain varied enough material, we found it advisable to have groups of six to eight doctors. In addition to the conferences we offer to any doctor who asks for it individual supervision of his cases — that is, about an hour a week of “private” discussion. While the conferences

are taken by the leader of the course, the individual supervision is provided — aided by some external help — by other clinic consultants. Psychotherapeutic technique is highly individual. In order to avoid the danger of muddling the practitioner by the often widely diverging views and approaches of the various consultants, the supervisors were asked to attend some of the case conferences before taking on any doctor for supervision. It was explicitly stated that they were not expected to subordinate their individual views to those of the course leader; on the contrary, they were asked to take part in the case discussions as frankly as they wanted. The reason for their attendance was that they should acquaint themselves with the atmosphere of the conferences, and, on the other hand, that the doctors should have the opportunity of finding out who they would like to supervise their cases. As these supervisions are expected to run on well-known lines, I wish to restrict my report to the psychodynamics of the case conferences.

I have already pointed out that we try to avoid so far as possible the ever-tempting teaching-being-taught atmosphere. Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when doctor and patient are together. This kind of listening is very different from "history-taking", and here we encountered much difficulty when trying to free the doctors from the automatic use of this kind of approach. The main difference is that history-taking is concerned almost exclusively with objective events or with events that can easily be expressed in words — that is, events towards which both doctor and patient can adopt a detached "scientifically objective" attitude. The events that are our concern are highly subjective and personal, often hardly conscious or even wholly beyond conscious control; also, as often as not, there exists no unequivocal way of describing them in words. Nevertheless, these events exist, and, moreover, they profoundly influence one's attitude to life in general and still more so to falling and being ill, accepting medical help, etc.

### **"Automatic Patterns"**

It may safely be said that these events, happening all the time in everybody's mind, are only partly sensible adaptations to the ever-changing environment; to a large extent they are governed by almost automatic patterns originating mainly in childhood but influenced by emotional experiences in later life. The first task for our scheme was to awaken in the doctors an awareness of these automatic patterns, and then to enable them to study more and more in detail how these patterns influence the patient's attitude towards his own illness, and, on the other hand, how they colour or even determine his relations to any human being, and especially to his doctor.

Another factor affecting the patient's developing relation to his doctor is the doctor's response, which also is partly governed by automatic patterns. The interplay of these two sets of patterns, whether and how they "click" with each other, determines to a large extent the efficiency of any treatment. Its influence is less important in short-lived acute illnesses, but almost crucial in chronic ones. In order to achieve a better fit, and with more patients, the doctor must have made a wide choice of responses, which means that he must become aware of his own automatic patterns and gradually acquire at least a modicum of freedom from them.

### **What is Needed**

Intellectual teaching, however good and erudite, has hardly any effect on this process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which one can face the experience that quite often one's actual behaviour is entirely different from what has been intended and from what one has always believed it to be. The realization of this discrepancy between one's actual behaviour and one's

intentions and beliefs is not an easy task. But if there is good cohesion between the doctors in the group, the mistakes, blind spots, and limitations of any individual member can be brought into the open and at least partially accepted by him. The group steadily develops a better understanding of its own problems, both collectively and individually. The individual can more easily face the realization of his mistakes when he feels that the group understands them and can identify with him in them, and when he can see that he is not the only one to make mistakes of this kind. Moreover, it takes only a short time for the group to discover that the technique of each member, including the psychiatrist group leader, is an expression of his personality, and so, of course, are his habitual mistakes.

Admittedly crises occur from time to time, when one or other member finds it difficult to accept the full implications of some of his ways of handling his patients, or the realization of some facets of his personality that he had been only dimly aware of. These, however, can be borne, as they are also group events and do not solely concern the individual. It has been easy to describe this state of affairs, but it is rather difficult to explain its dynamism. So long as the mutual identifications of the members are fairly strong, any individual member can face strains because he feels accepted and supported by the group. His mistakes and failings, although humiliating, are not felt as singling him out as a useless member; quite on the contrary, he feels that he has helped the group to progress, using his feelings as stepping-stones\* Crises may occur when there is some tension between one or the other member and the rest of the group which the leader has not detected soon enough (I would add that neither his role nor his psychiatric training confers on the group leader an absolute immunity against this hazard), and, instead of re-establishing good cohesion, his criticism may help to widen the gulf.

Signs of this isolation or tendency to isolation and the accompanying touchiness can be regarded as the equivalents of what psycho-analysis calls resistances. On the one hand, they are premonitory signs that some major personal attitude of the individual is being tackled in the group situation; on the other hand, by the way in which the isolation is achieved and maintained, they show what the problem is. In the same way the reaction of the integrated group towards such an attempt at isolation reveals the other side — that is, the counter-transferences of the group to the particular personality problem. The way in which a member isolates himself, as well as the way in which the group deals with it, must be shown up. They represent very valuable material for studying interpersonal relations, and their full realization is a necessary condition to the re-establishment of a workable cohesion.

If such crises occur too often, or leave a bitter resentment behind, it is a sign that the pace of training has been too exacting and that the group has been made to work under considerable strain for some time. It is an equally ominous sign, however, if no crises occur at all; it means that the sensitivity and grasp of the group are not developing, the group and its leader are in real danger of degenerating into a mutual admiration society where everything is fine and we are nice, clever, and sensible people. It is a fact that acquiring psychotherapeutic skill is tantamount to discovering some hard and not very pleasant facts about one's own limitations. This unpleasant strain must be faced, and the group develops as long as it can face up to it, and stops developing as soon as it tries to avoid it. It is the task of the group leader to create an atmosphere in which each member (including the leader) will be able to bear the brunt when it is his turn to bear it.

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\*In psychiatric terms, the depression caused by the realization of one's shortcomings must be fully accepted; identification with the common group ideal must remain, now as before, a desirable and attainable aim, but the group leader must watch very carefully when and how one or the other member is forced or allowed to slide into a paranoid position of the one who has been "singled out".

It is a precondition of our technique to establish this kind of atmosphere in the group, and it is only in such an atmosphere that it is possible to achieve what we term “the courage of one’s own stupidity”. This means that the doctor feels free to be himself with his patient — that is, to use all his past experiences and present skills without much inhibition. At the same time he is prepared to face severe objections by the group and occasionally even very searching criticism of what we call his “stupidity”. Although every report and case conference is definitely a strain and an effort, the result is almost always a widening of one’s individual possibilities and a better grasp of the problems.

### **Importance of Timing**

One of the most important factors in this kind of training is timing, which in the first approach means not to be in a hurry. It is better to allow the doctor to make his mistakes, perhaps even to encourage him in this, than to try to prevent them. This sounds rather foolhardy, but it is not; all our trainees have had considerable clinical experiences, and this “sink or swim” policy was justifiable. Apart from not undermining the confidence and dignity of the doctor, it has the added advantage of providing ample material for discussion, since everybody was seeing patients all the time and was anxious to report his findings and discoveries, his successes and difficulties. As I have confessed, this policy may have been too much for some doctors, and we had a fair number of “casualties” who did not wish to continue.

If the timing is good enough, the doctor feels free to be himself and will have “the courage of his own stupidity”. Gradually he becomes aware of the type of situation in which he is likely to lose his sensitivity and ease of response, or, in other words, to behave automatically. Meanwhile the reports of the other doctors have shown him what other ways might be adopted in similar situations. The discussion of the various individual ways, demonstrating their advantages and limitations, encourages him to experiment. (One practitioner announced the result of such an experiment thus: “I have done a real ‘Smith’ in this case — and it worked,” meaning he had adopted the attitude he felt Smith usually adopted.) Every such experiment means a step towards greater freedom and better skill.

### **Attitude of the Group Leader**

Perhaps the most important factor is the behaviour of the leader in the group. It is hardly an exaggeration to say that if he finds the right attitude he will teach more by his example than by everything else taken together. After all, the technique we advocate is based on exactly the same sort of listening that we expect the doctors to acquire. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues — that is, speaking only when something is really expected from him and making his point in a form which, instead of prescribing the right way, opens up possibilities for the doctor with the patient’s problems, the leader can demonstrate in the “here and now” situation what he wants to teach.

Obviously no one can live up to these exacting standards without some shortcomings. Fortunately there is no need for perfection. The group leader may make mistakes — in fact, he does quite often — without causing much harm if he can accept criticism on the same, or even somewhat sharper, terms as he expects his group to accept. This must be watched very carefully, and any hesitation by the group in exposing the leader’s mistakes must be pointed out. Obviously this freedom cannot develop if the leader tries to hedge or to explain away his failings. It is a very wholesome sign if the group can run the leader down, even if they have some fun at his expense, if only they can do so without rejecting him or turning hostile to him. (Incidentally, this frank criticism is another way in which practitioners can teach us specialists.)

### **The Training Technique**

One more word about the number of doctors who dropped out. The technique described here is still in its experimental stages — that is, it is crude and harsh. We are fully aware of this and we have decided to accept the risks involved. Our first consideration has been to develop a technique that is workable for a fair enough proportion of the doctors interested, in order to test out whether such a training technique is possible at all. The results of the two pilot projects — the Family Discussion Bureaux scheme for social workers and the Tavistock Clinic scheme for general practitioners — are highly encouraging, although as yet not final. As soon as our technique is fairly securely settled, our next concern will be to examine our “casualties” — that is, the reasons why so many of our entrants have to leave us. It is true that psychotherapy in the same way as, for instance, surgery, is not within everybody’s reach; nevertheless our “casualty rate” is too high. Conversely, this means that our training technique is, for the time being, inelastic and too exacting for a great number of practitioners.

There is, however, one very important difference between this kind of training and any other training in one or other of the many specialties in medicine. Any advance in therapy demands a new skill from the doctor, even if it amounts only to learning the correct ways of prescribing a new drug. In other words, mastering a new therapy means a change but, whereas the changes required by new techniques in any of the other branches of medicine do not touch much upon the doctor’s personality, the technique of psychotherapy involves the personality fairly deeply. From this angle the action of some doctors who dropped out is perhaps a sensible defence against an unauthorized violation of their private mental life, a defence that must be treated with respect. The diametrically opposite danger is that the group training may degenerate into therapy pure and simple. We are fully aware of this possible complication, which, in fact, is present in every form of psychiatric training, but as our scheme is a very young one we have not had to come up against it.

### **Summary**

A training scheme in psychotherapy is described, in which the emphasis has been put on acquiring a personal skill instead of on teaching. The aim is to make the general practitioners aware of what their patient wants to convey to them, not so much by his words as by his whole behaviour, and of how their own general behaviour and actual responses influence what the patient can actually tell them. We have tried not to teach them what psychoanalytic or any other theory could say about the working of the human mind; instead we have aimed at enabling them to be free enough to feel and understand what is going on between the patient and themselves in their surgery.

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# Obituary: Dr John Alexander Balint 1925-2016



Dr John Balint died on 16 December 2016 in Slingerlands, New York State, USA at the age of 91. He had a long and distinguished career, first as a gastroenterologist and later as the founder and director of the Center for Medical Ethics at Albany Medical Center, in New York State.

John Alexander Balint was born in Budapest, Hungary, on 11 February 1925. He was the only child of Michael Balint and his first wife, the psychoanalyst Alice Szekely-Kovacs. John described himself as ‘a conference child’ who, in his early years, was frequently carried round the medical and psychoanalytical conferences of Europe by his analyst parents. In 1939, because of the mounting threat of Nazi occupation, the family emigrated to England and settled initially in Manchester. Tragically, after only 7 months in England, Alice died suddenly of a ruptured aortic aneurysm at the age of 40. The 14-year-old John went to Abbotsholme boarding school in Staffordshire and subsequently studied medicine at Cambridge University where he met his wife Jean. They both graduated in 1945 after clinical studies at St Thomas’ Hospital in London. From 1950-1952 John served as an RAF medical officer. He then trained in gastroenterology at the Central Middlesex Hospital with Francis Avery-Jones as his consultant and mentor.

In 1958, he moved to the United States where he had been awarded a fellowship in hepatology in Cincinnati. He continued his career as a gastroenterologist and in 1963 he was recruited to establish the Gastroenterology division at Albany College. He served 18 years as chief of Gastroenterology and was chair of the Department of Medicine for 8 years. By then he was becoming increasingly interested in clinical medical ethics and in 1993, he took a year off to study the subject in a fellowship at the University of Chicago.

In 1994, he was back at Albany Medical Center where he quickly established their Center of Medical Ethics and served as its director till his retirement in 2005. Albany became a leading Medical Ethics Center and the first to award a PhD in the subject.

Throughout his long career, John Balint was admired and loved for the care he devoted to his patients and his pupils. He was a major contributor to research on both gastroenterology and medical ethics and received many awards including Laureates for Public Service in healthcare. He was a fellow of both the American College of Physicians and the Royal College of Physicians.

He is survived by Jean, his fellow medical student to who he was married for 67 years, their two children, grandchildren and great grandchildren.

Balint Society members may wonder how much John was influenced by his father's work and whether they talked about the doctor-patient relationship. Did such discussions sow the seeds of his subsequent absorption in medical ethics? In 1996, I was present at the International Balint Congress in Budapest which celebrated the centenary of Michael Balint's birth. Professor John Balint gave the opening address at the Congress. His subject was 'The doctor, his patient and the illness – revisited: forging a new model of the doctor-patient relationship'. In his talk, he described the traditional close relationship in which the welfare of the individual patient was the physician's over-riding concern. Although this is admirable its 'doctor knows best' attitude has more recently been criticised as too paternalistic and failing to respect the patient's autonomy. In addition, the physician is now seen as having a duty to society as a whole in that he has to be aware of the need to conserve scarce resources and not, for example, waste the community's money on medicines and investigations that are not strictly necessary. John Balint gives a good account of his father's ideas ('the psychodynamic model') and goes on to summarise a number of later models before giving his own vision of a physician-patient relationship in which the doctor is not only the patient's advocate and his teacher, but part of an alliance between patients and doctors aimed at safeguarding the healthcare of the whole community. You can read the full text of this lecture in the Journal of the Balint Society for 1996, volume 24.

**John Salinsky**

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# **Social Phenomena Developing in Supervision Process in Balint Group Work**

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## **Abstract**

The article focuses on the positive and beneficial social phenomena developing in Balint group work and which are related very much to the effect of the group. The effects of Balint groups which are largely contained in the active and energetic process of the increasing consciousness and self-reflection in individual participants, and in the group as a whole, are very much connected with the positive group phenomena. The article discusses some group phenomena which are avoided there and differentiate Balint groups from other groups (i.e. groupthink and others). Due to them a Balint group not only fulfills the function of professional (and human) growth, but also promotes a pronounced professional integrity of its members by maintaining their own internal integrity and makes their professional life quieter, easier, more successful.

In studying and describing the work of a Balint group, it becomes obvious that social processes occurring there are reminiscent to some degree of the dynamics in other groups. For that reason it would be rational to point out some important differences in the main aspects of the work and "behaviour" of Balint groups. They are the union of specialists who are professionals in "helping" and in health care and are created basically on specific and important ideas and aimed at finding ways to help them to become more aware in their professional communication, to promote their professional development and thus increase effectiveness of their work. This is a team of colleagues who share the same basic ideas and views, which allows the group to perform the activity for many years (the most long-term still acting group in our Society in St. Petersburg has existed since 1998).

In a Balint group the analytical process, which is a ground of the Balint work, could be characterised by the following specific group phenomena:

- Socialisation, when a member of the group sheds the feeling of his/her professional "isolation", finding himself/herself in an environment of acceptance and support.
- The phenomenon of a "mirror", when the member of the group relives different aspects of self-identity as well as identities of others. Through this identification he/she can discover new sides and aspects of self-concept and the interactions with patients.
- The phenomenon of a condenser, when the group strengthens and concentrates the components of interpersonal relations, specifically those which remained unconscious, while having both liberating and stimulating influence on their positive development.
- Exchange of essential information leading to increased mutual understanding and prompting emotional response inside the group. Every member of the group understands the same things differently, according to his/her education, experience, culture, personality etc and reacts to the same things in a different style, thus creating a source of a new and useful ideas and views.

- The group can offer an active social support, in case the balance between integrative and analytical tendencies, frustration and empathy is preserved thus promoting development of mutual understanding and mutual cooperative support.
- The group develops a new styles of communication when the non-communicable becomes communicable especially when it acquires clarity through verbal description. As a result the individuality of each member of the group becomes better understood, acknowledged and appreciated. Assistance in verbal communication and help in clarification of its context becomes the group's target and the task.

The ability to avoid many negative effects often present in other forms of group work is an important quality of Balint groups. Let's take a closer look at some of these. There's a phenomenon which occurs in many other kinds of small groups due to normative influence: some members of the group, guided by their conformist motives, strive to catch the prevailing or even dominant opinions and viewpoints, joining them and by this, reinforcing them further on. This provides the sense of accord and unanimity in the group, with the group members gaining a chance to avoid rejection, to be accepted and favoured by the others. If the sense of belonging and membership in the group are very important for the person, to the point of becoming a part of his/her self-identification, the person's conformism to what is being discussed in the group becomes even stronger. Thus, the reinforcement of conformism supports and protects the self-consciousness of the person. There are the circumstances that explain the stereotyped, although rather controversial view claiming the majority to be always right.

Successful avoidance of the "groupthink" effect or the "groupifying of thoughts" synonymous of "stupefying of thought" is an important and essential characteristic and evidently beneficial quality of a Balint group. The term "groupthink" was coined by American research psychologist Irving Janis who in 1971 defined the phenomenon as follows: "The term "groupthink" refers to the mode of thinking that persons engage in when concurrence-seeking becomes so dominant in a cohesive in-group that it tends to override realistic appraisal of alternative course of action. When facing the danger of disagreement, disputes and conflicts, members of the group are trying to lower the group cognitive dissonance and eliminate the accompanying negative emotions by attempting to find a solution convenient to everyone even if the solution is not an objective or a reasonable one from the viewpoint of each single member of the group".

