

# Journal of the Balint Society



2018

# JOURNAL OF THE BALINT SOCIETY

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Contents .....	Page
Journal Introduction .....	2
The Balint Society .....	2
Calendar of Events 2018-19 .....	3
The Web Site .....	4
Editorial.....	5

## Personal papers:

Caroline Palmer – Balint and the retention of empathy .....	6
Jane Dammers – London talk Feb 2018 .....	11
Konstantina Bezioula – The First Balint Group for the Child .....	15
Ray Brown – Iranian Balint groups.....	17
An Attending Iranian Psychiatrist .....	29
Dr Mahdiah Moin – Balint groups .....	30
UK Balint Society student Essay winner – Inseo Yun.....	32
Isabel Hanson – ‘Between a Beginning and an End’ .....	36
Annabelle Hughes – ‘Lessons from Luna’ .....	39
Simon Chadwick – ‘Sharing the Little Lights’ .....	42
John Salinsky – Mike Courtenay Obituary.....	45
John Salinsky - interview with Mike Courtenay 2004.....	51
Raluca Soreanu – ‘On Michael Balint....’ .....	57
Nina Arztberger – ‘Aspects of Diversity’ .....	64
Shameel Khan – Crossing Borders: Laying the Landscape of Balint .....	69
David Watt – Reflections on IBF 2017.....	75
Poem 2018 .....	77
Linda Mary Edwards ‘Silence’ .....	78
Claudia Calciu – Reflective writing 2017.....	80
Amos Ritter ‘Is there a doctor on board?’ .....	82
Henry Jablonski ‘Balint work and the Institutional setting’ .....	85
Eamonn Marshall & Caroline O’Reed Connor ‘Balint group for Medical students’ ...	97
John Salinsky – ‘What’s so special about Balint groups?’ .....	103

## Reports:

President’s Report 2017.....	111
Regional Reports .....	115

## Announcements:

The Balint Society Council 2018-19.....	127
Guidance for Contributors.....	127

Editor:  
Tom McAnea

**In memory of Dr Mike Courtenay 1923-2018**

**Cover image:** Vincent Van Gogh, “Portrait of Dr Félix Rey” (1889),  
The State Pushkin Museum of Fine Arts, Moscow



## **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 2018-2019

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:

Friday May 17th 2019 for a **50th Balint Society anniversary event**.

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

Whalley Abbey April 5th-7th 2019

Oxford September 2019

Belfast 16th-18th November 2018

## **One day events**

Leadership training Day Manchester 17th October 2018

Bristol Leadership Study Day 7th December 2018

Annual Dinner and Study Day Medical Society of London 8th February 2019

50th Balint Society Anniversary event and Michael Balint Memorial Lecture Friday May 17th 2019

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

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

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

**Newcastle upon Tyne:** Contact Jane Dammers ([jane.dammers@outlook.com](mailto:jane.dammers@outlook.com)). 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))

Dates for **Tavistock Clinic BGLW** are Tuesday 30th October 2018, Tuesday February 12th 2019 and Thursday May 9th 2019



### **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 2019 and sent to:

Helen Lycett, e-mail - [event@balint.co.uk](mailto:event@balint.co.uk)

### **Guidance for contributors**

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

## Editorial

It has been a memorable year for the UK Balint Society. The 2017 IBF Congress was held at Keble College Oxford in September and it was widely agreed to have been a great success. David Watt, ex-President of the UK Society and one of the organisers of the event gives his account in this year's Journal. If the Congress showed anything it was the reach of Balint work around the world and the enthusiasm and activity that exists in many countries. Two of the papers presented at the Congress are reproduced here – from Pakistan and Austria.

The international perspective continues this year with a fascinating account by Ray Brown of his work setting up Balint groups in Iran. Ray worked with colleagues there to start groups in an Iranian hospital and you can read his perspective of the unique social and political context of that country. There are two related accounts from Iranian colleagues offering their perspective on this work. It is an ongoing project and I am sure we will read more about their progress in future.

The future of Balint work depends upon the interest and enthusiasm of new colleagues setting out in their careers. Again we print the winner of the UK Medical Student essay competition but also the joint winners and the runner-up of the Australia and New Zealand Balint Society's essay competition. I am again impressed by the quality of the work and the depth of understanding and insight shown of the doctor-patient relationship.

The development of interest amongst students depends upon access to Balint work and in particular Balint groups. Eamonn Marshall and Caroline O'Reed Connor give a fascinating account of their medical student group at St George's Hospital Medical School in south London. Their experience working with these future doctors is yet another reminder of the importance of allowing colleagues to have a safe space to explore their feelings about their patients, and their work. There is clearly a great need for many as reflected in the high levels of attrition amongst junior doctors in the NHS. Another interesting perspective in setting up and running Balint groups for students is offered by Henry Jablonski, a regular contributor to this Journal and experienced Balint group leader and psychotherapist.

Vincent Van Gogh understood much about suffering, and what it means to be human. He had several doctors care for him in his life, one of whom was Dr Felix Réy, in Arles. As a gesture of thanks Van Gogh painted Réy and gave the portrait to him – rumour has it that it was subsequently used by Réy as a door to his chicken coop! What this says about his feelings for his patient remains unclear, but the portrait captures something of this doctor and how he was perceived by his patient. A fitting image for this year's cover in my view, and a reminder of how important doctors can be for their patients.

The progress and development of Balint work in the UK and indeed the existence of the Society itself is in no small part thanks to the work of Dr Mike Courtenay. Sadly, Mike died recently and the extent of his contribution is apparent in his obituary (by John Salinsky and Andrew Elder) and contributions from other colleagues who worked with, and were inspired by Mike. Thus a memorable year for the Society is also a sad one as we say goodbye to a colleague whom I never had the privilege to meet, but from the tributes made by others was clearly an inspiration and support to many during his career. Given this, I wish to dedicate this year's Journal to the memory of Dr Mike Courtenay with thanks for all his work, kindness and dedication to his patients and colleagues over many decades.

**Tom McAnea, Editor**  
**[tomcmc@doctors.org.uk](mailto:tomcmc@doctors.org.uk)**

# Balint & the retention of Empathy

An introductory talk given by Dr. Caroline Palmer at the Belfast  
Balint Weekend, November 18th 2016

It is a very great pleasure to be here in Belfast again, and an honour to have been asked by Glenda Mock and the organising committee to give this introductory talk. When Glenda first phoned me I have to admit that I gulped, and thought to myself, but I have nothing to say that is particularly learned or erudite, only experiences and feelings that *feel* personally valid. So I deferred my decision, and agreed to contact her by the end of the week to let her know my final reply.

During that week, certain thoughts kept coming to mind: that Balint work is all about validating the personal, giving attention, acknowledgement and expression to our feelings, examining them honestly and thoughtfully with others and hopefully being able to understand them better as a result. The idea of Balint encouraging one to be more authentically oneself, and Balint's phrase of "having the courage of one's own stupidity", also kept ringing in my ears... so by the end of the week I thought that I'd better do just that, and decided that I'd accept the invitation!

Glenda had commented that I'd had a lot of experience of different groups, and now I think about it, I see that this is so. I've been very lucky to have had Balint in my medical life since my GP trainee days in 1982, but how I wish that there had been Balint groups for medical students and junior hospital doctors in my day.

This is a personal account including some emotional hotspots in my medical career, when I really could have benefitted so much from a Balint group, but I'm aware that you will all have your own memories of emotional encounters and experiences seared into your own psyches and souls, so it could just as easily be one of you giving this talk as much as me.

When I applied to medical school, and eventually was interviewed, of course I was expecting to be asked why I wanted to study medicine and become a doctor. For some reason I had been told that we shouldn't say that it was because we wanted to help people, that in some ways this was sort of 'wet and pathetic'. So I dressed up my response with phrases such as it being a universally useful and practical job, allowing me to further study human biology and physiology which I found fascinating, all mixed with a sense of purposeful concern for human beings. So the foundation of my choice to study medicine was a wish to help allay peoples' suffering, but already I was being encouraged to bury and hide my empathy, and consciously tried to do so just to be accepted into medical school.

Sometimes people choose to study medicine as they have held in mind a good role model of a respected family GP, or have had experience themselves, or of a relative, being ill in hospital.

My choice may well also have stemmed from wanting to be a better doctor than the one who had so callously judged and condemned my mother as a "Refrigerator Mother" when my brother was diagnosed as autistic 60 years ago. We are all probably motivated by formative experiences in our childhood and most of us probably enter medical school with a heightened sense of empathy.

Anyway, my perseverance was rewarded and I was lucky to be accepted to study Medicine at the London Hospital in the east end of London on my attempt (there was nothing Royal about it in those days!) I had to wait 2 years before I could see and start talking with and clerking patients myself. I remember walking down the ward, wearing



this strange stiff starched protective white coat, with the old prayer book style British National Formulary in one pocket, and a strangely springy stethoscope like an unruly animal that kept trying to jump out of the other pocket when I went to see my first patient: a man who'd had a heart attack due to getting so excited watching West Ham score a goal on TV!

There were some wonderful consultants working there who were kindly and compassionate, whose evident empathy inspired me and that I wanted to emulate. However there were other doctors, usually younger, who seemed more cynical and were probably feeling exhausted and tired, out of their depth and stressed. No doubt they were deprived of sleep and moral support, concentrating on gaining technical prowess at the expense of communication skills, and appeared not to have any spare energy or attention to talk with or listen to their patients. I also saw a tendency to blame the patient if the procedure went wrong.

I vividly remember a man who had developed an arrhythmia, who needed a pacing wire inserting, and who was handled so insensitively. No-one else explained the x-ray equipment which was lowering over him as he was wheeled into the treatment room, nor that the solution his neck was being swabbed with would feel cold, or that they were about to thread a very fine wire along a vein into his heart. They just wrapped his head in a cloth, without a word of explanation, like an inert lump of dead meat at a packing factory.

So I responded. I thought how might it feel to be that man, was authentic to myself, already had the courage of my own stupidity, spoke with him gently and held his hand. He clung on. When we got him back to the ward he went into cardiac arrest. There was an attempt to resuscitate him, but it soon became half-hearted with someone ventilating him but no-one doing cardiac compressions, until I offered. In the end the attempt was abandoned, the poor man died and the junior registrar walked off in a rush. The next day he asked me 'If I was alright because I'd seemed upset', but not in a way that invited me to talk about what I'd experienced, rather in a way that made me feel that I should have been embarrassed or ashamed of my emotional response. I was furious. I felt that I *was* alright. I still had my emotions intact and was rightfully upset! Having been a junior doctor, working ridiculously and dangerously long hours myself since, I have much more compassion and empathy for that poor terrified junior registrar, who was probably brittle with anxiety and exhaustion. I see now how he could have done with so much more support and help himself. A Balint group might have been helpful for us all, possibly even life-saving for the patient.

Another time, while still a student, I was asked to clerk in a woman who had come from Glasgow for a heart valve replacement, quite a pioneering operation in those days. So I saw and spoke with her for two days before her operation then was able to watch having open heart surgery from the viewing teaching gallery above, and then I followed her up on ITU. The next day I came onto ITU to see her and found that she had died overnight. I was upset. I had developed a relationship with her. She'd had the courage to leave her family, travel to London for the first time ever and face a scary operation. And then she had died. I went to the loo and had a good cry. It seemed the very least that I could do for her. Again a doctor said to me that afternoon that "You won't make a good doctor as you are too emotional". I said that 'We would see!' Looking back, I can see that the system was creating casualties of the staff and patients equally. How much Balint would have helped us all. Thank God there is now a concerted effort in the UK to begin providing a Balint group experience to medical students.

Then my junior hospital posts: I remember a boy that came in by ambulance with suspended breathing due to a sudden attack of asthma, and tragically died. His sister had

run to get help from a neighbour as their parents had gone out to a party. The police went to find the parents, and when I asked them to come into the relatives' room, he said "Don't look at me like that, you bitch", then ran out into the road, banging his fists on the cars. I went out, came back in and waited. When he came back I led him into the resuscitation room where their poor boy was lying and let them hug and cry over him. How I could have done with a Balint Group then. Instead most of us dealt with the stress by drinking, smoking, flirting or having affairs!