J. Janis coined the term "groupthink" by analogy with "doublethink" that was part of the newspeak vocabulary in the novel "1984" by George Orwell. Originally he singled out as a key characteristic of this group phenomenon a very tight (probably even excessive) cohesion in the group and a predominant aspiration to retain unanimity at all costs. Janis lists a number of factors leading to the occurrence of groupthink. Here belongs the appeal of the group membership that causes an interest in promoting the long-term existence of the group and boosting the intra-group cohesion. It's an important mechanism for the formation of such a phenomenon since the level of the group cohesion is directly related to its appeal for the group members, which is the reason the members may easily change their individual views to coincide with those in the majority, while persuading themselves it's done for noble purposes, i.e. maintenance of harmony and good relationship in the group. Unanimity in such groups seems persuasive not only as a norm but also almost mandatory, as the most correct and optimal type of interaction within the group.

Another condition which beneficially differentiates Balint groups from others is the condition for groupthink which may come from a high homogeneity of the group

members with a high level of isolation from other groups, without a chance of the supervision of the process. Groupthink is frequently triggered by the authoritarian style of leadership within a group, the leader imposing his/her opinion in the group, high level of emotional arousal constantly maintained in the group combined with the group members' uncertainty about a possibility of forming another point of view or another style of interactions. Among the manifestations of groupthink is the belief in the invulnerability (or even infallibility) of judgments in a cohesive group, collective rationalisations as a type of psychological protection of the ingroup, stereotyped perception of other people, direct pressure on those who disagree or express alternative views, and strong internal censure (voluntary mind self-control – another reference to Orwell's "1984"). All of this creates the actively maintained illusion of like-mindedness and unanimity within a group (or a myth of their existence) which, in such cases becomes an end in itself.

The rules and principles of a Balint group, aimed at encouraging an open discussion, search and support different opinions, allow us to prevent groupthink in a Balint group. Its theoretical principles and practical working technologies contribute to the encouraging of criticism as a component of sound thinking, impartiality in the group members' judgment, and tolerance for difference in views without classifying them as 'correct or not'.

The latter is among the absolute merits of the Balint technology, allowing the group to avoid many problems that unanimous formal solution-oriented groups face usually (here we should once again remind the main rule of a Balint group work – it is not meant for finding a problem solution). For instance, Balint groups avoid the averaging of the group's opinion as a solution or a common point of view to be offered after the group discussion. The supervision technique implemented in Balint group allows us to prevent the phenomenon of superficial and so false social harmony, often seen and even welcome in many different forms of group work other than Balint. The phenomenon which occurs in group discussions and conversations implies the tendency to perceive and assess one's personal opinion or attitude to the issue discussed as reflecting the alternative views rather than their own. This phenomenon, in essence, reminds of the 'egocentric attribution effect' described by G. Kelly and co-authors in 1970.

Here, deep cognitive processes play an active role, since the description of a situation faced by a person, experiencing the effect mentioned above, inevitably lacks a lot of important details as well as information about the context, replaced by the imagination. This is why people in this process are forced to solve the problem of ambiguity in the information provided by imagining various details, completing the imaginary situation in different ways, thus readying the ground for the effect of a false social accord. The way in which the person solves the problem of ambiguity and lack of information, inevitably occurring in the description of any situation, affects not only the form of response chosen by the person but also his/her idea of the compliance of the response with social norms, linked to his/her conformism, since all of that actively affects the subjective "sense" of such a response.

For this reason it is necessary to once again stress that the effect of false social accord (the phenomenon which is nearly or never met in a Balint group) from the viewpoint of the subjective interpretation of any situation discussed and analysed in the group, calls for more than the statement of the rather banal fact that the "same" (?) situation is differently (sometimes totally differently) understood and interpreted by different people. There's an important point here: strange as it is, many people are incapable of realising this fact, so they often cannot admit that their descriptions and evaluations are only their views rather than the direct and objective reflection of a certain

reality in the case analysed. How often this happens and thus brings a lot of problems in the communication in different educational and supervision groups aimed at a solution, including advice, critical evaluation, direct recommendations etc.

The quality of collective discussions, especially those aimed at avoiding decisions (like in Balint group work), largely depends on the facilitation phenomenon, which suggests that not only participation of other people in joint activity, i.e. group discussion, but even their mere presence facilitates the work of every member of the group, increasing its common productivity. This is why the work in a Balint group is much more effective than other types of group supervision (i.e. clinical case conferences) as perceived in our experience during the last 20 years. This point of view was reported and proved by many colleagues participating in both forms of group work.

One of the frequent and rather complicated problems occurring in groups other than Balint groups, is the emotional tension of some group members who are trying to impose their views and beliefs or keeping them to themselves if they feel uncomfortable or uncertain, or they experience anxiety when not supported by others. Therefore, a compromise (or what seems to be one) in such a group can be a result of a lacking and unachieved group unity or approximation of positions, so in reality it will only be an imitation of accord. As we often witnessed this can create serious problems and hazards for physicians and consultants who, beside joint daily work in a medical or consulting institution, are also connected altogether through participation in a common supervision group, especially if the latter allows for dynamic processes in it, sometimes very uneasy. A Balint group, whose work is regulated by the well-known principles and rules allows successful avoidance of these risks. Thus, a Balint group not only fulfills the function of a professional (and human, of course) growth, but also promotes a pronounced professional integrity of its members by maintaining their own internal integrity.

Also, as described in many social psychology guides (e.g. David Myers, 2006) and which is characteristic of Balint groups, when people who feel mutual interest and are amicably disposed towards each other work in the same circle, it promotes greater mutual sympathy and support, lowers anxiety, embarrassment and fears of censure and critic, thus promoting openness and spontaneity, while in unfriendly groups the mutual antipathy and even animosity intensifies further. The aforementioned is a manifestation of the effect of social facilitation of the dominating reaction, in the former case – of amicable attention to each other shown by a person in the presence of other people. Thus, in space and depth, supervision in a Balint group is much closer to real life and to issues in the therapeutic practice than the individual or problem solution-focused supervision, since in a Balint group, the participants' internal and external realities merge to manifest themselves in various interpersonal relations formed during group interactions.

We believe the effects of Balint groups, which are largely contained in the active and energetic process of the increasing consciousness and self-reflection in individual participants, and in the group as a whole are very much related to the positive group phenomena mentioned above. This is often reflected in the Balint group participants' positive feedback in describing the follow-up effect, when the subsequent work with patients is perceived by the physician as quieter, easier, more successful and even more happy. This yet again confirms the idea about an illusion of our completely right and compliant understanding of "reality" in the interaction within our professional communication. What is more important is the coordinated understanding in a Balint group for a large scope of different interpretations and various aspects of this communication. This reflects the concept suggesting that there are neither "bad or good" patients nor "bad or good" physicians, there is only a wrongly chosen "distance" of

interaction in the process of therapy or counseling, as well as the “distance” and the direction in the group work, based on its basic philosophy.

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# **‘A very precious freedom not to react, not to say anything at all’ (Rueth, 2009): Adapting the Balint model to Headteachers in Ireland**

Michael Redmond and Belinda Moller

**THEME:** As more countries and professionals join the Balint movement, has underlying theory been adapted and with what effect?

## **Introduction**

Michael Redmond and Belinda Moller met in Dublin in 2014. Belinda, a group analyst, had recently run a year-long support group for headteachers who had found it a useful experience. Michael, a former headteacher now involved in management support, had recently conducted and completed his Ed.D. research on the emotional landscape of school leadership. In January 2015, they began to co-facilitate a Balint group with eleven headteachers from Dublin secondary schools. The schools serve students from 12 to 18 years. The average school has 600 pupils with a teaching staff of 36. The schools represent a mix of socio-economic locations. The group meets every six weeks for one and a half hours in a neutral venue. This paper explores the context of this group, assumptions and theoretical extensions that may influence its operation and approach.

## **Why would headteachers benefit from a Balint group?**

Michael’s recent research project into the emotional competencies of secondary school head-teachers in Ireland (Redmond, 2016) emphasised the need for ‘career-long, safe and affectively-articulate peer-delivered dialogic support’, a model supported by Spindler and Biott: (2005)

Reformers must acknowledge that it is the resilience and emotional engagement of headteachers, and teachers, rather than training programmes, which helps them to go beyond the call of duty when they are being subjected to relentless imposed change and to the ratcheting-up of targets. Instead of emphasising accountability measures and common sets of technical competencies for all headteachers, the focus should be on how to engender and support inter-generational learning in local districts.

Headteachers in the Irish voluntary secondary school<sup>1</sup> have access to a range of opportunities for meeting one another. A frequently-cited by-product of these, usually agenda-driven, events is the opportunity to engage with one’s peers in a collegial and ‘safe’ environment. That such encounters fulfil the requirements for ‘inter-generational learning’ is, however, doubtful. We cannot improve on Spindler and Biott’s identification of headteachers’ developmental needs within groupings constituted with this work in mind, i.e. allowing veterans to connect with the concerns of new headteachers; embracing emotional dimensions of starting out and keeping going in demanding circumstances, and making connections between repertoires of accumulated capital as part of the reservoir from which all head-teachers can derive sustenance.

Thus, while doubtless some pairings and small groups of headteachers have conspired to construct *ad hoc* relationships achieving these aims, the majority of school leaders in the Irish secondary school setting have no access to such a resource. The

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<sup>1</sup> ‘faith schools’, Catholic and Protestant, representing 50% of all post primary schools in the Republic.

challenge of meeting such developmental needs thus involved seeking to build a fit-for-purpose model of appropriate, workable and acceptable professional networks supporting the long-term sustainability of individuals, and it is into this space the Balint group emerges.

### **The context for head-teachers in Ireland**

The porous boundaries of contemporary schools admit successive waves of influence emerging from the external environment. In Ireland, the imposition of a national austerity programme, significant hegemonic change in terms of church-people-state relations, a loss of trust in fiscal, ecclesiastical and political authority and the emergence of a neo-liberal, evidence-based policy framework driving educational reforms (Lynch et al, 2012) have all conspired to produce a ‘perfect storm’ of unremitting change impacting on the psychological and emotional health of school communities (Harris, 2007). This state of flux coincides with an already challenging set of factors uniquely impinging on schools within the voluntary secondary sector in Ireland such as inequitable resourcing, inept middle management structures and diminishing commitment to ethos.

Such contextual factors are not, of course, unique to Ireland except perhaps in degree. A set of perennial human and organisational factors are universally intrinsic to school leadership and key dimensions of the affective landscape of headship, as are revealed in the theatre of the school, require the attention of practitioners themselves in seeking to discover sources of personal and professional sustainability.

### **‘Taken-for-granted’ occupational assumptions**

For the past two decades, emotions have been largely regarded as feminine, private and irrational and therefore remaining outside the domain of public, masculinised work (McWilliam and Hatcher, 2007). There has since, however, been an endorsement of soft skills achieving hard targets, demanding a new ‘leaderliness’ in schools – one that replaces distance with empathy, aloofness with warmth and power with partnership. The headteacher’s role has now been reconstituted as supporter, reinforcer and facilitator of school-wide change efforts, as opposed to the more authoritarian approaches of the transactional leader.

Such occupational assumptions inevitably bring with them a set of projections and fantasies in which the ‘head’ also becomes either the saviour of the school or the focus of everything that is wrong with it. The crucible of the Balint group offers a rare opportunity safely to unpack such emotional intricacies.

### **Theoretical extensions**

Wilke observes, ‘The biggest success story in applied psychoanalysis has been the Balint group...no comparable success story of applying the psychoanalytic method in organisations can yet be told’(Wilke, 2014). The model rests on analysing the interaction of the transference phenomenon between doctor and patient, viewed as part of the healing process. However, at the institutional and system level, organisation psychology consultants are reporting on the damaging consequences of unconscious anxieties and the social defences constructed to defend against them, right across the private sector, public education, health and welfare (See, for instance, Armstrong, 2014).

Wilke is a group analyst. He argues that the original Balint model needs to be adapted because the practice environments of GPs, psychiatrists, mental health professionals (in both the public and private sectors) and, in fact, all professionals, has changed dramatically. More and more professionals practise their craft in groups, in

multi-disciplinary teams, in virtual networks, and in complex organisation systems that no longer provide regular or secure holding structures. The headteacher works in just such a multi-dimensional context. She or he is required to attend, not only to the academic needs of the students and resource needs of staff, but to the psychological, moral and emotional health of the whole school community and often, its wider social system (e.g. families, social structures etc.).

Foulkes, the father of group analysis, said

No wonder the modern individual is afraid of the group – is afraid of losing his very existence, of his identity being submerged and submitted to the group. The individual, while helplessly compressed into a mere particle of social groups and masses, is at the same time left without any true companionship in regards to his inner mental life (Foulkes, 1990).

Bion's group analytic/group relations concept of container-contained (Bion, 1962) is most applicable to the adapted Balint group (Rueth, 2009). His concept refers to the mother as bearing the feelings and emotions of the infant in a holding environment. By containing the feelings and emotions of the child, the infant's experience of persecutory anxiety and the ever-present threat to survival is contained.

All our human relationships, whether they occur within a dyad, friendships, collegial/peer groups or within complex interdependent/interdisciplinary professional networks can be viewed through Bion's concept of container-contained. As social beings we have an innate and social need to be 'met', to be held, and to seek out, in others, the capacity to bear our anxieties and to acknowledge and tolerate our emotional experiences of life.

In the Balint group, the presenter is protected from the feeling of being submerged or of having to submit to this level of complexity. The companionship that Foulkes refers to is possible because the presenter, having presented his/her case, moves outside the group and listens in silence to the interaction of the group. Rueth (2009) has written about the Balint model viewed through Bion's thinking. He says with this simple act '*... all the problems, feelings, and even projections of the patient and the doctor are handed over to the group and its members symbolically, but also in a very concrete manner, to be discussed—the group now serving as a 'container'.*'

The special instruction to the group, to respond to the presenter's case by sharing through words, silence or gestures, random thoughts, felt associations, responses such as images, symbols, metaphors, and emotional feelings gives 'participants the ability to think their own thoughts, and not to think what has been projected on to them' (Pisani, 2013). Without this special instruction, the group will be activated by the institutional stress and anxiety in the system and resort to reactive approaches such as interrogating the presenter, giving advice, recalling a time when something similar happened etc.

One headteacher presented a case involving students from different religious, social and ethnic cultures. The issues were deeply shocking, grave and complex. After the presentation, the group simply remained silent. An opportunity for '*... dreaming, thinking, and building the apparatus to produce thoughts and linkages*' (Rueth, 2009). The silence of the presenter listening to her own internal dialogue, alongside the silent dialogue of the group.

### **Operational adjustments**

This group is run, more or less, along classic Balint lines. However, at the outset, the group really struggled to bear the presenter's dilemma and inner turmoil and an adjustment was made. Their difficulty in 'sitting with' the uncertainty of not knowing, of not being

able to 'fix' or to rationally resolve, mirrored the sheer complexity of the presenting cases. Rather than pull the chair back, the presenter and one of the facilitators sat outside, adjacent to the circle. This adjustment was designed to help the group to respond to the case without focusing on, or fixing it for the presenter. The arrangement prevented the group from seeing the presenter directly but did not impede on hearing. After the group's rumination, both retook their seats in the circle. This adjustment was used twice and, in subsequent debriefing discussions between the facilitators, was evaluated as having some potential, though not strictly adhering to the 'pure' Balint model. The group has reached a point in its development wherein it is capable of such experimentation and insights gained from a recent Balint training weekend have also informed our 'testing' of the model. At time of writing, the group has reached its first anniversary and a 'case-free' group meeting may prove helpful in evaluating developments and future approaches.

### **An opportunity for headteachers to learn to respond and manage their desire to react**

It is unreasonable to expect that overburdened headteachers will retreat from their roles to comprehend and discover how to implement models of effective practice. What is feasible however is that practitioners begin to develop their own continuing theory-of-action under real-time conditions. It means that the professional must learn to develop micro-theories of action that, when organised into a pattern, represent an effective theory of practice. (Argyris and Schon, 1974) The aim is thus to identify emotionally-attuned cognitive learning strategies which can set a pattern of successful behaviours. The 'discipline' of the Balint group, in which participants are encouraged to 'feel-don't-fix' represents precisely such a micro-theory which may be replicated in daily practice, with potentially transformative effects.

### **Conclusion**

The classic Balint model, used in conjunction with the concept of the container-contained and a group analytic lens, facilitates the group to think about the interpersonal complexities of organisational and institutional life. We are social beings, we crave connection and we crave to be understood and seen. Our need for relatedness is a given but we now mostly work in organisations that have dismantled regular, supported structures for relating and for interpersonal work. It is remarkable how in this application of Balint group to headteachers, the benefit has stood out over other forms of support and training. The case presentations indicate high levels of institutional and systemic stress in schools that evoke strong feelings of persecution and considerable threats to occupational and emotional survival. We do not yet fully understand the workings of this adapted group but we are convinced of its 'goodness of fit' for this cohort of professionals. Recent (unsolicited) commentary from group members affirms this claim:

'I am delighted to be part of this group and wish to thank you both for making it happen and supporting us in making every session such a cathartic and enriching experience'.

'Long may it continue. It is the greatest source of professional support I have experienced because it is about the whole person. We bring our whole selves to the job but have to keep most hidden. Balint is a realistic and supportive group to be in'.

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## Essay Prize Winner 2017

In this reflective essay, I will discuss a case that I presented to my student Balint group. I brought the case to the group as it was playing on my mind several months after it had happened. I wanted to discuss the situation in general, as well as my actions, but especially the patient and what it might have been like for him to be in the situation he was in at the time. In the interests of patient confidentiality, I will refer to the patient as Mr. B.