Thinking back, there are so many traumatic events and scenarios that we witness, as junior clinicians, it really can feel as if we have been on the battlefield, and both staff and patients probably suffer from some degree of PTSD. Empathy for the patient by this stage is often holding on by the flimsiest thread, as it feels to be either us or them who may drown or survive, but probably not both of us.

When I started training in general practice, I had to start seeing people on my own, in a consulting room, without a team readily there. I felt quite exposed and confused as to what was expected of me, as so many people had such complicated lives and problems. People could get very angry and demanding, expecting immediate answers and solutions. They seemed to come so thick and fast, 30 or even 40 a day. It was at this point, that I first encountered Balint: as my course organiser was a member of the Society and held a weekly group for trainees with a Psychoanalyst. Suddenly there was an opportunity to talk openly about the impact of the consultation with a patient on me, without haughty judgement, but with thoughtfulness. My curiosity, which had once been insatiable, was aroused once more.

This felt like a lifeline, and one that I'd been looking for since starting my clinical training 6 years previously. It was a revelation. I went to the Oxford Balint weekend in 1982, and have been to almost every one since. I think that without Balint I might not have stayed in Medicine. It has illuminated the way for me, and been a steadying companion throughout my career, supporting but also challenging me too at times, like a good robust friendship.

Not long after I joined my practice in Lancashire as a Partner, I had the opportunity to become a member of a group in Manchester for 3 years, which felt crucially important. It was another challenging time in my career: I was in for the long haul at the practice, and really getting to know my patients now. I had a sense of attachment to the people and place, so there was no way out of a relationship with them, but with the Balint group I learnt to bear the difficult ones, and retain some curiosity. I began to admit my sometimes complex or even hostile feelings, but could explore their basis a bit more and so understand and thus feel less confused and kidnapped by them. I was developing some empathy for myself too! My enthusiasm for Balint work was sustained over the years by attending the weekends in Oxford and Ripon, then by organising weekends at Chester and now Whalley Abbey, where I could present my own troubling cases, and started to co-lead groups too.

After my own retirement from clinical work, 4 years ago I began to co-lead a weekly group for Psychiatrists in training with a Psychotherapist in Preston, which has been a very rewarding experience. Watching people recover their sensitivity, developing more self-awareness, rediscovering the empathy that they had for so long hidden, and forced down while at medical school and in their junior training. It can be like watching people coming back from the dead! How wonderful if both doctor and patient can feel enlivened as a result!

I took over co-leading a group for F1 and F2 junior doctors, many of whom were struggling with the sudden heavy workload and the emotional intensity of the job after

qualifying. They felt that their empathy was being buried by the pressure of clinical work, mountains of paperwork and the expectations of their seniors. They all seemed to appreciate the space to reflect and really think about their problems with patients, but had great difficulty in attending due to commitments on the ward. Paradoxically the shorter shifts worked now meant that their work was more compressed into the hours, so there was less flexibility to attend the group. Their seniors also seemed quite unsupportive - perhaps they were jealous! Sadly after a year, the group folded.

More recently, I've had the opportunity to run a couple of taster sessions for final year medical students, which were really enthusiastically embraced, but they wished that they could have had the experience throughout their clinical training. We hope to start more regular input at Lancaster University Medical School in the academic year, and starting earlier in the curriculum.

A clinical psychologist colleague and I 2 months ago launched a group for Clinicians in Practice, local to where I live in Lancashire. This is proving very stimulating, as we have several GPs with differing levels of experience, a Psychiatrist and a Clinical Oncologist within the group. They seem to be feeling liberated, and to enjoy being able to talk freely about their feelings with regard to their patients and their work. It feels that they are developing more empathy for themselves too, as if they can accept that they may be 'good enough' doctors, rather in parallel with Winnicott's 'good enough' mothers.

For me, despite my retirement from clinical practice, my continued involvement with Balint work has been very enriching. I feel that I still live a medical life vicariously through the groups and the presentations, drawing on my 35 years of clinical experience to imagine what it may feel like to be that particular doctor or patient. It gives me a great sense of fulfilment and satisfaction to still be involved in these different groups. It's interesting for me to see that the experiences that wounded me most, or which had the most impact on me, were ones when I was only briefly in contact with patients, as either a medical student or a junior on the wards, before Balint entered my life.

Of course I had others too as a GP, like Christine, a young mum and teacher who came to see me complaining of feeling tired. I listened to her, examined her, organised some blood tests, and asked her to return to see me a week later. As the results were all normal I reassured her that nothing seemed seriously amiss. She returned for a third time, while I was away on holiday, so my partner organised a repeat blood test, which showed that she'd developed Acute Myeloid Leukaemia. On returning from my holiday I visited her at home, shared my upset and sadness at the diagnosis with her, and also my sense of guilt, at not having diagnosed her myself earlier, and my frustration at feeling falsely reassured by the first set of blood results. I went on visiting her and supporting the family over the months until she died, and supporting and looking after her husband, and their two children, until I retired 15 years later. In fact I bumped into him only two days ago in town, when he told me that he'd just become a granddad - his daughter Rosie having given birth to a son just two days before.

I suppose that in General Practice, we have the opportunity to try to put things right, and heal the wounds, as there is a continuing relationship and time available in which to do this. Also I had the resource of the Balint group, not only in reality, but also in my head, and the thought ...'Well what would the group think is going on?'

Even now, coming full circle back to my family I find it a helpful way to think about the variety of caring roles that I fulfil, with regard to my mother who now has Alzheimer's, as well as with my autistic brother, for both of whom I can feel great compassion but also considerable frustration at times. My past experience of being able to acknowledge and accept my more negative thoughts and feelings in a Balint Group perhaps allows me to



recognise, accept and understand my own negative emotions more easily in my family roles too, while still retaining my empathy for them.