Toward the end of my first term as a clinical medical student, I was on my haematology and infectious diseases placement at a hospital in North London. Unfortunately, for reasons that are not clear to me, on this particular day the hospital did not seem to have any patients fitting into one of those specialties who were deemed suitable by the staff to be clerked by a medical student. A medical student colleague and I had been traipsing from ward to ward for around an hour, as we needed to clerk some patients in order to present them at our teaching session later that day. Having had no luck in the main hospital building, we ventured to the rehabilitation ward, which we had not previously visited. It was on this ward that a member of the nursing staff directed us to Mr. B. He wasn't entirely relevant to our rotation per se, but he had been suffering from a cough recently. Thinking only of our teaching session and the annoyance of the doctor if we did not have at least something to present, we decided that he was the best we were going to get, for our purposes.

Mr. B was a well-dressed gentleman in his eighties. He was sat alone at a table in a small recreational area on the ward, watching television. The walls were adorned with patient artwork, creating an area reminiscent of a primary school rather than a ward for mostly elderly patients. Mr. B said he was more than happy to answer our questions, and I quickly got into the swing of my usual history-taking, albeit in a slightly rushed manner, as I was feeling stressed from having searched for a patient for so long. It quickly became clear that it was not going to be easy to obtain a clear history from Mr B. about his cough. He was keen to make conversation rather than to answer my questions about his cough; giving long, deviating answers and making it difficult for me to stick to the structure I had been trying to perfect for several months. Initially, I felt frustrated that he kept changing the subject and wasn't giving a clear history. I was tired and fed up of wandering around the hospital, and I'm ashamed to admit I was somewhat disappointed to have 'ended up with' what medical students sometimes think of as an overly chatty patient.

However, when his winding answers began to hint at how upset he was with his care and his situation, my view began to change. Mr. B revealed that he was feeling desperate to the point of not being able to cope anymore. He had been in hospital for over six weeks following a fracture of his femur, and was beginning to think that due to his age he would "never make it out alive". Being surrounded by lots of very elderly and unwell people was making him feel increasingly disconnected from the world of the living and healthy. Further, he felt that several members of staff behaved in an unprofessional and rude manner, making his time on the ward miserable. Suddenly, hearing him speak about his wife, children, and grandchildren, who visited but never frequently enough, I was able to imagine my own relatives being in a similar position. This is something that has really stuck with me regarding this encounter: the thought that someone speaking to an unwell relative of mine could be using the conversation solely for their own needs, something that strikes me as selfish.

Seeing Mr. B begin to cry and tell us about how he was feeling made me connect with him emotionally and see him as much more than the '80-year-old man with a cough

following fractured femur' that I had noted down. I like to think that despite my initial focus on just getting a history, I was able to comfort Mr. B, even just by listening to his worries. We sat with him for around an hour just chatting, listening and learning about his life. I also referred him to the Patient Liaison Service (PALS), in case he wanted to voice a complaint about some of the members of staff he felt were not delivering the best care. I wonder if they too in their busyness had forgotten to treat Mr. B as a person and not just another immobile elderly patient.

During the Balint group discussion about this case, we first discussed my behaviour and feelings during my interaction with Mr. B. It was reassuring to me to hear that other medical students sometimes felt this way before seeing patients – rushed by the academic pressures of medical school, and keen to quickly clerk and then get back to studying. We also discussed the fact that despite these academic pressures of study, sign-offs and seminars, we as medical students hold a privileged position. We do not have to spend time making decisions about patient care, or preparing food, or helping to bathe patients. This leaves us with time to be spent just talking, and more importantly, listening. A quote that I have always found meaningful is 'everyone you will ever meet knows something you don't'. As clinical year medical students, we are lucky in that we are now able to access the wards to learn, but even luckier in that we have time to spare where doctors and staff do not. I had time to talk, so I could have made conversation and asked how Mr. B was feeling before diving straight into questions about his cough (which was, of course, the least of his concerns). The other students in the group reassured me that it was likely a great comfort to Mr. B to be listened to, even if at first I was not prepared to deviate from taking a history. One suggested that perhaps just as I saw my grandfather in him, he may have seen a granddaughter in me. Perhaps it was reassuring to him to spend time talking to someone younger, rather than the other patients on the ward who he felt were very elderly and on the brink of death.

We also considered Mr. B, and what it might have felt like for him to be stuck in hospital for so long. For someone who seemed to me a fiercely independent gentleman, it must have been incredibly frustrating to have lost the ability to walk, and to rely on others for his every waking need. This brought to mind a sense of his having almost regressed to a childlike state in some ways: needing to be cared for and having to ask for – and being denied – permission to do things, being left by close family in an unfamiliar environment, much like school. I was reminded again of the primary-school-like television area, with its plastic seating, craft materials, and artwork on the walls. How demeaning it must have been as an old man to have his life entirely controlled by others, from going to the toilet, to getting out of bed, to not being permitted to leave the hospital. He mentioned several times during our conversation how independent he had been prior to his injury. I think he wanted to assure me, and more importantly himself, that he belonged in the world of the living rather than among people with little time left. Even worse, every departure of his wife and children from the ward would have been another reminder of life going on in his absence outside the confines of the hospital. It must have been an intensely lonely experience for him to have to say goodbye to his loved ones every evening and prepare for another long stint with only 'rude' staff and 'dying' patients to keep him company.

Unfortunately, I don't remember the specific details of his complaints about the staff, partly because I'm not sure I delved into the issue all that much during our conversation. However, it is possible that part of this complaint could be due to a rebellion against these new authority figures so reminiscent of parents or teachers. In such a frustrating situation, it is understandable that Mr. B would be particularly resentful

toward the nursing staff, who represented the authority that was keeping him in hospital. On the other hand, the staff did seem to me to be incredibly busy: during my conversation with Mr. B I had to get up to help another elderly gentleman with dementia who, despite clearly being unable to mobilise, was attempting to shuffle out of a chair. If it had not been for Mr. B, who noticed him, and myself then it is possible that he would have fallen. I have found myself wondering since whether this was a typical scenario on the ward, or whether I just happened to visit on a particularly busy day. I think the truth behind Mr. B's complaints was likely a combination of his frustration at being in stasis for so long, and a team who were overworked and therefore rushed and somewhat brusque in their behaviour.

Looking back, I am humbled by the fact that Mr. B chose to speak so openly to me about how low he was feeling. I wish I had taken the time to collect myself before approaching, to forget about the stressful morning that had come before and to prepare myself to listen to and get to know him. This is something that I will keep in mind during future encounters with patients – the necessity of disconnecting from the stressful surroundings of the hospital and my own studies for the brief time that I spend with patients. I will endeavour to make the most of the opportunities that I have to improve patient care by simply listening, rather than always starting a clerking with only my own aims in mind. Toward the end of our group discussion of my case, I shared with the group something a hospital chaplain once said to me; he suggested that when someone is going through a difficult experience, trying to show them the 'light at the end of the tunnel' can almost seem as if you are making light of their pain. Often, it is better to simply sit in the tunnel with them and listen; to quietly be there in the dark. Discussing this experience in the Balint group reminded me of the one of the most important privileges of my role as a medical student: time to be with and listen to patients. I sincerely hope that the time I spent listening to Mr. B gave him some comfort in the darkness of his recovery.

**Harriet Hall**

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**BALINT SOCIETY LONDON**  
**LEADERSHIP DAY – FEB 10th 2017**  
**Balint Group Leadership:**  
**conceptual foundations and a framework**  
**for leadership development?**

‘A leader is an ordinary person in an extraordinary position’

Donald Winnicott

Andrew Elder UK

andrewelder@blueyonder.co.uk

**The Question**

How much do we know about *how each other think* about Balint leadership? **How clearly do any of us conceptualise what we are doing when we lead?** Many aspects of leadership would be quickly agreed, at least in outline – clear boundaries, focus on the doctor-patient relationship - **but is that enough?** Against what theoretical background do we debate the relative merits of an intervention we might make (or, just as important, not make), or the value of a particular technique, or shift in emphasis? In short, is there a set of Basic Balint Concepts (a sort of BBC) which form an agreed *conceptual framework* for our work? After all, there are many close relatives to Balint work. **Is all group work that focuses on the doctor-patient relationship Balint work?**

Apart from the Appendix on Training in ‘The Doctor, His Patient and the Illness’ (Balint M 1957) and the two chapters that Enid wrote later in ‘While I’m here, doctor’ (Elder and Samuel 1987) and The Doctor, the Patient and the Group (Balint E et al 1993), the Balints wrote little about their approach to leading groups. The experience of Michael Balint’s leadership has been described as ‘like taking strong medicine’ (Courtenay 1994). Enid had a deeply containing presence, and when leading a group created a secure but challenging atmosphere. It was her view that a Balint group was a special and highly sophisticated ‘*instrument*’ for observing key aspects of the doctor-patient relationship which would otherwise go unnoticed and unstudied.

**Underlying Principles: Psychoanalysis, Medicine and Mutuality**

Although originally called research-cum-training seminars, Balint groups are rooted in the reality of the consulting room where body and mind are one and where the burdens of professional work are great. The research was twofold: to explore how things *are* in a particular doctor-patient relationship (not how they should be); and secondly, to evaluate the changes that occur in the subsequent interactions between doctor and patient after discussion in the group. The training of course was to facilitate the participants’ understanding and use of themselves as ‘drug doctors’. Psychoanalysts and psychotherapists who work in Balint groups do not bring psychoanalytic theory but an open-minded attitude to enquiry and a special atmosphere of attention; deep listening, acceptance of contradiction and a long term view of human relationships with awareness of their unconscious aspects.

The mutuality of work between the two disciplines (psychoanalysis and medicine) has always been central to Balint work. At the outset both Balints were clear that an

analyst (or psychiatrist, or psychologist) who had not been subjected to what they called the *thinking, feeling, despair and pleasure* of family doctors was not equipped to lead a Balint group. Whilst it remains true that psychiatrists and psychotherapists are required to gain experience of working in groups before training to become leaders, the Balints' phrase carries more than this. It expresses the need for leaders to be aware of what they don't know, and encourages them to feel and think alongside their group members in a spirit of shared enquiry. Whereas originally the creative partnership was between leader (PA) and group members (GP), that partnership now often resides in the co-leadership pair, one from the psyche professions and the other from medical practice. But in Michael Courtenay's words **'both must make a journey, in becoming Balint leaders – analysts and non-analysts alike – into a Balint 'space of special expertise' by working together'** (Courtenay, 2004).

The American literary academic Kathryn Montgomery states 'Despite its own emphatic claims to the contrary, medicine is not a science at all – and nor, incidentally, is it an art. Medicine is a practice.' (Montgomery 2006). Balint group leadership is certainly a practice and the internalised experience of *being* in a Balint group (for as long as feels necessary) remains the best possible starting point for our eventual attempts at leadership.

I now want to sketch what I see as one of the **cornerstones of Basic Balint Concepts: the parallel process between consulting room and group and vice versa between group and consulting room.**

### **Parallel Process: The Consulting Room and the Group**

We speak a lot about parallel process in Balint work. The significance of parallel process arises from our particular understanding of the interpersonal relationship between patient and doctor. In *The Basic Fault* (Balint 1968) Michael Balint uses a rather striking phrase to describe an early aspect of the mother-infant relationship: he calls it a harmonious interpenetrating mix-up. The professional-patient relationship may not always be harmonious but it can often be an interpenetrating mix-up! Echoes of these early parent-child relationships come into professional-patient relationships all the time and can be intensified by examination of the body and anxieties about death and dependency. Sometimes resembling a marital relationship, the long-term familiarity of the doctor-patient relationship can further entangle the mix-up. When a doctor brings a case to a Balint group, *patient and doctor arrive in the group together*. As members of the group listen to the freestyle presentation of a case, the presenter's emotions become clearer, as do their defences or blind spots. Sometimes the presenter demonstrates a close identification with the patient and at other times takes pains to distance herself. As Gosling expresses it, 'whatever the psychological distance, the patient is always present. It is one of the tasks of the leader to encourage the group to discover in what ways the patient may be influencing the doctor and to distinguish the patient's influence from the doctor's own distorting tendencies and professional needs' (Gosling and Turquet 1967). In other words, who is speaking? Is it the patient or the doctor? Perhaps we need to be careful when we use those apparently distinct and deceptively circumscribed words 'doctor' and 'patient'. Both are more porous than we imagine.

As discussion of a case proceeds, different aspects are taken up by (or will subdue) different members of the group according to their personal psychological disposition (often called valency). In a well established group, a leader may become familiar with the group member's personal patterns of reaction, enabling her to 'read' unconscious aspects of the case in the reactions of the group. The leader tries to listen to how the group takes

up the case and how the other participants work with the presenter. It is these processes that are the focus of the group work as the detailed interaction between doctor and patient is revealed in the parallel between the reactions of the participants in the group and the presenting doctor. All this, of course, the poor leaders have to try and observe as well as being part of the process. The leaders have to be prepared to be alone in their role and to withstand the many pressures to which they will feel subjected.

Perhaps we can say, as a **Balint Basic** that there are three key inter-connected layers of relationship in a working Balint group. The doctor-patient relationship as expressed to the group by the presenting doctor; the relationship that develops between the participants in the group and the presenter as the case is discussed; and the relationship between the leader(s) and the work of the group. Another important relationship for a leader to consider is that between herself and the presenting doctor. (Elder 2007).

### **Work of the Group**

Medicine is about serious matters. Tom Main, a close colleague of the Balints reminds us in a comparison between medicine and war, 'that both are concerned with issues of life and death, crippledom and loss, sadnesses and terrors about external dangers; and both are also complicated by anxieties from the inner world, unconscious fantasies of primitive sadism, punishment and so on' (Main T 1978). Just as doctors have their necessary defences which enable them to function in a professional setting, so do individual group members and groups as collective entities. Some of these defences will be personal or derive from disturbing aspects of the case whilst others will be connected with the unconscious preoccupations of the group itself.

How do we think about groups? **If we come to leadership without psychodynamic training do we simply absorb enough about group process to lead a Balint group?** There are many different theories of group dynamics. Michael and Enid Balint were not much interested in group theory. It was the Balints' colleagues at the Tavistock – principally Robert Gosling and Pierre Turquet who developed Wilfred Bion's theory of groups to elaborate the theoretical foundations of the work of a Balint group and the role of its leader. Their slim volume 'The use of small groups in training' (Gosling and Turquet 1967) sets out their ideas clearly and is an invaluable discussion on the role of the leader in a Balint group. They describe the unconscious defences found in all groups which distract the group from pursuing its primary task. How we think about our role as a leader in a Balint group depends on our view of how groups function (or refuse to function). Groups will sometimes do almost anything but stick to their task! Some of us may have a benign view of group function and feel that a group left to its own will work. I'm not sure I share this view. The balance between needing to lead and allowing the group to find its own way is a delicate one. **Facilitator, conductor or leader? Which term do we choose and why?** My personal preference is for leader: in the sense of leading into awkward places, creating space for the group where it may not want to go. If the leader can't go there, what hope for the group? If the doctor can't go there, what hope for the patient?

### **Parallel Process: The Group and the Consulting Room**

Parallel process goes both ways. It is one of the cornerstones of Balint theory that the attitude of the leader and the atmosphere of the work in the group become incorporated in the doctors' work back in her consulting room. Eventually, the reflective function of the group (the third ear or third eye) is carried within the doctor when she is consulting.

**Perhaps it is helpful to think about Balint work both beginning and ending in the consulting room, continuously circuiting through the group until internalised in the participating doctor.** Michael Balint was clear: ‘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’ (Balint 1957). This takes us to the paradox of teaching. The injunction not to teach is easy to understand even if not to fulfil! Balint is clear about the ever present dangers of the teacher-pupil relationship and the mutual admiration society (Balint 1957). This is harder to avoid than we may think. **And it may be particularly so in mono-professional groups: a GP leader leading a group of GPs or a psychiatrist leading a group of trainee psychiatrists for instance.** But the second bit is trickier to study: that a leader is influencing the group all the time by his behaviour and attitude. So, we mustn’t teach but everything we do is teaching! The question to study becomes not whether we teach but what we teach. For Balint this was about the group as a laboratory for learning deeper listening. ‘After all, he said, the technique we advocate (in leadership) is based on exactly the same sort of listening that we expect the doctors to learn and then to practise with their patients’ (Balint 1957). The emphasis on leaders not teaching arose from the Balints’ concern that doctors should find **their own way and not short-circuit their experience of working through to new ways of thinking.** Although it is important for group members to feel free enough to explore their fantasies and irrational thoughts, the loop back to the consulting room also provides the necessary reality testing of the group’s ideas. Leaders need to bear in mind that the presenting doctor is the only person in the group who has actual contact with the patient. For this reason, follow-up reports were always encouraged by the Balints and their colleagues.

### **Developments**

Now I want to step aside and in the light of what I have said so far, consider some of the changes and developments that have taken place in Balint groups.

**First, a word about co-leadership.** Although many groups are still led by single leaders, there has been a slow growth in co-leadership as a preferred model, often with pairing between GP and psychotherapist. Co-leadership gives the possibility of a ‘reflective pair’ and the value of mutual de-briefing after a session. Leading on your own may feel more exposed but can also feel freer. For members of the group, the feeling of being contained by a parental couple will clearly be stronger in a group with co-leadership, and correspondingly, there may be more rivalry for a single leader’s attention or a desire to pair with him or her. **Whether leading singly or in a pair, every case will put pressure on the leaders in different ways depending on the unconscious conflicts present in the case.** And there are many potential fault lines for the case material to exploit: different professional backgrounds, gender, and perceived or actual seniority relationships in the co-leadership pair. How does each leader think about their role? How much time is given to discussing these things? In on-going groups these issues increase in importance and underline the need for a clear structure of supervision for leaders.

### **Pushback**

The technique of inviting the presenting doctor to ‘pushback’ during discussion of her case has been frequently debated in the last few years. In some countries it has become a widely used technique although it was not part of Balint methodology for the first thirty years or more. Clearly it has some merit, otherwise it would not have become so popular,

but it also has some disadvantages. Some leaders may find it helpful to have additional structure when they are leading a group, others may find it encumbering or defensive. It is sometimes preferred by presenting doctors but preference by participants is not necessarily a good criterion for adopting practice. For those new to Balint it may be a help to have the reflective aspect of presenting a case protected, or 'ring fenced'. If we view pushback from the perspective of basic Balint concepts, it does interrupt the dynamic of the parallel process between doctor-patient relationship and the group (by removing the doctor you are also removing the patient), and it alters the structure of (what I earlier called) the listening laboratory in the group. However these effects are mitigated if the presenting doctor returns to the group for a sufficiently long period before the discussion is closed. There is also a danger that a group encouraged to fantasise in the absence of the presenting doctor loses contact with the clinical reality of the doctor's consulting room. The Balints were clear that the work should focus on the doctor's actual work and that the aim of this was for the benefit of the patient. If pushback is used, it gives rise to an additional layer of attention for the leader as its use will alter the dynamics of the group discussion in different ways depending on the characteristics of the case presented. Pushback certainly underlines the experience of listening to oneself from the outside and thus can enhance the development of reflective capacity. As with so many things, leaders must find a way of leading that suits them but know why they have made that choice and what the relative merits and drawbacks are of their approach. **My main point is that we can only discuss these questions if we have a clear conceptual framework within which to do so.**

I'd like to give the last word on this to Enid Balint who wrote the following: **'Leading a Balint group well is extremely complicated and the more you change individual components, the more complicated you make it, until you might make it impossible'**

The last area I want to highlight **is a subtle shift in the aim of Balint work towards** a more explicit concern with morale. Low morale is of great concern but there is a need for clarity about the role of Balint groups as a potential remedy. Perhaps some confusion has arisen because of our need to undertake quantitative studies to demonstrate the benefit of Balint groups. In doing this, researchers have often used measurable outcomes related to morale. The relationship between Balint work and morale is complex. Clearly patients are unlikely to be helped by demoralised or depressed doctors. And doctors may need to have sufficiently good morale to work in a Balint group at all. Balint group leaders may need to pay attention to the morale of participants whilst not losing sight of the fundamental object of Balint work. The paradox is put very well in Gosling's description of the early days of the Tavistock GP training scheme. He says their stated motto was **"All ye who enter here, take up your burdens"**. He continues, 'No easy way out is offered. It is to be a struggle. Our general practitioners declare themselves to be harder worked as a result of coming to these seminars. The important change is that they understand their work better and derive more satisfaction from what they are doing; their morale is therefore higher' (Gosling and Turquet 1967). Nothing comforting or reassuring is being offered. **Improved morale may be the result of Balint work but is not the aim.**

The aims of a Balint group for medical students or for professional trainees are different from those for a long-term group. Outcome measurements for educational groups are quite properly tailored to relevant educational aims. Groups with different aims require correspondingly different approaches to leadership.

## Conclusion

In all Balint work there is the need for a secure frame which enables the freedom and creativity of the participants to flourish. There are many ways in which we could think about the creativity of a Balint leader in attempting to embody that frame: use of clear language which resonates with the group members, free of euphemisms or jargon; supporting the creativity of members of the group - perhaps thinking of leadership as something that passes from member to member; and allowing the group members time to discover their own ways of thinking about the difficulties presented. Disturbing ideas tend to shut down thinking. A Balint group is a place in which to explore and play with new ideas. The space for exploration in the group is, to a certain extent, a function of the negative capability in the leader's mind. Borrowing from Keats, perhaps we could say: when a Balint leader is **capable of being in uncertainties, mysteries, doubts, without too much irritable reaching after fact and reason**. And for this to occur, the leader must be sufficiently comfortable to lead in his or her own way, not in any correct way, but keeping in mind the **Basic Concepts of a Balint Group and the Leader's Role within that Framework**.

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# Rules

Dr. Patricia Tate

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the Michael Balint Memorial Lecture 2017

On two days each week, I walk to and from school with young grandchildren. One day, the 9-year-old girl was talking about how much she looks forward to being allowed to walk to school on her own. Without much thought, I said, “I suppose there will have to be rules.” “What do you mean, rules?” “Well”, I said, “for example, Don’t run across the road without looking. Don’t forget your book bag, and so on.” She got the drift and added, “Don’t lose your gloves” and we were quickly into a game of devising more and more exciting and unusual rules: Don’t steal someone else’s scooter, Don’t lie down and roll in a mud puddle, Don’t climb a tree, Don’t throw stones at the school custodian, Don’t break a car window, Don’t put dog poo in your pocket, Don’t shout at old ladies—until she said, “Don’t do anything stupid on the way to school.” Ah. At this point, the game was over, and we had returned to the sober adult world from that of the transgressive child; we had come to The One Rule That Rules Them All.

What the 9-year-old was using was Rule Utilitarianism—the idea that deciding on the utility of many individual acts to maximise pleasure, and minimise pain, is impractical. So, one should act according to general rules that tend to lead to the greatest good. Another example of Rule Utilitarianism is NICE guidance on clinical priorities.

The authors of the Rule Book I was given in 1955, when I moved into a Women’s University Hall of Residence, would have been well advised to think along those lines, for I was quick to notice an omission; among the various detailed proscriptions about radios and gramophones, there was no rule against having a baby grand piano in one’s room, and playing it all night. The scale of neither my room nor my budget made that practical, but I was delighted that they had forgotten to forbid it. And this illustrates one aspect of our relationship with rules—the enjoyment in finding one’s way round them. Freud said, “Happiness is the belated fulfilment of an early wish. We are only really happy when we satisfy a childhood wish. And one of our childhood wishes is for the kind of pleasure that is essentially transgressive”.

Adam Philips points out that getting away with things is always a pleasure, however brief. We like to do it ourselves, and we like to hear of other people who do it. At its most minimal, getting away with something—not paying on the train, insider dealing, cheating successfully in an exam—can be thrilling. Adam and Eve found out what happens when you break rules, and, importantly, they found out that it was indeed possible to break rules. It is not simply that rules are made to be broken, but that the rules tell you that there is something to break. If there were no law, it would be impossible to transgress. The rules, whatever else they might be, are an invitation to find out what rules are.

Every time we react to the transgressions of others, we relocate ourselves, firmly and safely, within the rules, within the protective walls of our society. In these moments, we are reminded of how the world should be, and that someone who knows the rules, and can enforce them, is looking after us. It reassures us to see that we clearly know what the rules are, because we can then be outraged when they are broken. In Alan Bennett’s play, ‘Getting On’, a character says, “We started off trying to set up a small anarchist community, but people wouldn’t obey the rules.”

The Victorian poet, educator and devoted assistant to Florence Nightingale, Arthur Hugh Clough, delighted in going against the popular religious and social ideas of his day.

He wrote a satirical poem, 'The Latest Decalogue', an alternative version of the Ten Commandments-- these, surely, being the rules which come to us on the most potent authority of all. Clough's paraphrase of The Commandments goes like this:

Thou shalt have one God only; who  
Would be at the expense of two?  
No graven images may be  
Worshipped, except the currency.  
Swear not at all; since for thy curse  
Thine enemy is not the worse:  
At church on Sunday to attend  
Will help to keep the world thy friend;  
Honour thy parents; that is, all  
From whom advancement may befall:  
Thou shalt not kill; but needst not strive  
Officiously to keep alive:  
Do not adultery commit;  
Advantage rarely comes of it:  
Thou shalt not steal; an empty feat,  
When 'tis so lucrative to cheat:  
Bear not false witness; let the lie  
Have time on its own wings to fly:  
Thou shalt not covet, but tradition  
Approves all forms of competition.

Phillips suggests that perhaps as part of growing up we need to break rules, just to be able to find out what rules are made of, and why they matter. Should then parents or schools be saying, "Our rules are made to be broken, because we know that, for at least some of you, only transgression or risk will make you feel fully alive?" Adolescence is the time in people's lives when they begin to notice that there are other things you can do with rules rather than be bound by them. An adolescent senses herself to be a potentially serious rulebreaker.

In thinking about this lecture, for the last few months I have asked every clinician I encountered—general practitioner, consultant, therapist, nurse, even my dentist—their first reaction to the word, "Rules". You might want to do so now for yourself. What I found was that about 3 in 4 people had a negative association. They said things like, "school", "constraints", "break", "bollocks", or "ugh". ("Break" was the offering of a Jungian psychoanalyst.) About a quarter of the sample, in which I am included, said things like "security", "structure" or "safety". For some of us, rules must be sought and clung to, like vines across a crocodile-infested swamp. My working hypothesis about this highly unscientific data is that those of us with a superego on the harsh side find comfort in knowing rules, so that we are less at risk of wrongdoing. In fact, I may have stumbled here upon a simple, near-patient test for the harsh superego.

Because of our ambivalence about rules, and the risk of negative reactions, we often go to a good deal of trouble to avoid using the actual word, utilizing a richness of synonym and euphemism. "Protocols", "boundaries", "principles", "algorithms" "precepts", "maxims", "codes", or "technique" somehow feel less frightening and controlling. The Balint Society does not have rules for group leaders or rules for group members—it has 'conventions', 'guidelines', 'aims', an 'agenda'. The leader has 'responsibilities'; an optimal

group session is described on the website, but there are no Dos and no Don'ts. "Ground Rules" IS one Balint Society website entry, but these are the gentle general rules of all groupwork, touching on respect and confidentiality. Perhaps, it could all be summarised as "DON'T DO ANYTHING STUPID IN A BALINT GROUP".

Another little girl, aged 7 and, like my 9-year-old granddaughter, in the sexually tranquil period of latency, is Alice. In *Wonderland* and *Through the Looking Glass*, her latency opens an array of alternative worlds, and realises fresh impossibilities. Alice encounters ridiculous rules and peremptory injunctions, which parody the highly constrained life of a Victorian child. The books are preoccupied with rules, and delight in identifying them, as well as in breaking or reversing them. The Alice books explore profound affinities and contradictions in childhood experience. But the heroine is definitely a child, not an incipient adolescent. From latency, she can challenge a good deal of adult wisdom about child rearing, as well as adult categories of knowledge. (Gillian Beer's recent engaging commentary, 'Alice In Space', offers playful insight into these books.)

Throughout the two books, Alice is always seeking rules: rules for 'shutting up like a telescope', for having jam for tea ("The rule is, jam tomorrow and jam yesterday, but never jam today.") or sneezing ("Maybe it's always pepper that makes people hot-tempered", she went on to say, very much pleased at having found out a new kind of rule.") Or, as the White Queen hopes, for being glad. "I wish I could manage to be glad", the Queen said, "Only, I never can remember the rule." Most of the creatures Alice meets operate by rules that exaggerate and satirise the various struggles of alienation in adult life. Alice is continually concerned about fair shares and proper behaviour: in the croquet game she exclaims, "They don't seem to have any rules in particular; at least, if there are, nobody attends to them." Or, in the Courtroom scene, when 'Rule 42' is declaimed, (you may recall that Rule 42 is, "All persons more than a mile high to leave the court") Alice cries out, "That's not a regular rule, you invented it just now!" and is told, "It's the oldest rule in the book". To which she replies, "Then it ought to be Rule Number One."

In *Wonderland*, the child has the power of logic and is able to assert it. When the Queen rebukes Alice with, "Speak when you're spoken to!", Alice rejoins, "But if everybody obeyed that rule (she was always ready for a little argument) and if you only spoke when you were spoken to, and the other person always waited for you to begin, you see nobody would ever say anything." The child-mind is learning to understand the world and itself, and there is a dawning conception of consequences, order and reason.

The Alice books are a refreshing contrast to the 'improving' children's literature of the time. Before this, children's books were educational tracts, preaching conformity and obedience, and indeed, the edifying verses of 'Divine and Moral Songs for Children' by the Rev. Isaac Watts DD, which Victorian children learned by rote as lessons, are satirised unmercifully. When Alice, as a reality check, tried to work out if she had been changed into someone else, she "crossed her hands on her lap, as if she were saying lessons, and tried to repeat "How doth the little...", which in the Rev. Watts' original reads, in part:

"How doth the little busy bee  
Improve each shining hour,  
And gather honey all the day  
From every opening flower!"

In works of labour, or of skill,  
I would be busy too;  
For Satan finds some mischief still

For idle hands to do.

However, for Alice on this occasion, the words do not come out as she had learned them:  
“How doth the little ....crocodile  
Improve..... his shining tail.  
And pour the waters of the Nile  
On every golden scale!

How cheerfully he seems to grin,  
How neatly spreads his claws,  
And welcomes little fishes in,  
With gently smiling jaws!”

Although Carroll’s day job was as a mathematician and logician, both elements, whimsical imagination and rigid definition, were present in the one person. Carroll disclaimed any interference in the writing from his conscious mind, saying that the books “came of themselves”. Wonderland was published in 1865, so there could have been no influence from Freud; however, Carroll was very broadly well-read, and the catalogue of his library includes 21 works on Psychology or The Mind, including the first Psychiatric book published in Britain (in 1860), and Henry Maudsley’s ‘Physiology and Pathology of the Mind’. William Empson wrote, “To make the dream-story from which Wonderland was elaborated seem Freudian, one only has to tell it.”

It has been suggested that, even 150 years later, the reason that the Alice books interest present-day children is because they face the same challenges and issues regarding rules, a reasonable view of the universe, and growing up, as Alice does. In more recent literature, one of William Golding’s schoolboys in *Lord of the Flies* says, “We’ve got to have rules and obey them. After all, we’re not savages. We’re English, and the English are best at everything. So we’ve got to do the right thing.”

Freud has now, by my count, crept into our lecture three times, so perhaps we should acknowledge his rightful and important place in any discussion of rules.

Freud brought something unique into being with the creation of the Psychoanalytic method. He introduced the Fundamental Rule of free association (*Grundregel*) for the first time in the second of his six technical papers, “The Dynamics of Transference”, in 1912. This is the very basis of psychoanalytic practice and is, seemingly, very simple, but its application is not. Rycroft has described the fundamental rule in his ‘Critical Dictionary’ as, “the injunction that the patient do his best to tell the analyst whatever comes to mind without reservation”. The fundamental rule is in effect an agreement that each patient is asked to accept at the beginning of analysis; Freud called it a pledge or promise. Free association is more easily recommended than performed; when asked to “talk about anything that comes into your mind without censorship, however irrelevant or inappropriate”, one can imagine the patient replying, “If I could do that I wouldn’t be here in the first place.”

For the analyst, the counterweight of the fundamental rule was the rule of listening with neutrality, described as evenly poised or suspended attention. This ‘rule of abstinence’ also required that the analyst should not satisfy the patient’s desires, such as curiosity about the analyst’s life.

Rycroft emphasizes the historical context in which the fundamental rule was originally conceived, which was at the point when Freud introduced free association as an alternative to hypnosis. Subsequently, Freud did not publish a comprehensive work about technique— the papers that emerged between 1911 and 1915 did not lay down firm

rules, but were rather formulated as 'advice'. They were also, as he would later notice himself, "entirely inadequate", helpful only for "beginners" and "essentially negative". Other elements of analysis, such as use of the couch, or the duration and frequency of sessions, became generally accepted, but were not seen by Freud as rules.

I think it is fair to say that there has been much more written about Freud's rules by others than by Freud himself, an example of how slippery a thing is the ownership of a rule.

Here is another instance of that: J.D. Bernal recounts, "In my own field, x-ray crystallography, we used to work out the structure of minerals by various dodges which we never bothered to write down, we just used them. Then Linus Pauling came along to the laboratory, saw what we were doing and wrote out what we now call Pauling's Rules. We had all been using Pauling's Rules for years before Pauling told us what the rules were."

In psychotherapy, clearly, the purpose of rules is to establish order, safety and efficacy. The analytic setting is ordered so that it can contain the process. Freud made particular recommendations about the setting that HE found useful, but he prudently suggested that those recommendations might not suit all analysts, or all patients. The very nature of analytic rules seems to require that they be flexible, that we mould them to our own personalities, as Freud moulded them to his. Taking rules too literally risks denying the spontaneous and creative nature of analysis, and indeed, its purpose.

Freud's views on technique became more relaxed as he got older; this seems true of many analysts, and suggests that age may bring a degree of confidence. Since his death, the analytic community has disagreed with Freud in his lack of rigidity, and Freud is sometimes accused of not having been 'classical enough.' It seems that perhaps Freud was not an orthodox Freudian.

Writing to Ferenczi in 1928 about the technical papers, Freud said: "The recommendations on technique which I wrote long ago were essentially of a negative nature. Almost everything positive that one SHOULD do I have left to 'tact'." He was certain, however, that one could not devise a rule on how to be tactful.

The final ambiguity is the contrast between Freud's practice as we know it from his case records and his analysands' recall, and his 'official' position on rules as it appears in the technical papers. We know that he chatted with patients, addressed them by nicknames, sometimes complimented them on their insight, and made friends with several of them. We know that he served food to the Rat Man, offered money to another, walked around the Ringstrasse with another, gives a set of his collected works to another. And John Dorsey, who was in analysis with Freud between 1935 and 1937, related, "I recall during a session his leaning over the couch and singing one or two strains to me from Mozart's Don Giovanni." As Ernst Falzeder has said, "It almost seems as if with him these aberrations are not the exception, but the rule."

Clarence Oberndorfer, speaking of his analysis, says, "The fact that Freud talked to me excited a good deal of attention in Vienna, so much so that one day I was honoured with an invitation to tea by James Strachey and John Rickman...John Rickman said to me, "I understand Freud talks to you.' I said, 'Yes, he does, all the time.' They said, 'Well, how do you do it?' I answered, 'I don't exactly know...How is it with you?'. They both said, 'He never says a word'"

An interesting English translation of an analysand's diary appeared only last year, entitled, 'What Is This Professor Freud Like?' It consists of session-by-session recollections of what each party said, and casts a spotlight on Freud's actual treatment methods in 1921. This diary gives a picture of Freud as an accomplished conversationalist,

who covered a broad range of topics in a wide variety of styles, in a fluid fashion.