Balint theory and practice has been a Lode Star for me throughout my career, orientating my work, allowing me to be authentically myself, to retain my empathy, while also developing resilience as a doctor, Balint group member, Balint group-leader, family member, carer, and even introductory speaker! I believe that it has supported me throughout my working life and thereby my patients too.

**Caroline Palmer.  
November 2016.**

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# **‘The medical - psychoanalytic relationship. How important is it in conceiving Balint groups?’**

Talk given by Dr Jane Dammers at the  
Balint Society London Study Day February 9th 2018.

The study day focussed on starting up Balint groups and keeping them going in different settings, understanding the ups and downs, supporting leaders and the role of supervision.

Does medicine need psychotherapy and psychoanalysis, does psychotherapy and psychoanalysis need medicine for Balint work to be successful and flourish? In this talk I am going to look at the origins of Balint work, why Michael Balint might have chosen to work with General Practitioners and what is important about medicine and general practice to the development of the work. I will also give some examples of when the relationship has flourished and when it has foundered. I conclude that we need both disciplines working together on the ground to establish Balint groups and help them to flourish.

Balint work is founded in psycho-analytic theory and principles. It was Michael Balint's inspiration to bring these principles to the task of examining the doctor – patient relationship with a group of London GPs in 1946, bringing together the two disciplines of psychoanalysis and medicine.

We might wonder why Balint chose to work with general practitioners? He was born in Hungary in 1896 and his father was a General Practitioner. We can imagine the impact his father's work would have had on family life. No doubt the young Balint would have been curious about what his father was up to and what was going on with the patients. Balint trained as an analyst and became particularly interested in examining the role of the **analyst** in the analytic relationship with the patient. Perhaps it was a small step for him to become interested in the doctor – patient relationship in general practice, with a curiosity about the **doctor**, as much as the patient - how the doctor's attitude, stance and capacity influences the potential for a therapeutic relationship. It was with this in mind that Balint work developed through examining the doctor's countertransference to the patient.

Those of us who have worked in general practice know that ‘all of life is here’. I remember well the alarming realisation when I first started training that anybody can walk through the door, anytime, with almost any kind of problem. That is what makes it so interesting and at times so difficult. We can assume that Balint deliberately chose this very broad-based environment in which to develop the work. Jan Weiner, a psychoanalyst, and I coined the notion of ‘the souk and the citadel’ - the souk being general practice and the citadel the world of psychoanalysis. Balint work needs the souk and everything that goes on there in order to flourish. Many areas of medicine and other community based endeavours such as social work and education may provide this broad base. But there may be difficulties when the base becomes too narrow or too specialised – for example a Balint group for psychiatry trainees who almost exclusively bring cases of psychiatric inpatients may become repetitive, or a Balint group for a very specialised team may be tricky.

What else is there about medicine and general practice which has fostered the

development of Balint work? General practice is a place where the struggle to integrate mind and body is played out in almost every consultation. Balint was interested in the body, how the patient's world is expressed in the body, and the physicality of the relationship between the doctor and patient including the experience of a physical examination? Does Balint work need to incorporate some notion of the body? In health care the body is usually part of the story, although it is often neglected in Balint groups which can become preoccupied only with the mind. What about Balint groups for other professions? For example groups have been set up with clergy in the Christian faith. Interestingly clergy have quite a lot to do with bodies – at baptisms, ministering to people who are ill and at funerals. Also 'the body of christ' is important symbolically. In other settings, for example Balint for teachers it may be important to recognise what could be lost if this bodily component is missing.

So Balint chose the grounding of the soul, the body, the earth for this work. What of the citadel, the soul and the sky? Does Balint work need psychoanalysis and psychoanalytic psychotherapy? The short answer to this must be 'yes' as Balint is securely founded on the principles of analytic thinking. Free association, transference, counter transference and the third position being some of the fundamental concepts in our work. In conceiving Balint work in our minds and in giving birth to Balint groups and nurturing their development what does this mean in practice? Do we need analytically trained people? Let's broaden that a little to say do we need psycho-dynamically trained people for Balint work to flourish?

I would like to reflect on two situations.

The first concerns the UK Balint Society. Enid Balint did a lot of work in the '70s and '80s to develop Balint work as we know it. She trained as a social worker as well as an analyst and was perhaps able to represent and move freely between the citadel and the soul. She was very important in the Society which I believe went through a long period of mourning after her death in 1994. I was working in south London where there were no Balint groups in the early nineties, and then busy with small children, and was hardly engaged with the Balint society until I came back to it around 2005. It seemed to me at that point that something had got lost. A small group of longstanding GPs, mostly London based and some of whom are here today, were carrying on the society but the analytic frame was hardly represented. Doris Blass who trained as a GP and then an analyst, and Andrew Elder a GP who also did four years analytic training at the Institute seemed to be carrying flag for the analysts. Maybe there were a few others but as someone by now living outside London I was hardly aware of them. At the same time I felt a significant loosening of the idea of what Balint work is, and what it is not. Without the analytic hold the framework was slipping and at risk of becoming very unclear. Andrew held something very important, giving theoretical presentations at meetings and starting to develop ideas around leadership training. Fortunately around this time Gearoid Fitzgerald, a psychiatrist and analyst and Esti Rimmer a psychodynamically trained psychotherapist and clinical psychologist became involved with the society, the council and the leadership training, bringing with them secure theoretical understanding and underpinning of the basis of what we are about. More recently Judy Malone a dual trained GP and psychotherapist, Helen Sheldon and Eamonn Marshall both psychotherapists and Anne Tyndale, a psychoanalyst, have come on board, getting involved in the core business of the society and leadership training. We have needed these people, in person and on the ground to keep Balint and the Society as we know it going. Without them I suspect it would have turned into something else, something useful perhaps but not what I would recognise as Balint.