M.G. Thompson, in his work 'The Truth About Freud's Technique', says, "When I read Freud, I see a man whose rules are not etched in stone. His recommendations about the practice of analysis were uncommonly flexible by today's standards. We, in turn, are invited to do the same, whilst using our heads."

In other words, DON'T DO ANYTHING STUPID IN THE CONSULTING ROOM.

After the Technical Writings of 1912 to 1915, Freud scarcely touched on technical problems in his writing, his interest turning to fundamental psychoanalytic ideas and theories. His last work on technique already showed the influence of Ferenczi, who, in his 1919 papers, "On the Technique of Psychoanalysis" and "Technical Difficulties", dealt with the resistances that can attach to the rules of free association and free-floating attention. Ferenczi observes how rules themselves can lead to resistances, and that by following the model too closely, the analyst might well repeat some of the patient's traumas. He questioned whether the analyst should not continuously vary his attitude to suit the treatment. This question is the springboard for what has been called 'Ferenczi's experiments with technique.' In his Clinical Diary, Ferenczi writes, "The analytic situation, but specifically its rigid technical rules, mostly produce in the patient an unalleviated suffering, and, in the analyst, an unjustifiable sense of superiority."

This is not the place to trace the sad trajectory of the Freud/Ferenczi relationship, from being honoured colleagues, with Ferenczi the expected heir, to coldness and disagreement. Michael Balint, who was analyzed by Ferenczi and was his editor and literary executor, supported Ferenczi's condemnation of an authoritarian attitude in analysis, and the Hungarian School of Ferenczi and Balint emphasized the idea that the analyst contributes more than just a setting, a transference object and interpretations.

When Michael Balint and his wife (along with their son John, who, incidentally, died in the USA 5 months ago at the age of 91) came to London in 1939, they transplanted the Budapest school of thought; Balint is recorded as saying, "The human mind is not essentially different in London from what it is in Vienna or in Budapest." Balint joined a deeply divided British Psychoanalytic Society, but found a place in the Middle Group or Independents. He continued Ferenczi's way of thinking, but with perhaps even more level-headedness.

In a 1939 paper, Alice and Michael Balint described how each analyst has his own way of proceeding, which suits him, and which he thinks is right. But it is not a matter of being right. The contribution made by the Balints, in Ferenczi's footsteps, was the introduction of the analyst himself as a subject of observation. And this is not susceptible to rules. In this way, we come to realize that psychoanalysis is not only a technique, it is much more a relation between two people.

Presumably Balint, like Ferenczi, was convinced that he was working in a direct line with Freud's fundamental discoveries. Balint shares one feature common to all great psychoanalytic investigators—his ability to transcend taboos (or should we call them rules?). He gave priority to experience over theoretical abstractions. In 'The Basic Fault' he says, "Some analysts are firmly convinced that the limits set by Freud's technical recommendations must remain absolute forever, and any technique going beyond them must not be called analytic. In my opinion, they are too rigid." And again, "If my train of thought proves valid, 'the correct technique' is a nightmarish chimera, a fantastic compilation from incompatible bits of reality."

The last ten minutes or so must have been pretty heavy going, so let us lighten things with a Balint anecdote (only obliquely to do with Rules) which I was surprised to come across in reading for this lecture. It is translated by Andre Haynal from a French paper

published by Balint in 1970. In Budapest in the 1930's, Balint had already decided to gather a few general practitioners in a kind of seminar for the study of psychoanalytic possibilities in their practice. However, the political situation was very tense, and, as Balint records, "We were ordered to notify the police of every one of our meetings, with the result that a plain-clothes policeman attended each of them, taking copious notes of everything that was said. We could never find out what these notes contained or who read them. The only result we knew of was that on several occasions the detective, after the meeting, consulted one of us either about himself, his wife, or his children." Even today's most challenged group leader does not, I think, face such a situation.

Balint's 1951 paper, 'The Problem of Discipline', is pertinent in thinking about rules. His point is that education consists in imparting simple rules to the new generation, expressed as "You must" or "You must not", but, that there are two classes of such rules. The first class is self-evident, its prototype being 'You must not go too near the fire,'--or, as we have already agreed, 'Don't do anything stupid on the way to school'.

Balint's second class consists of rules that are not self-evident—the use of 'Please', 'Thank you' or 'Keep to the left'. In a way these rules are nonsensical; they have no inherent logic, no relation to reality; harm does not necessarily follow if you do not comply with them. Balint points out that the rules of Type 1 are the same everywhere in the world, but those of Type 2 show amazing and baffling variations from one society or group to another.

My question is this: are the rules of psychoanalysis and psychotherapy which we use today, and which derive from Freud and his followers—are these Type 1 or Type 2 in Balint's formulation? By meticulously applying all of the rules suggested by Freud, are we avoiding disaster, or are we merely enforcing the norms of our intellectual sub-culture? Do these rules come from a strong, critically minded and realist ego, or have we been taught these rules by the building up of an unbending super-ego?

The biologist Peter Medawar, who was my postgraduate professor, has written, "We can say with confidence that there is no such thing as a schedule of rules by following which we are conducted to a truth. Given any rule, however fundamental or necessary, there are always circumstances when it is advisable not only to ignore the rule, but, to adopt its opposite." Which makes me think of Michael Balint's thought (when speaking of defences): "Anyone who is running away from something is running toward something else."

Psychoanalysis is not only a technique, it is much more a relation between two people. As in playing the piano, at first a technique IS necessary (rules must be learned) but the artist's interpretation is far more than technical execution. Balint's aim was that the patient should be able to find himself, to discover his own way, and not be shown 'the right way'. He has said that the analyst must be "a discreet ordinary person, who does not offer himself as omniscient or omnipotent." That thought leads me naturally to Balint's student and his colleague in the Middle Group, my own analyst, Peter Lomas, since 'ordinary' was Peter's byword in therapy and in his writing.

Lomas was independent-minded and quietly influential. He had a deep understanding of psychoanalytic theory, with great respect for Freud, and fondness and admiration for Ferenczi and for Winnicott, who was his supervisor. He is on record as admiring Balint. But, like his own analyst Charles Rycroft, he found the world of psychoanalysis dogmatic. His central argument was that psychotherapy lies in the realm of the moral, rather than the scientific, and that psychotherapists stand or fall by what Aristotle called 'practical wisdom', rather than the tyranny of convention and technique. With others, he set up The Guild of Psychotherapists as a training organization, and, later,

the Cambridge Society for Psychotherapy, known to its friends as ‘The Outfit’, and offering a radical departure in psychotherapy training.

In his 1993 book “Cultivating Intuition”, Lomas says, “We exist in a tradition, which informs our attitudes. Although crucially influenced by Freud—for it is he who has picked us up and placed us on the path of psychotherapy—I find that I am deeply and consistently moved by a desire to emphasize, in a way that psychoanalysis does not, the intrinsic worth of the personal relationship. But there is always the temptation, in aiming for the security of certainty and professional respectability, of following the method unthinkingly, thereby allowing it to dominate and corrupt the relationship. The tenet that there can be a rule for all people and all situations stems from a failure to recognize the diversity of human beings. The need now is to demystify the practice of psychotherapy, and to recognize that the experiences within it are not only part of the natural world, but can be encompassed by our ordinary capacities for experience. In some very important senses, therapy is an ordinary activity and the therapist is there as an ordinary person.”

Lomas has also written, “Is it morally right that, in an engagement between two people, it should be set up so that one person is so dominant, that the therapist is the one who makes the rules? If you take it out of the therapy setting, and you see two people talking together and one is making all the rules, one would probably say that was bullying, and not morally right.”

For his students and colleagues in the Cambridge Society, Peter suggested his own tongue-in-cheek “Seven Rules of Psychotherapy”.

- 1) Say to yourself before each session, ‘I am not Winnicott, nor Jesus Christ’.
- 2) All you have got is this person in front of you. He is your only hope. Perhaps he can tell you something, so listen.
- 3) Silence is not golden. After awhile say something, if only telling the patient the cricket score.
- 4) If you get into a rage, don’t hit the patient. Just say, ‘I need a pee’ and go out and meditate for a while.
- 5) The patient’s money is precious, you mustn’t be.
- 6) Do not worry if you find you are more screwed up than the patient. This is quite normal. It is called the Inequality of the Therapeutic Relationship.
- 7) Remember that you can never get it right.

Which reminds me of Bion’s comment, that before any psychoanalytic session there ought to be two rather frightened people, and if there weren’t, what was the point?

I want to conclude with some thoughts about a part of my own work. These days, I am mainly a psychoanalytic psychotherapist in private practice, but, as well as walking people to school, for the past 7 years I have done two sessions a week in a general practice, offering long appointments of 45 minutes. This is not therapy (the 45 minute duration is a private trick to remind myself of that), but it is extended general practice. The part of me that is a GP had yearned to be again in that setting, so I went to a practice with a proposal: I would come to their surgery and see the patients they wished they had more time for—as simple as that. My only negative stipulation was that they not send me eating disorders or addiction problems, as those are conditions which need structured care. And what I wanted to offer was very unstructured care; patients would be able to come as often as they liked, the only restriction being availability of appointments, just as it is for the other GPs. Patients would be able to self-refer. And, importantly, I would be taking no responsibility for continuity—that would remain with the patient, if they wanted it.

Long appointments are far from a unique idea—John Salinsky has written about them, my own GP trainer offered a long appointment at the start of morning surgeries, I

did so myself throughout my time as a Principal. However, the present setting is different, in that I do not have access to the online medical record, and I do not prescribe or refer, though I might suggest such steps to the colleagues. I keep a few brief working comments in a private notebook. Confidentiality is preserved, unless I have fear for the patient, in which case I can speak to the referring GP or the on-call doctor immediately.

On the rooms allocation list, I am referred to as ‘The Counsellor’. That’s fine by me, but medical knowledge greatly widens what I can offer, and the doctors use me in interesting ways. The usual discussion about the pros and cons of taking the antidepressant tablets takes more than 10 minutes. So does the woman with a disappointing knee replacement, who had planned for it so carefully and then felt let down, and wants me to examine the joint and feel the scar. There is the man with a rare cancer who comes through the door saying, “I’m dying”, who needs someone with whom he can look up information about his condition, and there is also the clinical medical student, just weeks before finals, who has just been given a diagnosis of multiple sclerosis, and who has all too much information about the condition. There are struggles with bereavement, with pornography, and the doctor who doesn’t want to be one. One woman came with 4 sides of closely typed A4, describing the long history of her (very unusual) symptoms; I asked her to read it out to me, which took up the full 45 minutes. When she came back, she announced with surprise that things were better.

I mention that work in this lecture because the absence of rules seems beneficial for these patients, preserving autonomy, and, I think, contributing to the care. Patients can come every week if they want to and they can continue coming as long as they like. Sometimes they attend regularly for a year, vanish for 3 years, and return—just as they do with their other doctors. And, I am convinced that the lack of rules plus the absence of a waiting list are large determinants of the success of this experiment. In his iconoclastic 1978 novel about medical training, ‘The House of God’, Samuel Shem explains that compassionate care involves breaking senseless rules. His protagonist states, “The delivery of good medical care is to do as much nothing as possible.”

Anthony Storr has written, of analysts, that some of us tend to an inappropriate dogmatism. There is the risk that we avoid anxiety by holding onto rules so rigidly that we may prevent productive therapeutic transformation taking place. Rules and codes may be a means of defending ourselves from responsibility. Storr also records, “I once had a conversation with the director of a monastery. ‘Everybody who comes to us’, the monk said, ‘does so for the wrong reasons.’ Storr points out that the same is generally true of people who become psychotherapists, and he adds: “For the most part, we have to put up with what we can get; namely, ourselves.” Rycroft, of course, has described ours as ‘an intrinsically odd profession.’

I have a great propensity for falling in love. In reading for this lecture, I have fallen in love all over again with Freud, Ferenczi, Balint, Lomas and Alice. I confess it. I have delighted in their writing. The Society has honoured me by its invitation to give this lecture in memory of Michael Balint, and I thank you. Balint work has been indispensable to my education, and I admire and revere Balint as a wise, inspirational and practical link between Freud’s discoveries and our own work today.

Tom Main’s paper, ‘Some Medical Defences Against Involvement With Patients’ has long been my favourite analytic paper of all time, but I had forgotten, until recently, that he presented it as the 1978 Balint Memorial Lecture. In conclusion this evening, I can do no better than to repeat for you the ending of Tom Main’s lecture, when he said, “I think you know that for each patient encounter there can be only one safe general rule, which is: do not have a general rule.”

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# The Doctor, the External Reality and Balint Group Work

This is a modified version of the introductory lecture to the conference arranged by the Serbian Balint Society hosting the IBF Council Meeting in Belgrade on May 19-21, 2017

A famous 20th century philosopher said: “If you do not have anything intelligent to say you can always tell a story”. I will surely not please this philosopher, because I will tell you a few stories. Maybe, in the end you will agree with the philosopher? But hopefully these stories may initiate a discussion.

Let me first ask a couple of provocative questions:

Is Balint group work always compatible with the external conditions of the practising doctor?

How may the external reality affect the scope and contents of Balint group work?

Do not expect me to provide you with a simple answer and I hope you will not try to offer me a simple answer either!

At this moment I expect you to object that the *external* reality and the working conditions of doctors are intertwined with their *inner* reality, the unique pathway through which individual doctors perceive their working conditions. As humans we have a variety of ways of coping with daily life situations. I would rather not use ‘coping strategies’, as that term implies something conscious or behavioural to be easily corrected – you just change strategy. Conscious strategy is just one aspect. Through Balint work as clinicians we have the opportunity to become increasingly aware of how our spontaneous or repressed reactions/responses are triggered by our daily interactions with people – be they patients or staff members or colleagues. These aspects are often deeply embedded in our personalities. It is a fascinating experience for doctors doing Balint work to compare the variety of such reactions and this tends to widen the perspectives for the individual members of the group.

Though the paper Andrew Elder first presented at the Warsaw leadership meeting last year might bring about a change, in my view the frame of Balint group work is discussed too little these days. By that I do not primarily mean the Balint “liturgy” – whether to use push-back or not, whether to be allowed to address the presenter or not. I rather refer to how the Balint leader explores the motivation of the members, the institutional and general conditions of their working life, and how the leader manages to articulate and introduce the New Reality of the Balint group . The Balint group - with its frame, purpose and limitations - becomes a new part of the external reality of its members and intersects with other professional and private realities, which in turn have their frames and aims.

Over the past say 5 years, I have become increasingly concerned about the working conditions of doctors in public health care in Stockholm. I have never experienced before during my 30 odd years as a Balint group leader that competent and efficient GPs – I am not talking about vulnerable colleagues – would cut down on their working hours and salary or find alternative part-time incomes (indeed a privileged option!) or leave their specialty altogether.

This leads to another question: What do doctors in general and GPs in particular want out of life? On one extreme we have iconic colleagues like Dr José Tomás de Sousa Martins of Lisbon fighting infectious diseases, tuberculosis particularly, in the poor parts

of the city, and Henryk Goldschmidt of Warsaw, more known as Janusz Korczak, the pediatrician and pioneer of children's rights who created educational institutions for orphans and other socially extremely exposed children. These were doctors completely devoted to their mission, based on an enlightened and secular approach to their fellow human beings. They sacrificed their lives as a consequence of their commitment. There is something saintly about them. In fact there is still a hundred and twenty years after his death a pseudo-religious cult paying homage to Dr Sousa Martins.

Then at the other extreme I am reminded of quite a few colleagues in a variety of medical specialties who are mainly concerned with their own well-being and glory, keen to consume, discussing golf, tennis or sailing rather than patients, eager to closely follow the development of the stock exchange even when they are on duty, and so on and so forth. When I presented Balint work at a WONCA congress some years ago I had a conversation with a high ranking WONCA official, a GP professor, who cut me short by saying: "You know, what doctors want is a good and comfortable life." As if advocating Balint work were contrary to it. Do I sound misanthropic? Then you hear me wrong. With the coming of age I have no illusions with some members of our profession but great hopes for others.

I think it takes a unique mix of personal and social conditions to shape doctors like Sousa Martins and Korczak. But for most doctors balancing a deep professional commitment and a decent private life is compatible, though at times it is complicated and conflicting. Such issues are part of Balint work. However, it does not resolve the problems of skews in the health care system featuring hard working underpaid doctors on the one hand and other doctors who can benefit grossly, some of them without even delivering the reasonable needs of the citizens whom they are supposed to serve.

Balint group participation in Sweden is voluntary. That is why I meet with committed doctors, and why I am spared the contact with those doctors who habitually take the easy way out. There was always much work for a committed doctor but I never before experienced that clinical work became *chronically too much*. Competent and resourceful colleagues who have a decent private life are becoming emotionally exhausted and mentally depleted. My understanding of the situation is that they are worn down by trying to fulfill an administratively impossible workload. This also makes them less resistant to the secondary traumatization inflicted on them by the predicament and demands of some of their patients. The significance of my impression was underpinned by a report in February this year: the prevalence of young female doctors, age 30-35, on the sick list in Sweden has more than trebled over the past 7 years, ( from 2.7/1000 employed in 2010 to 8.6/1000 today) the main reason being burn-out/exhaustion depression and similar conditions. Just before I came here the radio news confirmed that a noticeable number of doctors in Sweden are leaving GP practice.

Our Serbian Balint colleagues have given thought to and are involved in research on how Balint group work can be used to deal with burn-out among doctors. Certainly this issue is not only Swedish and Serbian. Indeed, the research on doctor's work satisfaction is methodologically more accessible rather than trying to measure the impact of Balint group participation for the patients of the group member (see Kjeldmand D: The Doctor, The Group and the Task, 2006).