My second example concerns Balint work in the North East of England. We set up Balint groups for all GP trainees on the Northumberland GP training scheme, one of the biggest in the country. It involved eight psychotherapists who co-led fortnightly groups with a GP trainer. These groups were well received by the trainees, and the trainers and therapists got a lot out of working work. By the way, I have yet to meet a psychotherapist who does not become interested in the world of general practice once they get a glimpse. Unfortunately the programme director, who had a superficial knowledge of Balint took the view that GP trainers should be able to do this work by themselves – the omnipotent view of being able to do everything on one's own is sadly common among doctors, and maybe therapists too. So at a time of some financial difficulties he took the opportunity to axe the psychotherapists' input. What happened? Some of the GP trainers continued with Balint style case discussion for a short time but very soon it more or less fizzled out. This is in contrast to the groups which we run for GPs, foundation doctors and others in the North East which we have always insisted on being co-lead by a psychotherapist and doctor, which are flourishing. We have four groups in the North East for GPs with another two starting. Also two foundation doctor groups and a proposal to role out Balint for all foundation doctors in the region.

When two disciplines come together there may be a wish for them to merge, like rubbing the charcoal in a picture, blurring the boundaries. Each party may want to feel they will absorb enough of the other to somehow become both at once. They might then choose to set off on their own. In Balint work I think this is a mistake. It is precisely the differences in approaches and ways of thinking which is creative. I have been re-reading John Berger's 'A Fortunate Man' – an wonderful exploration of the professional life of a single handed GP working in a rural community of foresters in the 1960s. In it he says that it is evident to everybody that the doctor is privileged, and that this does not concern his income, his car or his house. He is privileged because of the way he can think and can talk. The villagers do not consider him privileged because they find his thinking so impressive. It is the style of his thinking which they immediately recognise as different from theirs, and they value this.

I have been doing Balint work for a long time, I have learned much from my analyst and psychotherapy friends, we have led many groups together. I know that I think differently from them and they from me. We are differently trained, we work in different ways, we have different languages. There lies the pleasure and also the challenge.

Balint work is conceived between medicine and psychoanalysis and we need both disciplines represented, in person, in starting Balint groups and keeping them going. All of you here today have already made something of a leap in your minds in bringing the two disciplines together. If we were running Balint groups today we might well be delighted by the way people from different professions seem to come together easily, share ideas and work together in a Balint group. But maybe it's not so simple. The outward apparent simplicity of a Balint group belies the complex tasks the leaders undertake in leading the group. And when we think about setting up Balint groups we are faced with the question of how do we make connections on the ground between doctors and therapists and analysts to develop the work locally? What helps and what gets in the way? How do we get people together to start this work? People who are dual trained in medicine and analytic thinking seem to be quite important in the Society's history, so maybe we should look out for them.

I have deliberately taken a hard line in this talk saying that I believe the two disciplines need to be represented on the ground when we think about establishing Balint groups and keeping them going. It is not enough to have some theoretical understanding

of the relationship in our minds which is not put into practice. I have framed my talk within the discipline of medicine and general practice because that is what I know about, and it is where Balint comes from. I am also aware others may see the history of the society over the last twenty years in a different way. I hope that my talk will stimulate further discussion and exploration in our workshops during the day.

## Reference

A Fortunate Man: *The story of a Country Doctor* John Berger 2015 Canongate Books Ltd Edinburgh ISBN 978 1 78211 501 4. First published in Great Britain by Allen Lane, The Penguin Press 1967

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## **“The First Balint Group for the Child”**

Over the last year, my interest in supporting teachers as an Educational Psychologist came to fruition so I have been running, with the supervision of Mrs. Lida Bitrou, a Balint Group for teachers which is a very enriching experience both for me and for the educators in my team. At some point my supervisor and I came up with what turned out to be a great idea which was to have a Balint group workshop with the participation of members from various disciplines that care for children. This invitation had a good appeal and on the 20th of May in 2018 this very innovative and especially interesting meeting took place: “An independent Balint Group for the Child” among practitioners from different disciplines.

This group worked like a communication bridge between different disciplines and especially between a paediatrician, child-psychiatrist, 2 psychologists and 2 educators that all care for children. The spherical and multileveled understanding that came out of the way that each discipline perceived and expressed the relationship that grows with the children gave us, and continues to give us the motive to create and develop more such enriching groups.

The structure of the programme was as the one that the Hellenic Balint Groups follow in the weekend workshops, namely to conduct 4 case-discussion groups and a final report-feedback of the day. In the final report, both the leaders and the members had the opportunity to express their opinion in accordance with the point that they enjoyed the most and on the points that they would like to change or amend in future events.

In general, all four cases discussed gave space for thinking, self-reflection and free-association to all members. Through the narrative of our members' experiences and the comments made, everyone's differences and diversity has emerged very vividly, as well as the different colours that understanding, empathy and active listening can take in the various disciplines. In the case discussions psychologists offered their psychological thinking in the understanding of psychological processes that take place between the two members of the therapeutic relationship, while the doctors gave a more practical and maybe logical perspective at times, which helped seeing things in a more neutral perspective and focused on the relationship rather than on the psychological characteristics each member had. The educators' perspective was also of great importance since they gave a multifaceted perspective with many more members involved in it, such as the family, the student, the classmates, the whole group dynamic etc. What was also of great importance was the fact that in all cases parents were present in all discussions, something that is very common when someone works with children. Also, when it comes to children it was very evident that all disciplines attached great importance to the relationship between the child and the parents. There were always 4-5 people on the discussion table: the therapist or educator, the child, the mother, the father, maybe the siblings and classmates. In addition to that, it was evident that people from disciplines that care for children all share the burden that is imposed on them by the great expectations from others, such as to play multiple roles for the children and their family, eg for the educators to help the family make serious decisions about how to announce to the child that he/she is adopted etc. This makes obvious how important Balint groups are for these disciplines since through the group they could get the appropriate help, encouragement and empathy they need.

Overall, this group meeting was a very good opportunity for all of us to hear each other's work difficulties with children, share our understanding, feel accepted, feel cared



for and enrich our perspective with more fruitful views.

Finally, I would like to thank my supervisor Mrs. Lida Bitrou for her useful support in developing my understanding and my Balint group-leading skills. Also, I would like to share my pleasure in co-ordinating with her on this group. Finally, I am very glad that most of us that day agreed that we should repeat this meeting on a regular basis since it was of great interest to all of us.

**Ntina Bezioula**  
**Educational Psychologist – Psychotherapist**  
**Member of the Hellenic Balint Group**

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# Iranian Balint Groups

## Culture, Context and Development

Ray Brown, Consultant Psychotherapist

### Culture and Context

The considerations of Iranian culture and context are very complex and extensive and I can only give the briefest outline from my own limited perspective for the purpose of orientation.

Iran is an ancient country, which has made and continues to make major contributions to world culture and scientific thought. Geographically, Iran has a land area as extensive as the areas of France, Italy, Germany and the United Kingdom combined. Iran extends for 1398 miles (SE – NW) and 870 miles (NE -SW), with a multi-ethnic population of over 80 million. The climate varies from one region to another with latitude. For example, in spring the area in the north in Azarbayjan is cool or cold, in Tehran, though the temperatures are higher than an average British summer, it is still possible to ski on pristine slopes in the Alborz mountains to the North of Tehran. In the south, in the Persian Gulf, with unspoilt coral reefs, the temperatures are typically near thirty degrees celsius.

Iran became an Islamic Republic in the 1979 popular Revolution which deposed the Shah, with subsequent changes politically, socially and culturally. Between 1980 and



**The staff at Razi Hospital.**

1988, Iran was in the grip of a brutal war imposed by neighbouring Iraq. Casualties were very heavy. *“For the first time ever on a battlefield, nerve agents including sarin and tabun were unleashed by Iraqi forces”*<sup>1</sup> on Iranian troops and bordering villages with *“more than 100,000 severely injured and about 7,000 dying immediately.”* *“More than 55,000 Iranian survivors [are] still receiving treatment for chronic CW-related illness.”* *to this day*<sup>2</sup>. *The precursor chemicals were supplied by the west. Significantly, with the religious ban on all WMD as a sin, Iran never retaliated these repeated attacks*<sup>3</sup>. The death toll for Iranian military personnel is estimated to vary between 250,000 to over 300,000 which does not include civilian deaths and casualties and is probably an underestimation. In addition to the war, there have been sanctions imposed on Iran led by the United States for nearly four decades. These sanctions, which are primarily targeted against the civilian population for the purpose of forced regime change, have caused great social suffering. They are illegal under international law and Article 2 of the UN Charter in relation to the violation of national sovereignty. It has been argued, as was the case with the sanctions on Iraq, that comprehensive sanctions against populations inflicting immense suffering and death are collective punishment contravening the UN Convention on Genocide which defines genocide as “acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such...[including] causing serious bodily or mental harm to members of the group; [and] deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part.”<sup>4,5</sup>

The men and woman with whom I worked in Iran were all of an age group in which they and their parents would have been impacted by the experiences of the Revolution, the Iran-Iraq war and the sanctions. The facts of the events I have outlined are in the Iranian national psyche. In spite of this, I found my experience of this culture strangely familiar, having been born into a Roman Catholic family and spending my childhood years in the 1950s in Dublin.

## **Luck**

In October 2016, I was in Tehran with my wife, Mehrnaz Shahabi-Sirjani, who is Iranian. We have been visiting Iran together over the last 26 years. It was in this context that I first had the experience of an extended family. I remember on a flight to Tehran, by myself, I sat next to an Anglo-Iranian middle-aged man who had lived in Kent since he was seventeen, quietly grumbling that his Iranian family were “too hospitable” and “looked after him too much”. Indeed, Iranian hospitality is very well-known and both my wife and I had been cared for by the extended family with the greatest of hospitality, but felt at times over-protected and felt the need to do things independently of the family.

I wanted to make contact with Iranian doctors to find my own connections with the culture in the context of my profession and areas of interest. I enquired and I was invited to attend the 33rd Annual Conference of the Iranian Psychiatric Association which was being held in the Milad Hospital. Milad Hospital is a large university teaching hospital in the centre of Tehran. During the first tea break in the morning, I was introduced to Professor Mohammad Sana’ati and his wife, Dr Mahdieh Moin and Dr Mansoureh Kian-Dehkardi, all psychiatrists and psychoanalytic psychotherapists.

Dr Moin and Dr Sana’ati have developed a training programme<sup>6</sup>, a Fellowship in psychoanalytic psychotherapy for doctors already fully trained in psychiatry, based at Roozbeh Hospital. The Department of Psychotherapy at Roozbeh Hospital is within the faculty of Medical Sciences of Tehran University and is now headed by Dr Moin. Dr Moin’s help in my embarking on the provision of Balint Days in Tehran has been central.

I then received an invitation from Dr Moin to attend a case conference at Roozbeh Hospital. There I met those undertaking the fellowship in psychoanalytic psychotherapy, three men and three women. Chai and delicious shirini (tea and cream cakes) were an important part of the conference. The plate of cakes made the rounds twice, at least! Two developments followed from the case conference in Roozbeh. I was asked if I wanted to teach a series of seminars on the psychoanalytic concepts of holding and containing (Winnicott and Bion) and on psychoanalytic couple therapy<sup>7,8</sup> by Skype. I also persuaded Dr Moin to try and hold Balint training days in the following spring of 2017 at Roozbeh Hospital. I facilitated 30 seminars on Mondays at 9.30am (1pm Tehran time) lasting 1 hour, by Skype. I made it clear that I was interested in assisting an Iranian style of development suited to the culture, context, possibilities and needs. The same stance applied to the Balint Days too. The concepts of holding and containing, from my perspective as a psychoanalytic psychotherapist, are central to ongoing work, not only with patients receiving psychotherapy but to all patients and for all health care professionals providing treatment.