Today one often hears that Balint group work is important for the maintenance of the professional capacity of the doctor and the prevention of burn-out. The argument has a useful "political value" - to justify the establishment of Balint groups.

But is this its most important function? Is it essentially its aim? What happened to Michael Balint's formula *research with training*?

### **The social and medical context for Balint work**

I once tried to describe the professional predicament of the general practitioner. But the more I have worked with other specialists the more convinced I am that this description fits doctors in other specialities of the public health service. It goes like this:

*The art of general practice requires an ability to improvise constantly according to the climate that is created between the doctor and the patient. The purpose of the consultation is not always clear - there may be important hidden agendas.*

*Working as a clinician demands flexibility, good working capacity, professional integrity, tolerance, social competence, care and respect for the most varied expressions of lifestyles and demands. This job is full of inner contradictions and, at the same time, it offers a possibility to be near life and people. If you want to build an ivory tower – try another profession.*

*I should also add the importance of clinical intuition, which is a natural gift but also improves with experience and a continuous medical training, such as Balint group work, which will help you to find the balance between trusting and doubting your senses.*

I am not alone in thinking that the function of the Balint group is primarily to support the doctor in doing her work adequately, in making her the *best possible version of herself* to her patients. As I see it, burnout prevention comes as a spin-off of this project.

I continue to be impressed by the personal qualities and training skills it takes to be a “good enough” doctor in public health. I am equally impressed by a particularity: that colleagues bringing cases to the groups so often are so dissatisfied with what they have achieved with their patients. As it turns out after a discussion on the case in the group, this is often due to the fact that these doctors are confused. They cannot distinguish the external reality of the consultation with their internal psychic reality! They think that they have done a bad job, whereas a critical, *primarily non-supportive but respectful, scrutiny* will reveal that they have done a decent job, sometimes even outstanding. But this does not match the doctor’s own perception! With some colleagues it really takes time for them to understand that they are as good as they actually are. The psychological mechanisms are complicated and can be phrased in many ways hidden so to speak behind doors carrying signs like *transference* and *countertransference*, *projection* and *projective identification*, and *depressive introjective propensity*. Missenard conceptualised one aspect in an *Ideal Medical Self* which silently is exerting its power inside many conscientious doctors, and serving as an unreachable standard of which we always fall short. It is a Procrustean inner situation which can deplete a good doctor. Not every doctor is conscientious, committed and sensitive. But doctors in voluntary Balint groups tend to be. Politicians and administrators for the sake of the citizens who have empowered them should promote and support such doctors. I dare even offer a cost-benefit analysis in support of this recommendation. Society will profit even when you see public spending as strictly a business enterprise.

### **The vicissitudes of Balint group work**

I mentioned the confusion of the doctor. The value of a Balint group shows particularly when you find it is impossible to sort out your professional discomfort on your own. It is a little miracle how fast at times a group discussion can help a confused doctor to gain a deeper insight – to become more conscious and less impulsively acting out, or complying to unrealistic demands. But Balint work is not always a dance on roses. Balint group participation even under favourable external conditions may be temporarily upsetting because professional defences and habits of the doctor, although dealt with in a

considerate way, nevertheless constitute a challenge to the doctor's equilibrium.

Sometimes impossible working conditions of the doctors are exposed, against which they are defending themselves, like loyal children who try to make their best in a dysfunctional family by blindfolding themselves to the worst insights. With loyal and hard-working doctors it can take years to see "the naked truth" so to speak.

In view of these challenges the group must be open to feedback of "bad/negative" feelings and thoughts that these discussions are triggering. A colleague may say:

*"I felt really miserable after the previous meeting, I did not know what to do with myself and with all the viewpoints you offered. And you as a leader were not of much help either".*

Those without Balint experience may think that such a remark would be the start of a deteriorating mutual trust, but in my experience with only two exceptions in 31 years, it is the other way around: it is a way to assert oneself and constructively criticise group work. It will help the presenters to gradually work through their difficulties, and it will help the group and group leader to reflect on what we are doing to each other.

### **Is there a shift of aim in Balint work?**

I have a feeling that there is a gradual shift of focus and aim of Balint work taking place in the past 15 years. Or was there a split all the time without my recognising it?

- from exploration (research cum training as Balint said) to support
- from development to maintenance and prevention of burn-out
- from exploration of the psychological defenses of the doctor in relation to the patients to support of the existing defensive structures or diverse (and sometimes diverse) educational techniques intended to bring relief
- from making sense of feelings and thoughts to staging catharsis through expression of feelings, dramatising scenes and educating group members how to reach feelings, even educating them how feelings should be expressed "properly" in a Balint group

Whether this is a developing trend or a long-lasting split I think it reflects how external conditions - including petrified local Balint traditions - affect and dilute Balint group work.

Now, I am brought back to a conference arranged by the Serbian Balint Society in 2010 here in Belgrade. I was invited to give a speech on the advantages of Balint work for the practitioner, to facilitate relatedness. A doctor in the audience said something like:

*"I do not have time for relatedness. I see 40-45 patients in the morning, I have five minutes for each of them. I have to finish my surgery by early afternoon and rush off to my next assignment. I try to do the best with each patient but it is not enough. What use can I make of a Balint group?"*

In retrospect I have to admit that I partially avoided her challenge. I said that the British GPs also only had, well, not five minutes but six minutes for the patient. Still they found it worthwhile to explore what went on in their meetings, and that we should not underestimate our clinical and human capacity which makes it possible, often instantaneously, to sense what is happening in a meeting. I probably made other optimistic and light-hearted remarks which I have by now forgotten. This colleague was a solid woman, she was radiating: *"Cut the crap, what are you here for?"* I felt I would not mind being her patient. If I would have a serious medical problem she would surely recognise it and deal with it adequately.

There is a Swedish poem beginning: "Not for warriors, but for farmers who without

complaint are toiling their soil, a God is playing the flute...". I imagine my Serbian colleague similarly as such a hard working farmer. But my concern is that no God was playing the flute to her, that she just tried to manage day by day an enormous work load which – with all respect - few of us visiting Belgrade here today would find manageable. In retrospect I think that she gave voice to what I just said: to explore complicated relationships through Balint group work is also exacting. Yes, true that Balint work can give immediate relief to the presenter. But primarily Balint group work is *not* a quick fix., the individual professional development is not always uncomplicated.

So back in 2010 in Belgrade I should also have answered my Serbian colleague that she was right and added that Balint work is not the cure for unsustainable working conditions.

I will tell you another story: Some years ago I met with an Eastern European psychiatrist who told me that he was leaving public health to establish himself as a private practitioner. It was a big step. You have to visualise him as serious doctor committed to his patients. I congratulated him on his independence and wished him good luck in the transition. He then answered with an ironic smile: "*From now on I will work in cosmetic psychiatry*".

He had obviously not learnt the lesson: never say anything jokingly to a psychoanalyst! I became quite upset at his way of characterizing the shift. I asked him why he described himself as a caricature? Was he not going to do a good job? Was he going to prostitute himself by only taking on members of the nomenclature who needed a shrink to get some distraction? Certainly not! Of course there was a painful inequality. Many of his previous patients at the psychiatric institutions could not afford treatment in private care. But most of them would also have great difficulties to benefit from a more extensive psychotherapeutic therapy.

While in public service he had tried to do something for his patients with the limited resources available. I knew that he had been brought up in a good psychiatric and psychotherapeutic tradition. I said that I imagined he now could care for people with substantial problems but who also had the inner resources to deal with them. He agreed.

I think this episode among other things illustrates the impact that the condition of the patients has on the doctor. I interpreted "cosmetic psychiatry" as partly an expression of guilt for abandoning very sick patients confined to the insufficient public psychiatric care system. Because, no matter how insufficient such a system is, good and well-trained people make a difference.

Again, it is an administrative and political task to provide resources to attract competent and committed doctors to public service. Politicians and administrators all over Europe have many important lessons to learn from previous successes and failures.

I am reminded that in 1984 I was working as a senior psychiatrist at a psychiatric hospital, a previous asylum for chronic psychotic patients, in Stockholm. I loved the work, challenging, transforming the wards to become adequate for the patients, integrating hospital care with outpatient facilities. I took five hours off very week to have a few therapy patients as a private practitioner affiliated to the national health subsidy system.

Suddenly the rules changed: NHS affiliated part-time practice was not allowed for those publicly employed. . To me it was a matter of being able to practice as a psychotherapist and psychoanalyst for people with ordinary incomes, as the tax system only allows for wealthy persons to pay for such treatments out of their own pockets. Within these few weeks at this hospital, we were seven

psychiatric specialists handing in our resignations so not to lose our NHS-affiliated private practices. The transition of this hospital from an asylum to a dynamic, efficient and caring psychiatric unit was thus hampered considerably. (As was my income leaving a deputy chief psychiatrist position but I made up for it by working two night shifts a week as a GP emergency doctor in an ambulatory service, which was an important experience and probably made me a more adequate Balint leader) For many years I felt sad about leaving so abruptly as I do not think I have done too bad a job as a private practitioner. But in retrospect, I think I would have been of better service to my society if it would have been possible to work part-time in both sectors.

### **Similarities and differences in the skews of health care systems**

I suppose generally in Western Europe as I see it in Sweden, the deteriorating public health care has created a market of private medicare insurance policies, hardly existing 20 years ago. With a private insurance you get specialised medical attention faster than those in equal need who are not insured. Several private clinics and hospitals have contracts both with public health and private companies and insurance companies. These companies function as middlemen for the money that will unevenly trickle down to the health care services.

Another skew in Sweden and I assume also in other Western European countries derives from public health becoming “market orientated” insofar that private companies are entering as care-givers. This carries the possibility of performing more efficiently than institutions under public governance, meaning better value for taxpayers’ money. After all, public health is not a market economy. It has a much greater resemblance to the planned socialist economy. The allocation of money depends on political decisions, market mechanisms are secondary. The price for various services is decided by an administrative, not a market procedure. Quality and price measures are subject to political intentions which contain a smaller or larger amount of arbitrariness, instability and skews which shrewd private actors will know how to take advantage of, much faster than they can be corrected, and thus the totality of public health resources will be used inefficiently. One consequence, in Sweden, is the economic conditions for running GP health centres in a serious way has been undermined. In contradiction, running an internet service for seemingly simple requests from patients all over the country without any knowledge of the particular patient, is extremely lucrative. Each such 5-10 minutes consultation is generously paid, a multiple of a visit to the local GP centre, and more than 10 times the fee I could claim as an NHS-affiliated specialist. Thus the local health care budgets are depleted by innovative entrepreneurs using loopholes in the system..

In the east as I understand, there are often parallel informal and well organised systems for paying extras within the public health care: you pay ward nurses and surgeons, otherwise you will not be treated or you will have to wait or be neglected. Here, if I understand it correctly, the trickle down is direct with no external middlemen. Another skew consists in the medical hierarchies, which of course affects your “trickle down-postion”. As a doctor in primary care your options using your medical skills are very restricted and might affect your decision making in the end. You are not allowed to refer for more extensive diagnostic procedures, even when it is obvious from a medical viewpoint that they are required. Only the simplest and cheapest diagnostic procedures are at your disposal. Otherwise, you will have to refer to the next level. GP practice thus becomes less prestigious and competent, less efficient and less comprehensive – a place

western European GPs left many decades ago.

I am tempted to say much more about the macroeconomic consequences for health care with these systems but it is too far-reaching for this presentation.

*Demanding patients* can from time to time constitute a severe problem: in the west the doctor is not only a provider of care but the mediator of significant social benefits that she can authorise or not. The doctor also is the provider of subsidised attractive and or expensive drugs. Some patients are very difficult to resist and once you are caught in the web it is difficult to free yourself. In the east the demands of the patients can be aggravated by the instability of social conditions, doctors will not infrequently feel literally threatened if they try to maintain their professional boundaries. But this has become increasingly frequent in the West as well.

*The entry of western pharmaceutical companies* into new eastern European markets caused a largely unrestricted commercialisation. People previously deprived of the latest fashions in every aspect of life during the communist era, through advertising – so I was told by Eastern European Balint doctors - have become attracted to the latest *pharmaceutical* fashion. Also in Western Europe these days, neo-liberalism allows for an increasingly seductive and aggressive advertising.

Given all these circumstances, the autonomy of the doctor is relative. But when does it become a real threat to professionalism? Balint work can make these conditions clearer and visible, but also cause more pain and frustration. I remember a Balkan Balint colleague saying about a case: “To those whom you love you do not want to tell the naked truth”. ( because it is thought of as too painful)

The Balint group is good for serious and constructive talks on subjects that cannot possibly be discussed in public. And I think that a good and trusting Balint group allows for saying uncomfortable truths out of concern. I also think protecting colleagues from relevant painful aspects of their work also can cause long term injuries. Winnicott divided people into avoiders and seekers. I guess that most people are a little of both. But I think Balint work is designed for doctors with primarily a seeking – and not an avoiding - inclination. To see one’s conditions as they are takes time. But in the end it will promote professional maturity and so the patients will have a better and more trustworthy doctor.

**Given by Dr Henry Jablonski**

## President's Report 2017

My last year as President of the Society, after which I will leave council, after about 25 years, began after the Oxford 2016 conference with a trip to Warsaw for the IBF Leadership Conference, which is a biennial event. Apart from the attraction of sharing leadership skills around the world which this meeting gives, I needed to go to the IBF Council meeting to update the IBF on our plans for the 20th IBF Congress, to be held in Oxford from 6-10 September this year, 2017. The IBF council meets twice a year, and is made up of members, chiefly officers, from all the member societies. It discusses IBF business brought to it by the IBF Board which is the executive of the IBF, consisting of its officers only. The IBF also has a general assembly meeting, which will happen at Oxford, and is open to all like our Balint Society's AGMs.

Organising the Oxford congress has taken up a lot of my thoughts, along with those of Ceri Dornan, Caroline Palmer and Martin Tilling (my partner), who constitute the organising committee. Other council members and others have also been helpfully involved with the planning on a less mundane level. The other activities of the society have also been pursued by our active council. Chiefly, at the moment, leadership training, groups for psychiatry CTs (and associated liaison with the Royal College of Psychiatrists), and the wide dissemination of Balint groups for medical students, taking place through psychiatry. Doing these last two things has brought the question dramatically to the fore of why the Royal College of Psychiatrists is so interested in Balint groups, whereas the Royal College of General Practitioners seems practically to ignore them. I will return to this later on

From the start we set out to make the Oxford IBF congress a large meeting, up to 200 delegates is the target. Overseas trips for me to promote the congress have been many. Apart from Warsaw, I have been to Aachen for a German Balint weekend (described elsewhere in the journal), to Belgrade for the first international Serbian Balint weekend and another IBF council meeting, and I will be in Ireland for the Sligo Balint weekend, and lastly before the autumn, in Moscow leading groups for Russian and Armenian Balintians, alongside a group of German leaders, and Andrew Elder. Of course I enjoy the travel but it is also hard Balint work, and hard socialising to promote our society and the British way of doing Balint, which has perhaps changed less from its origins than that in other countries.

Apart from working at weekends with many psychiatrists and psychotherapists, I have been involved in leadership training events, in February in London before the annual dinner, and in June in London. There was also a day organised in January by the RCPsych to talk about student groups, at which, along with others, I represented the Society. The Balint Society seems to have a lot of respect from the RCPsych, and many prospective, and existing Balint group leaders, who are members, continue to seek leadership accreditation through our society.

I have this spring approached the RCGP directly to try to see how we can work with them. The new Chair of Council, Helen Stokes-Lampard will speak at the annual dinner in February 2018, but we have also hosted the last few Council Chairs to little ongoing effect. We have been an "affiliated society" since I became president, but this has lapsed into inactivity on their part. I pointed this out, and that the documents in relation to the proposed lengthening of the VTS period to 4 years mention the essential nature of the consultation, but assume that it is "sorted" in the first year as a GP registrar. I hope it is in relation to these that we have now arranged a meeting with two high level RCGP officers

in July. I will go with Suni Perera, a long time NW London Balint doctor, who is still active in practice and runs a VTS scheme. My hopes for this meeting are to ascertain how the RCGP views us, how they view ongoing education/learning in consultation skills, and whether we may be a part of this. Also whether we may play a part in their wider educational and research agenda, providing expert advice on the doctor-patient relationship and the consultation? I feel this may be a tall order and that the meeting hopefully will prove more of a reintroduction and form part of an evolving positive new relationship. I am all too aware of the huge problems the profession faces which the RCGP has to deal with but hope that we can help not to lose the basis of general practice, the ongoing doctor/patient relationship in the consultation.

After the Oxford conference, I look forward to continuing to be involved in the 4 Balint groups I lead in, to continue to attend British Balint weekends, and to go on representing us overseas as required. My long service to the Balint society and the Balint Society Council has been almost equal for me professionally and personally to the 25 years long relationships with patients and colleagues, from which I retired almost 4 years ago. It will continue for some years yet, but without organisational involvement on Council.

**D Watt**

## **Balint Society Secretary's report 2016 – 2017**

The Balint Society has had an active year on a number of fronts including engagement with other organisations and the involvement of more members.

Much time and effort has gone into preparations for the International Balint Federation Congress, which we are hosting in Oxford In September 2017. By the time you read this, the Congress will have come and gone and will be reported on in full in next year's Journal, but just now the anticipatory anxiety levels are fairly high, but so is the excitement. The theme of 'Balint Theory and Practice: Exploring Diversity', has attracted some very interesting submissions of papers. posters and workshops and registrations have already, in June, almost reached our limit of 200. People from 29 different countries have registered to come. A day for medical students is planned for the Saturday of the conference. David Watt, in his President's report, has mentioned the many international connections we have and wish to continue.