The seminars which preceded the Balint Days were not didactic; I did not teach anything but brought to the group's attention a series of papers which as a group they felt they would like to read. The reading of the papers was to be accompanied by clinical presentations with the intention of linking theoretical knowledge with experiential aspects of learning so the individuals in the group could make a link between their own personal experiences and the concepts and discover if the concepts were of use to them, or not. The group then said they would like to learn about psychoanalytic couple therapy. After some thought, I suggested the book on couple therapy by Drs David and Jill Scharff. I suggested this book because it is full of clinical examples and open sharing of mistakes and the authors discuss their uncertainties. The book is object relations based and introduced again the very useful concept of projective identification, an intra and inter-psychic mechanism, operating between individuals, relevant to the understanding of the doctor-patient relationship, Balint's "harmonious mix-up", and parallel process. Incidentally, it seemed to me that the book advances a leadership model in the relationship between David and Jill Scharff. The group brought cases of the marital therapies they were involved in and we completed the seminars based on the whole book, reading the material together. It was this background experience which occurred in the run up to the first Balint Days which established some basis for trust and shared understanding.

### **The Balint Leadership Days**

Roozbeh Hospital is in the south of Tehran, on South Kargar Street (South "Worker Street"). I had arrived about 30 minutes early, so I strolled on the quiet, still, sunny, early morning street outside. The appearance of the hospital was very pleasant with a quad, tall shading trees and a central working fountain. The walls are covered with softly coloured, mainly blue and green, murals of landscapes, streams and countryside. Entering that Iranian hospital was for me like joining an extended family. All the staff I met seemed to have easy relationships with each other and a degree of warm familiarity. During the middle of one of the Balint Groups, a porter walked in carrying an air-conditioning unit (It was hot). My reaction to the intrusion was one of feelings of protectiveness towards the group and hence annoyance, but no one else turned a hair, and the air-conditioning was working in no time at all. The porters were a very important part of the hospital ethos and atmosphere. I was always greeted very warmly and had many friendly encounters with them. I realised later that the porter had thought the group might be too hot and



had brought in the air-conditioning unit on his own initiative. Cups of tea would also unexpectedly arrive for myself and others. This was part of the ethos of Iranian hospitality trying to anticipate the needs of the guest!

Twenty five people attended the first Balint Days which started at 7.30am and finished in the late afternoon. There were introductory talks in the morning and I gave a lecture for an all-hospital conference at lunchtime on the first day. The twenty five people just fitted into the conference room comfortably and I convened four Balint Groups on each day of the two days, lasting an hour each with 30 minutes for post-group discussion. All the groups were recorded on film for teaching purposes and for subsequent reflection, discussion and criticism. The Balint Days were then repeated for one day in October 2017, two days in April 2018, and two days are planned for October 2018. Dr Mozhgan Amini has to be thanked for all her work that led to the smooth organisation of the days. The first days, though enjoyable, were also rather daunting. It was a new experience for me. I required a translator.

The department provided a very able psychologist, Ms Nina Jamshid-Nedjad, fully fluent in both English and Farsi. Guidelines had been circulated before the days to give some indication of the role of the leaders and application of a technique for structuring time and process, in essence, the selection of leaders, initial announcements by leaders, and case presentation for an approximate duration. This led into the “push-back”, group discussion, and then the recall of the presenter for the final discussion. On viewing the videos of the groups, all the groups “look like” Balint Groups which is both a starting point and a form of holding. I sat outside the group with the translator, who was translating the group process from Farsi to English for me, and my remarks from English to Farsi for the group. In the first groups, I would make interventions from outside the group if I felt the group was going too off-track or forgetting about the presenter. In the early groups - and perhaps this reflected the attendees’ need for supervision or a wish to get rid of distressing memories and feelings – serial “cases” were presented by the group members, one after another, but the original presenter would be forgotten though the links between the cases were indicating identification with the presenter. However, this took the form of, while sympathising and identifying with the presenter: “See, I have a case just like yours or even more difficult than yours”. Initially, there would be limited exploration of the experience of the presenter in the relation to the patient they discussed. This improved with familiarity and practice. My interventions were intended to draw the leaders’ attention to the deviation from the expectation of exploring the doctor-patient relationship and to help keep them focussed on that task.

The majority of attendees were women from a background in psychiatry and psychotherapy, but there were also attendees from other disciplines, including consultants in palliative care, obstetrics and gynaecology, ophthalmic surgery, and very interestingly a male consultant in A&E. The groups overall were highly emotional and very social, in that the group members enjoyed talking and communication, and were also open about their personal lives and in the expression of their feelings. Individuals seemed to be able to cry without shame. When someone did cry, others would start to cry with them. Sometimes I became tearful too. I believe that open displays of emotion socially are much more acceptable in Iran than in the UK. A further impression relates to the concepts of kindness and gentleness. However, there are complex (to me) codes of conduct and though I am aware of some of them, I could and did certainly miss many nuances. Ta’arof is one example of this. For example, in making a purchase in a shop, or paying for a taxi ride, when it comes to payment, the shopkeeper or the taxi driver, may say with feeling “It is nothing. Please be my guest”. To respond with “Okay, thank you very much” is

completely wrong and unexpected! My understanding is that this offer has to be declined, a number of times in the right way, so that the offer of generosity is respected, and then the payment is made. The interaction is a very customary expression of courtesy, humility and generosity so that there is a shift of emphasis from a solely financial exchange. The same principle may apply to verbal exchanges and what is accepted or declined.

In addition to Balint Groups at Roozbeh, I was also involved in the running of Balint training days in two other locations; in Raazi Hospital and Imam Khomeini Hospital. Raazi Hospital is the largest psychiatric Hospital in Iran with 2000 patients and 2000 staff. I was invited there by Dr Mansoureh Kian-Dehkardi. The hospital is based in the very ancient area of Shahr-e-Rey in the South of Tehran. Two Balint training days have been held there, in October 2017 and in April 2018. Another day is planned for October 2018. The other setting was in the Department of Oncology of Imam Khomeini Teaching Hospital in central Tehran. I was invited there by Dr Mamak Tahmasebi who is a senior Consultant in Palliative Care.

Both of these locations I visited with some trepidation. Raazi Hospital was set in very beautiful grounds at the base of the surrounding mountains. The garden was full of pine trees and flowers. Before the day started, a lovely breakfast of freshly baked warm Barbari bread, cheese, honey, cream, fruit and chai (coffee available too) had been set out for all the attendees. The buildings were all of a good standard and well-maintained and the large conference room was airy, bright and pleasant. About 50 staff from all disciplines attended the meetings. These included nurses, professors of psychiatry, drama and art therapists, consultant psychiatrists, social workers, senior psychologists, and some of the hospital managers. The majority of attendees were women as was the case in Roozbeh Hospital. Three Balint Groups were held during the day in April 2018.