We think our website based event application system is working well, with some learning still in progress to make optimal use of the CiviCRM software. We are lucky to have Helen Lycett as administrator with willingness and ability to grasp the challenge of getting to know the intricacies of CiviCRM, with the support of IT Consultant Graham Mitchell. There are occasional interesting hurdles to jump, such as the time when we found that if two people try to register for something using the same email address, you end up with two registrations under the same name as well. All part of our development we suppose. We still have to find the best way to take recurring membership payments so our database is automatically updated, but there is a system to join online for a year. The next tasks are to develop an online record for the leadership pathway and work on the information which we would like to be able to take out of the system for development of our main purpose, which is to promote Balint work more widely.

The regional reports published later in this Journal, show how much has happened throughout the UK over the last year and how more areas are becoming Balint active.

Much of this activity is thanks to the work of the Leadership Team and willingness to go to sites expressing interest to offer training, with the benefit of leaving leadership skills behind to cascade out further. Weekends continue to draw people and leadership days are happening across the country.

The Annual Dinner was held on 10th February 2017, once again at the Medical Society of London premises and following a successful leadership study day. The guest speaker was Professor Jocelyn Cornwell, CEO of The Point of Care Foundation, which has as its mission to humanise healthcare, for those who are cared for and those who care. Professor Cornwell spoke in particular about Schwartz rounds, which offer an opportunity for staff at all levels of an organisation to be part of a case discussion, with an emphasis on emotional impact. The examples given illustrated how often forgotten members of staff, such as porters and bed managers, can be both present for patients at key times during their time at hospital and be affected by their interactions with patients and relatives, and the value for other staff of hearing this.

2017 has been a year for the Michael Balint Memorial Lecture to be delivered. Dr Pat Tate, GP and Psychoanalytic Psychotherapist, spoke on the title 'Rules'. This was a beautifully crafted talk, taking the audience from a lively conversation with a grandchild on the way to school, to Alice in Wonderland and all its upside down ideas, to the early rules of psychoanalysis (often broken by their originator, Freud) and interpretation of these by analysts such as Balint. To give more detail would be to spoil the opportunity for you to hear for yourself. A podcast of the talk is available on the Balint Society website Rules: Dr Pat Tate.

The RCPsych Medical Student Psychotherapy Schemes project, started three years ago by Professor Sir Simon Wessley, has resulted in wide interest amongst medical schools. The activity is mostly to run Balint groups, some as pilot projects, some on-going. A day held in January to present and demonstrate the work was very well attended and ably illustrated by medical students themselves. Balint Society representatives have been on the working party for this project and involved in development of many of the schemes. Fortunately, although Simon's term has ended, the RCPsych is continuing the project and the Balint Society will continue to be represented.

In addition to our usual Council meetings, Council, the Leadership Team and several longstanding Society members met on 11th March 2017 for an away day thanks to the generous hospitality of Andrew and Penny Elder. We had very helpful facilitation from Charles Lauder and Wallen Matthie of Talawa Consulting, who had worked with health organisations but are not themselves health practitioners. Council thought that it was timely to think about the direction of travel of our Society at a time when membership is growing, more members are now from professions other than General Practice and Balint work is being taken up actively by medical schools, for junior doctors and in non-health settings such as teaching. Leadership training and supervision have been an expanding focus for several years. The day was the starting point for an on-going working group to take the main ideas generated forward into a development plan for the next few years. Members will hear more about this later in the year. Much energy was generated by the day, so the future looks positive for the Society.

On a personal note, as I leave Council I would like to thank Council colleagues, and others in the Society, who have supported me as Secretary over the last few years. I think we have achieved a lot together. I have every confidence that the work of Council will be very ably continued by the proposed new members and the remaining members, and that the Society will flourish in their care.

**Ceri Dornan**

## Reports from around the Regions

*Balint work continues to develop in the UK as you will see from these reports from our regional representatives. If you would like to know more about what is going on in your region and get involved please get in touch with them, or our secretary. We are encouraging the development of peer supervision groups for Balint leaders – details of these groups including the person to contact if you would like to join and be on the mailing list are on our website [www.balint.co.uk](http://www.balint.co.uk) and in the Journal. If you are interested in becoming an accredited Balint group leader have a look at the pathway on the website and come along to our leadership training days and weekend workshops. We can put you in touch with an accredited leader to provide some supervision. Finally, if you are leading or in a Balint group which we don't know about, or would like to start something new we would love to hear from you.*

### Balint in Ireland: A story of unfolding

Planting seed and germination is an art. It requires both good ground and seed with attention to detail. At an official level General Practice training policy pays scant attention to the emotional intelligence of doctors. Individual GP training schemes provide Balint groups to their trainees, but this is not organised in a cohesive way with few of the providers having any exposure to group training or Balint training themselves. The challenge here remains that of cultivating this interest and developing the skill set. No Balint is better than bad Balint! It is difficult to quantify the amount of Balint activity in Ireland given that what work is occurring is unstructured. It is growing though and is at an early stage. The hope is that Balint will grow through GP training schemes and groups for doctors in the community organically.



**Delegates dining at the Sligo Weekend.**

### **Sligo Balint weekend 2017**

The Sligo Balint Symposium in June 2017 was very successful. Forty eight participants from across the breadth of professions were very active in the splendour of Yeats country. Discussion both within the formal and informal setting was lively and old friendships strengthened while new ones were forged. The Plenary threw up the dilemma of how to engage the medics in reflective activity and how to make participation in Balint easier. A plan is in formation to increase the visibility of Balint in Ireland and will involve symposiums in Cork and Dublin respectively. The vision being Cork, Dublin, Sligo and Belfast working together in a loose affiliation to 'cover' the country.

**Patsy Brady**  
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### **Belfast Balint Weekend 2016**

The third Belfast weekend was held in November 2016 at the Holiday Inn organised by Glenda Mock, Marie King and Christine Christie. Thirty seven delegates from the UK and Ireland enjoyed the unusually good weather and the festive atmosphere. The incoming Balint Society UK president Caroline Palmer spoke movingly of her own experience working in Medicine. During the weekend there were four 90 minute Balint sessions, a leaders Workshop and a fishbowl experience. On Saturday afternoon professional Irish Historian Dr Chris Loughlin led an interesting walk around central Belfast landmarks. Fortunately the weather was dry. Saturdays dinner was again held in the Robinson and Cleavers restaurant from where we could see the switching on of the Christmas tree lights in front of the City Hall. Many delegates also explored the Christmas markets and the local hostelrys late into the evening! As always, it was the participation of the leaders and delegates that made the experience so rewarding. We hope to run the next event in Belfast in November 2018 and look forward to welcoming many friends back again; as well as meeting new ones.

### **New Balint Group in Belfast**

Christine Christie and Glenda Mock have opened a new Balint group based in Belfast, This is intended to run on a long term basis. We are delighted to include four GPs, two psychiatrists, a clinical psychologist and a dentist. Many of the members have had previous experience of Balint work and so the group established itself very quickly. Balint group work is now mentioned on the Northern Ireland Medical and Dental Training Agency website thanks to Marie and hopefully this will also raise Balint awareness in the Province.

**Dr Glenda Mock**  
**glenda.mock@doctors.org.uk Belfast N Ireland**

## **London and the South East**

The year started as usual at Corpus Christi College with the Oxford Balint Weekend in September 2016, with the theme 'Enriching your Practice'. Andrew Elder gave the keynote address to the forty six participants. The Balint Study Day and Dinner in February at the Medical Society of London, organised largely by Dr Jane Dammers, was well attended - both the leadership training day, and the evening, when the after dinner speech was given by Jocelyn Cornwell, CEO of the Point of Care Foundation. The next day was the fourth

Supervision Study day for those accredited leaders offering supervision to other leaders. We held a second leadership training day in London in June led by Dr David Watt and Dr Helen Sheldon.

Three GP Balint groups continue in London and one in Brighton. We hope that another group will start soon in West London. There are also some slightly different Balint groups - an ongoing group at the PHP (Physician Health Partnership), led by Andrew Elder and Anne Tyndale, three Balint groups operating within large general practice partnerships, and groups in several GP Vocational training schemes.

### **Medical Student groups**

The Royal College of Psychiatrists working group for developing medical student psychotherapy schemes and Balint groups continues to meet on a quarterly basis and has promoted the development of medical student Balint groups in England. They are offered at a number of London medical schools viz

University College London: Balint groups are well established for students in their first clinical year. Unfortunately the groups are no longer offered as a Student Selected Component (SSC) and student uptake has decreased slightly.

Imperial College School of Medicine: Anne Patterson has organised Balint groups for students in their psychiatry placements since October 2016

St George's Medical School: Eamonn Marshall has been leading a medical student Balint group with Dr Caroline Reed O'Connor. Balint Group work with medical students was piloted at St George's in the spring of 2016. The first group of eight students ran for eight weeks and is the subject of an ongoing research project, examining narrative accounts of the group process by the Leaders and structured interviews with the participants after the conclusion of the group. A second group of eight participants ran over twelve weeks between October 2016 and February 2017. The third group of four students for twelve weeks concludes in July 2017. These groups have been offered as an SSC in the first clinical year of training – their Transition or "T"-year, in which the students venture out more fully into hospital wards and GP surgeries for the first time. Funding for leadership fees is through SIFT (Service Increment for Teaching) funding and the room, administration and Registrar time are provided by South West London and St George's Mental Health Trust. We hope to run a group for eight students over twelve weeks or longer from Sept 2017. Apart from the evident benefits of examining the complexities of the student-patient relationship the leaders have been struck by the relief being expressed by the students about the relative luxury of having a dedicated open forum for reflecting upon the unique pressures they experience in these early years of clinical practice.

Barts and the London School/Queen Mary University: a new project offering Balint groups to 1st year medical students during their day in practice as part of the Medicine in Society module. There are five groups, being co-led by psychiatry trainees and GPs. Helen Sheldon has provided supervision to the ten leaders.

Kings College London School of Medicine: weekly Balint groups will be offered as an SSC from September 2017. The groups will be co-led by higher trainees in psychiatry and supervised by Barbara Wood and Helen Sheldon.

A leadership training day for trainee psychiatrist leaders involved in the Barts scheme took place in September 2016 and will be repeated this year. Two leadership training days at Kings are planned for July and October 2017.

### **Foundation Year groups**

There are FY1 and FY2 groups at Newham run by David Watt and Paul Julian, although recently their continuation has come under threat due to funding issues. At UCH there is a FY1 group which meets weekly during the surgical rotation. The groups are co-led by psychiatry trainees under supervision from Helen Sheldon.

The London Balint Group Leaders Workshop continues to meet three times a year at the Tavistock, supporting all the work in London and the SE, co-ordinated by David Watt. Usual attendance is between eight and twelve people, one of whom, or a leadership pair, presents their group. We all work hard to help the presenter and understand group leadership issues which arise.

**David Watt david.watt7@nhs.net**  
**Helen Sheldon helen@sheldon51.co.uk**  
**and Eamonn Marshall**

## **Bristol**

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

This scheme, which was started in 2012 by Ami Kothari and Judy Malone, is now in its fifth year and continues to offer all 3rd year medical students at Bristol University the opportunity to participate in Balint groups. Since we started we have offered Balint groups to 780 medical students and over 20 psychiatry trainees, from CT1-ST6 grades, have had the experience of leading groups. This year we offered 16 groups led by fourteen trainees, one SAS doctor and one consultant. Evaluation of the scheme is ongoing and feedback continues to be mostly positive. The scheme has become embedded in the medical student curriculum and continues to be endorsed by the Severn Deanery School of Psychiatry which values and supports the use of trainee special interest time for participation.

We have continued to develop Balint groups for Foundation doctors and trainees are keen to gain more experience in Balint group leadership. Two trainees have been successful in gaining accreditation as group leaders.

We have continued to use our funding from Health Education England and the Royal College of Psychiatrists to share our model and link with interested psychiatry trainees across the UK and have delivered training in Birmingham and London over the year.

We are pleased to be members of the Medical Student Psychotherapy Schemes Working Group at the Royal College of Psychiatrists and were delighted to support two of our medical students presenting at the Medical Student Psychotherapy Schemes Symposium in London in January 2017. This one day symposium was organised with the aim of informing others about established UK medical student Balint groups and psychotherapy schemes with the hope of assisting the establishment and development of similar schemes.

We are pleased to have decided to involve medical students in our planning and steering groups. From September 2017 2 medical students will join with more experienced leaders to co-lead medical student Balint groups and they will attend supervision and training. Medical students who have experienced Balint groups will be invited to join the team in offering an introduction to Balint for the following year group. Students are keen to choose Balint group work as a topic for student selected component (SSC) work in the next academic year.

### **Leadership training**

Trainees leading groups attend regular supervision with Judy Malone; Eva Stigaard Laird and Clare Trevelyan have offered peer supervision this year. We are grateful to Jane Dammers for offering additional supervision and support. We continue to offer trainees biannual leadership training days. The second Bristol Balint leadership study day was held in December 2016, in conjunction with the Balint Society. The event was very successful and was attended by a range of clinicians from different disciplines and from the private, voluntary and public sectors. We are holding a further study day on Friday December 1st 2017 along with a presentation by Dr Gearoid Fitzgerald on Saturday morning December 2nd - see website for further details.

### **Balint groups in Bristol**

There are numerous Balint groups that continue to run across Avon and Wiltshire Mental Health Partnership Trust. Judy Malone continues to lead a Balint group for GPs in Bristol and there is interest in and around Bristol and the South West for further groups to develop.

**Dr Judy Malone**

**Psychoanalytic Psychotherapist and Psychotherapy tutor, AWP NHS Trust**  
**[judy.malone.work@gmail.com](mailto:judy.malone.work@gmail.com)**

## **Midlands**

### **Leadership development and peer supervision group**

There is a continuing increase in interest across the region in Balint work. More people are proceeding to accreditation for Balint Group Leadership, and groups are popping up into being. A new Balint Peer Supervision group has begun meeting in Birmingham at the Edgbaston Golf Club midweek, every two months, and has a potential membership of 18 members. At least seven members are in the process of acquiring leadership accreditation at present and are joined by an unspecified number of interested parties. There are clear signs of growing interest in Balint in the region.

### **Balint groups in the Midlands**

1. The **Telford** group is now well into its third year and well supported. This mixed group of GPs, Palliative Care consultants and psychiatrists meets monthly. Facilitation is by Shake Seigel, assisted by Diana Webb and recently Chris Brown who is currently embarking on leadership accreditation. The venue is Severn Hospice and meets monthly. This group could possibly accept new members.
2. The longstanding **Burton-Lichfield-Tamworth** group still meets monthly after 34 years. Facilitation is done in rotation by members in private homes.
3. Two **Birmingham** groups continue to meet regularly. One in central Birmingham being facilitated by Sylvia Chudley, and another in the south of Birmingham facilitated on a rotating basis by members.
4. **Sandwell** Hospital has started a new group, facilitated by Diana Webb. This group consists of mixed hospital specialities.
5. Palliative Care group: trainees and new consultants have continued to meet as a group in private homes.

6. A group has also been established in **Nottingham** and is being facilitated by Bertram Karrasch. This group is open to new members. A GP VTS trainee in Nottingham is looking to run a research project on the potential benefits of being in a Balint group. Watch this space.
7. A “**skype**” group of former GP trainees from the region still exists. This is a creative alternative for young GPs who have chosen to stay in touch by skype, following a short series of introductory groups run by Bitty Muller and Shake Seigel. Geographically they are now scattered across England.
8. **Birmingham University Medical School** has introduced groups during psychiatry attachments and community health. These are being facilitated by Isabelle Akinojo and Helen Campbell as well as Specialist Registrars in training.
9. A mixed membership group, but mainly drawing from the **West Midlands Institute of Psychotherapy (WMIIP)** membership, has been meeting monthly at the Friends Meeting House in Edgbaston for the past 18 months. This group is currently facilitated by Shake Seigel.

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

## North West of England

### **Manchester area Balint groups**

Two groups continue in South Manchester. One is co-led by Louise Ivinson, Psychoanalytic Psychotherapist and Ceri Dornan, former GP. This began as an all-GP group but now includes two psychiatrists and is seeking new members across disciplines. The second group is an all GP group at present, co-led by Simon Henshall, GP, and Ceri. This group is also seeking new members from all primary care disciplines.

Simon Henshall, supported by Ceri and Mark Perry, has introduced two Balint sessions per year to the Salford and Trafford VTS, a tradition which is becoming well established in the programme.

Alison Summers, a NW Medical Psychotherapist who volunteers at the Centre for Victims of Torture, was supported by Ceri to run a Balint group session for clinical staff working with clients. At the moment, this is not ongoing, partly due to geographical problems in getting people together, but gives the centre management something to consider, after a powerful group experience.

### **Balint leadership training days and North West Peer Supervision Group**

Following a day in April 2016, Helen Sheldon, who previously worked and lived in the NW, and Ceri, ran a further day in October 2016 and have another planned for October 2017. At the meeting in October we experimented with different approaches to running a group – on that occasion we had one group with the presenter sitting in and one with the presenter sitting out,. This offered different ‘live’ experiences leading to stimulating discussions. Of note is the shortage of GPs coming forward for leadership training. Our peer supervision group draws members from a wide geographical area including North Wales, Cumbria, Lancashire, Merseyside, West Yorkshire and Derbyshire as Manchester is accessible from these all areas. While numbers are mainly too small to set up more local groups at present, this may change as interest grows. We meet on a Saturday morning

and usually discuss someone's group as well as general matters. There is enthusiasm to keep in touch, even though not everyone makes each meeting.

**Ceri Dornan**  
**ceri.dornan@gmail.com**

### **Balint Activities in Lancashire**

In early April there was another very successful Balint Weekend Workshop at the delightful venue of Whalley Abbey, attracting over 40 participants from a culturally diverse working landscape, though sadly with only a few GPs. People travelled from far and wide, including a psychiatrist from Australia who came for the weekend. We ran two leadership training groups, with rotating leadership, group membership and observer roles, as well as two 'normal' Balint groups. Although the overnight accommodation at the Abbey conference house is limited there is plenty of additional accommodation locally, and everyone agreed that the venue is so



**Delegates at Whalley Abbey.**



**Whalley Abbey.**



**Delegates dining at Whalley Abbey.**

special and conducive to thoughtful reflection that we should continue to meet there. So Whalley Abbey has been booked again from 16-18 March 2018 and 6-8 April 2019.

Weekly Balint groups for Psychiatrists in training are running in Preston, Blackburn and Blackpool led by medical psychotherapists Dr. Phil Brown, Dr. Swapna Kongara and Dr. Alison Summers who are all accredited leaders. Some of the group members attending seem to find the sessions very interesting and appear keen to continue with Balint group attendance and experiences beyond their designated quota which is encouraging.



**Drinks at Whalley Abbey.**

Since last summer, a group for 'Clinicians in Practice' has been running fortnightly during term times at a community hospital in East Lancashire, led by a retired local GP, Caroline Palmer and at first co-led by Clinical Psychologist Laura Fisk and more recently by Nurse Psychotherapist, Cheryl Williams. This has attracted GPs, consultant psychiatrists, a clinical oncologist, a nurse practitioner and an osteopath. This has proved a rewarding experience, with such a rich diversity of perspectives represented. Sadly the pressure of work on some of the GPs has meant that although they have found the group both stimulating and supportive they have had to withdraw until the autumn, when they hope that time pressures may have eased allowing them to return to the group.

A Balint Group has been running in Preston for Manchester University Medical Students who are keen enough to opt in to it, led by Drs Phil Brown, Consultant Psychotherapist, and Simon Belderbos, Consultant Psychiatrist and Undergraduate Tutor. New groups for medical students are being launched in August this year, allowing all Manchester students based in Preston to experience Balint group work during their Psychiatry placement. There have been positive talks with the University of Lancaster to provide further experience of Balint work for all medical students. There has been definite and gratifying progress since the taster sessions that Sally Wraight, a GP in Kendal, and Caroline Palmer ran in the summer of 2015.

Overall it is pleasing that there has been growing Balint activity in the North West of England but it would be heartening to be able to engage with more GPs.

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

## **North East England and Leeds**

### **Tyneside and Teeside**

We have four thriving mixed groups for GPs and other professionals in and around Newcastle and hope to start a new group on Teeside in the coming year. A pilot scheme for foundation doctors in South Tyneside has been successful and is being extended to a second group north of the river which is very encouraging. The group for psychiatry trainees in the region continues and there is Balint work in the VTS scheme on Teeside. Some embryonic Balint groups for medical students are happening in Newcastle Medical School.

We invite all our leaders to attend our termly peer supervision workshop and are encouraging new leaders to co-lead with an experienced leader. We had a Balint evening at the Miners Institute in Newcastle in June for all those involved in Balint work in the area. It was well attended and good to bring people together. Esti Rimmer and Jane Dammers gave a version of their talk 'Balint and the Body' which was presented at the Newcastle weekend in 2016. We plan to have another weekend in Newcastle in June 2018. Esti and Jane are also planning a leadership training day with colleagues in Scotland in the autumn.

**Dr Jane Dammers**  
**jane.dammers@ncl.ac.uk**

## Leeds

Balint in Leeds and surrounds continues apace. In Leeds we have a scheme now for medical students on their placement in psychiatry and a second group for specialist registrars in all psychiatric sub-specialities. Some new group leaders are in training and Balint groups are held in North Yorkshire, South West Yorkshire, Bradford and Leeds training schemes in psychiatry. We plan to set up a peer supervision group for Balint leaders in the area starting in early 2018.

**Dr Gearoid Fitzgerald**  
**gearoid.fitzgerald@nhs.net**

## Wales

### **Balint Regional Report for Wales**

An exciting development for Balint work in Wales is the Experiential Balint Group Study Day being held in Chepstow on 7th July 2017, hosted by the Royal College of Psychiatrists in Wales Medical Psychotherapy Working Group. This event is intended for a multidisciplinary range of clinicians including GPs and Trainees and will consist of three Balint groups led by Judy Malone, Clare Trevelyan, Linda Mary Edwards, Ray Brown, Kate Dufton and Clare Cribb. Dr Kate Dufton, Medical Psychotherapist is happy to respond to any queries about Balint opportunities in South East Wales at [kedufton@doctors.org.uk](mailto:kedufton@doctors.org.uk)

Despite a lot of interest in Balint work, the monthly Wrexham Balint group struggles with attendance, due in large part to the geography of North Wales and the pressures on clinicians. When the group meets, it works well. The group is led by Ann Evans, GP, and members consist of GPs, Counsellors and a Counselling Psychotherapist.

The termly Balint group for the Dyffryn Clwyd GP VTS, led by Ann Evans and Linda Mary Edwards, Group Analyst, continues to thrive with group members participating well in the Balint process.

**Dr Ann Evans**  
**evansann@live.co.uk**

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# South Yorkshire Region report: 2017

## Leadership.

There are several people going through the accreditation process. – attending weekends and study days and leading the groups under supervision. The interest in accreditation is steadily rising. Alex Pavlovic is currently supervising one person and planning to take two more later in the year.

There will be a Balint Weekend 24th to 26th November 2017 at Kenwood Hall. Applications will be opened at the beginning of July.

A number of groups are running in South Yorkshire:

1. In St George's there is a group for trainee Clinical Psychologists and another one for trainee psychiatrists. There is also a group for Foundation Years doctors at Fulwood House and these have been evaluated by local psychiatrists and the evaluation will be published.
2. In Chesterfield Royal Hospital there is a trainee psychiatrist group.
3. Sheffield Medical School is very keen on Balint Groups for Medical Students and runs successfully 3B ILA Masterclasses, a type of Student Selected Component. It runs 5 times for 3 hours. This is set up by a group including Undergraduate Lead for Psychiatry Helen Crimlisk, Primary Care Lead Jenny Swann, Consultant Psychotherapist Harriet Fletcher and Consultant Psychotherapist Joanne Carley and are run by local GPs and Psychiatrists.
4. There is a Balint Group for Occupational Health Practitioners at Occupational Health Services lead by Dr Kerry Hicks, Clinical Psychologist.
5. Steve Delaney and Libby Kerr are starting a group in October for psychotherapists, GPs and anyone else interested at Share Psychotherapy. They are running an introductory workshop on the 24 July at Share Psychotherapy – this will be an opportunity to introduce the Balint Groups to a wider audience.

## Research

Alice Monk, Daniel Hind and Helen Crimlisk from the School of Health and Related Research (ScHARR), The University of Sheffield, have conducted a systematic review of Balint groups in undergraduate medical education and this is now submitted for publishing. It is an important piece of work as it summarises available evidence and points to a gap in research. We hope this will give an impetus to further studies in this area.

**Regional rep: Dr Alex Pavlovic email [dralex@doctors.org.uk](mailto:dralex@doctors.org.uk)**

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## A German Balint Weekend-in Aachen

The German Balint Society (Deutsche Balintgesellschaft) has a tradition of weekend meetings as old as ours. Their society being much larger than ours, the choice is huge. There is one almost every weekend of the year in a different part of the country, often in beautiful historic places. A new departure has been made by Dr Guido Flatten in Aachen, where for the last 3 years he has tried to make an international weekend. I was invited this year for a second time to lead an international Balint group from May 12th to 14th. The title of the conference was “Embodiment-BodySoul in primary care”. The venue is right in the city centre, and is a convenient, modern Catholic meeting centre.

The structure of the weekend is somewhat similar to ours, but not the same. We started at 3pm on the Friday afternoon with welcome speeches, then a 90 minute large group. German large groups are not the same as ours. They are a variant of an ordinary group, rather than a specifically teaching/learning or demonstration group. A small group works within the outer circle of all the conference participants, but then after the group has discussed the case, and the presenter has returned to the group, the leaders allow the whole outer group to comment/discuss the case, returning to the small group at the end for 10 minutes or so. The case presented on this occasion was from a GP, and was a depressing story of a young man from a dysfunctional family, resorting to heavy cannabis use, apparently limiting his progress in life, which the doctor wanted to encourage.

Next, till 7pm, was the first meeting of the small Balint groups. There were more than 50 participants, so there were 3 ‘ordinary’ Balint groups, 2 leadership training groups, and my ‘international’ group. The largest foreign presence at the conference was about 8 older doctors and therapists from Russia, who speak neither German or English. They have a simultaneous translator for all the sessions and are not placed in the International group. After the small groups there was a lecture about philosophy in medicine by an eminent specialist at 19:15, followed by a convivial buffet dinner. Saturday had 3 small group meetings, and from 17:00 two lecture presentations. Lunch was not provided but there was plenty of time in the break between the second and third groups for a bite, and some sightseeing in the lovely spring weather. The first of the two lectures was from a Danish scholar and doctor, Dr Annette Davidsen, postulating that Balint and mentalization together make sense of the unique work in primary care, which we need to preserve in all our countries. The second paper was about “Authentic Movement”, a kind of therapy related to dance therapy, involving looking at free movement by the patient. Both these talks had translated hard copies available to follow, but it was still very tiring at the end of the day. The Saturday also had an influx of students and doctors joining the other groups for a “Sniffer” (rather than taster) day of Balint. The International folk were entertained very nicely by Dr Flatten in the evening at his home, a small holding on the edge of the city, where he keeps horses, sheep, chickens, dogs and cats!

On Sunday was the last small group session, another large group run in the same way as the first one. The patient this time was an 8yr old girl at the centre of a very complicated refugee family in Armenia that the presenter had had to leave when she got married recently and moved to Berlin. The conference ended with a short plenary session, and then those involved with next year’s conference (which appears to include me) met for a brainstorming session over coffee.

I will briefly describe the small group I was involved with. My group, co-led by Dr Flatten, had 8 participants (plus one who joined only on Saturday). Most were German doctors who wish to speak English, 2 of whom (a couple) were GPs locally, 2 ordinary

psychiatrists working nearby at a 450 bed mental hospital. Others were a Greek therapist who works in English in Aachen, a Romanian immigrant Doctor training in psychiatry, a medical psychotherapist, a young Armenian psychologist, recently moved to Berlin, and a young Russian psychologist, desperately trying to improve her English! The man who joined on Saturday was a Dutch psychoanalyst. The group formed very well and delved deeply through the weekend. Most cases were discussed for 90 minutes, but I did introduce one session where we had two 45 minute cases. This was interesting as it elicited recent brief contacts, who had just been seen and would be seen the next few days again. They were urgent, rather than cases of long standing difficulty for the presenter. The patient would definitely be helped by this reflection in the group very soon. If there was a theme in the cases it was definitely the inclusion of the body with the mind, patients with physical and mental problems. For instance, a mid-40s train driver unable to work because of right arm pain, coming to the end of his benefits payments, a 74 year old female nurse with thoracic spine damage when she was working in the USA who has returned depressed to small town Germany with few links. The group worked hard, but was very warm, even in its criticism.

The whole conference was pervaded by warmth, heartfelt welcome, and hard work. These characteristics of Balint workers are shared between us. The language was hard for me, but people were willing to either speak English, or help translate for me (particularly in the large groups). I would thoroughly recommend GPs, psychiatrists and therapists from the UK to go to this meeting next year, and in the future. I would like not to be the only one apologising for Brexit, and presenting our desire to remain partners in Balint, but also in Europe and the world. The Aachener und Internationale Balintstudentagung in 2018 will be the weekend of 8th to 10 June. It's worth the travel-very convenient on the Eurostar to Brussels and high speed from there, or make a driving holiday-it's only 4 hours from Calais!

**Dr David Watt**

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## Obituary: Antonia Shooter

Died 06/12/16



Antonia Shooter was a psychoanalyst who worked with Enid Balint at the Family Discussion Bureau at the Tavistock Clinic. She had lived and worked in France for some years and was fluent in French and used to attend all the French Balint Society events.

She was a regular and enthusiastic participant in the activities of the Balint Society and co-led groups at the annual meetings, first in Reading and then at Oxford. She also joined with many of us in running groups for both trainees and established GPs. Although very quiet, she had a lively sense of humour and was great fun.

I enjoyed co-leading groups with her for several years and admired her undoctrinaire approach. She just quietly watched the group, making notes, and only when she felt it would help did she offer a comment, but her insights about the whole process were subtle and the our discussions after the group session taught me a new dimension of understanding about groups.

She was devoted to travelling and well into her advance years would go all over the world, sketching and ever expanding her range of friends. When her family persuaded her to give up living alone, she joined the Mary Feilding Guild and moved into their home in Highgate, where many of the residents were her intellectual equals. She used that as her base while travelling alone on trips to India and elsewhere. But she decided that communal living was not for her so moved to Lewes which she loved and where she spent her declining years. She was a tough and resilient character, unwilling to give into physical inconveniences, and determined to enjoy life, but always interested and amusing. Someone all who knew her will greatly miss.

**Dr Oliver Samuel**

## Book Review:

### Tristimania

Jay Griffiths

Penguin Books (London, 2017)

First published Hamish Hamilton (2016)

ISBN: 978-0-241-97204-5

Tristimania is a beautifully written, poetic, fearlessly honest self-exploration of a year in the author's life with manic depression. It starts with 'My Maddest Wednesday' and ends with 'Mind Flight' a harrowing account of her determination to walk her way back to health along the Camino de Santiago. Jay Griffiths is a well established writer in her mid-fifties who won her first literary award in 2002 and was the Hay Festival International Fellow in 2016. The beauty of her prose and the directness with which she addresses the reader immediately engaged my attention. I can think of no other book which speaks so movingly about the importance of the doctor-patient relationship in the troubled life of a patient. Patients co-create their doctors and Jay Griffiths found a GP able to stay with her through her many trials and who always remained human, sometimes funny, listening and attentive. No GP will be unmoved by her account of how she relied on her doctor through the storms and desolate periods that befell her. The book is rich with insights about patients and their doctors.

The description of her first appointment with her GP and how she discovered that she could trust him is worth quoting in full. She had spent three months in the isolated immobility of a deep depression, frozen, alone and unable to act.

'I eventually made an appointment, walking into his office with some almost-but-not-quite-fictitious ailment, unable to say anything about depression. He dealt swiftly with this semi-fiction. Then he slowed right down, and I felt him searching my face.

He asked what I did for a living.

- I'm a writer.

There was a pause.

- That must be very lonely.

Five words.

I wept and wept.

As well as being appreciative (and a bit in love) with her doctor, she is very understanding of doctors in general. She says: 'I feel sorry for doctors: we take our dodgy psyches, our warts and bad breath, our boring aches and non-descript pains...' and continues this list with a pitch-perfect paragraph recital of what most doctors face day in and day out as they do their surgeries! Brilliant! Her mind has a visionary quality and an astonishing capacity for understanding the world around her, perhaps part of what she calls the over-connectedness of mania: the porous quality of an exceptional mind but one that carries the risk of over-exposure and the tragic fall of Icarus. For sheer honesty in describing mental illness, to my mind, her only recent peer is the American psychiatrist Kay Redfield Jamison whose book 'An Unquiet Mind' is a searing account of her manic-depressive illness whilst also practicing as a psychiatrist.

Needless to say, in writing for the Balint Journal, I have emphasised the book's insights about illness and the vicissitudes of professional help but it is a far more profound text than that. The book becomes a literary exploration of the author's varying states of

mind. Jay Griffiths takes her own experience as her starting point and extends this into a wide-ranging meditation on the meaning of moods, mythology and metaphor. The volume closes with a short collection of her poems which resonate from the themes of the book. Her approach is profoundly literary throughout and many other writers accompany her on her journey: Rilke, Keats, Coleridge (accessed through Richard Holmes' marvellous biography), William Styron, Shakespeare (of course) and Emily Dickinson.

She chooses not to include any account of her early experiences or close relationships. During the time of which she is writing, she is living alone in Wales working as a professional writer and seems to be supported by a network of remarkable friends who manage to stay in touch and respond in crises. A friend rings and then comes round, 'You didn't sound right' she says. A diagnosis in the sound of a single word?

Towards the end she quotes from Joseph Campbell and the archetypal idea of the 'Hero's Journey' and then goes on to say 'I had 'left' myself, psychologically, in a terrible withdrawal from sanity, and then I'd physically withdrawn to walk the Camino, so I needed to return, to come home to myself in all senses'.

At the end of the book I felt truly grateful for an author who had taken me on such an epic journey with a great deal of insight and courage. If the number of pencilled scribbles and underlinings are a measure of a readers' appreciation of a text, then this slim volume would be near the top of my personal list of inscribed volumes! Some vocational training sessions for GPs and Psychiatrists use literature as an approach to teaching and also have sessions (I hope) called 'learning from the patient'. Tristimania should be required reading on both counts.

**Dr Andrew Elder**

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**The Balint Society**  
(Founded 1969)  
**Council 2017/2018**

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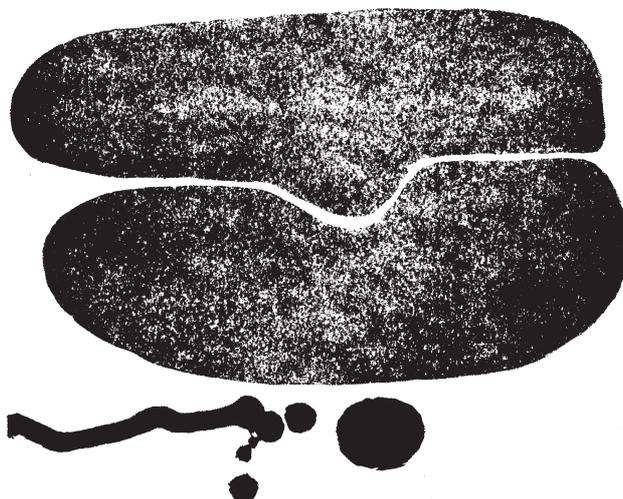
## **Guidance for Contributors**

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

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

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

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