Again, there was preparation beforehand but because of numbers, the Balint Groups had to be conducted in a fish bowl style. I was very grateful that on this occasion, as in the two days in April 2018 in Roozbeh Hospital, my wife, Mehrnaz Shahabi-Sirjani, who is a translator, psychosocial researcher, and has had training in psychotherapy and therefore is familiar with psychoanalytic concepts, and knows the Iranian culture very well, acted as the translator. This led to the idea that we could work as a team and there are already plans for us to visit other cities. (A day is planned for Balint Days in Kerman city in October this year following an invitation from Dr Naveed Khalili, graduate of the Roozbeh Fellowship in Psychoanalytic Psychotherapy, who now holds a senior position in Kerman.) My wife has helped me to further develop my understanding of the Iranian social codes since we discuss contents from the point of view of nuances at the time of the translation and afterwards.

The groups in Raazi were very diverse and there were case presentations from different disciplines. Raazi's primary focus is psychiatric rehabilitation and long-term care. There was a general practitioner from Yazd, 400 miles south east of Tehran, who had travelled overnight by train to attend the meeting starting at 7.30am and who subsequently co-led a group and also invited us to hold a Balint Day in Yazd. There was a particularly moving presentation from a senior female nurse who headed a ward and was feeling exclusively responsible for a young woman who had very severe difficulties. After discussing her case the nurse felt less alone and less exclusively responsible. The meetings in Raazi were filmed and are currently being used for training purposes. The main need for Dr Mansoureh Kiani-Dehkardi, who organised the days in Raazi, was to communicate to the managers the importance of staff support and the Balint Group model.

The experience in the Department of Oncology and Palliative Care in Imam Khomeini Hospital was interesting, moving and difficult. Dr Mamak Tahmasebi, consultant in palliative care, following her attendance at the Balint Day in Roozbeh Hospital in October 2017, raised the idea of running a Balint Group for specialists in oncology and palliative care in her department. Mrs Nina Jamshid-Nedjad, psychologist, and Dr Valentin Artounian, Consultant psychiatrist, who had both attended the Balint Days at Roozbeh, offered to be co-leaders working with supervision.

The meeting was held in an extremely unsuitable seminar room with chairs fixed round a very long rectangular table. About 40 people, equal numbers of men and women, attended. What struck me immediately was that the palliative care consultants, mainly women, were dressed in their usual clothes, but the oncologists who were mainly men, all wore long white coats. I gave an introduction during which the oncologists seemed to be getting on with other work on their laptops and telephones. I found it very unpromising and later that night I dreamt of white mice, so visual was the split between the oncologists and the palliative care doctors. Later, on free associating to this dream, I felt that death and dying were heavily present in this group, which was obvious really. Eventually, a group of individuals responded to my invitation to form a group co-led by Dr Artounian and Mrs Jamshid-Nejad. A suitable area was found in the room for the formation of the group with the others observing. One male oncologist had volunteered to be part of the group and the rest of the eight people who had volunteered were women from palliative care. The oncologist bravely talked of the case of a child with a cancerous growth on his back who had undergone mutilating surgery and his great emotional difficulties with cases of that sort. For reasons of confidentiality, even though I have the doctor's permission to write an account of the case, I will not describe this in full detail.

*The presentation was extremely moving. He explained by introduction that he experienced emotional turmoil when treating children with cancer. He emphasised how difficult this was for him. He felt that he might not know what to do or say. He wanted to run away. He had fears that his colleagues would think badly of him. He said that when he is with his own child he can't bear to hold him because the images of his patient's terrible injuries would come to mind and feel unbearable. He felt he had become emotionally distant from his own child. He said that he felt lonely at home because he was unable to talk to his wife about these feelings. He was also feeling isolated at work. When he pushed back from the group after finishing the presentation of his case, there was a long silence and then members of the group began very gently to contribute in turn, almost murmuring. The essence of the different communications was that other group members had experienced similar emotions with cases like this. He was told that his responses and emotions were understandable. Moreover, they were normal and that it was understandable how difficult it must have been that he was not able to communicate his feelings to anyone. Mrs Jamshid-Nejad and Dr Artounian kept the group on track, maintaining the focus on the doctor-patient relationship. The response of the presenting doctor was a sense of relief at having been able to share his emotional experiences and that he had felt understood. He looked as if a ton weight had been lifted from his shoulders. When the Balint Group ended, there was a general discussion including the observers. The main theme was that doctors generally did not talk about their feelings in relation to their patients with each other and an important obstacle identified was the fear of being thought of as not a good doctor and then being judged by colleagues. Before the end of the meeting, a number of people amongst the attendees said that they would like to attend a Balint Group and whether one could be set up for the Departments of Oncology and Palliative Care.*

I am in regular communication with Dr Tahmasebi for the purpose of planning an ongoing Balint Group but whereas the palliative care consultants, mainly women, wish to attend a group, the consultants in oncology, nearly all men, seem not to be able to find a time because they are too busy. We are still working on this. I have enquired about the oncologist who presented the case while I was seeking his permission to write about the case he presented, in this article. Dr Tahmasebi knows him very well and he had told her that he was grateful to have had the opportunity to talk about his case. He has since decided to move to the area of adult oncology and feels good about that decision.

### **What Now?**

Following the Balint Days, in Spring 2018, twenty people have been initially identified as working towards becoming Iranian Balint Leaders. A sub-group of that twenty met to discuss how to proceed, at the end of the two Balint Days in April 2018. The requirements to become an accredited Balint Leader in a number of countries, including the UK, were reviewed.

An organising and co-ordinating group for Iranian Balint work has now been established, based on the proposal by the Psychotherapy Department of Roozbeh Hospital. The organising group for Iranian Balint Group work is within the Psychotherapy Committee of the National Association of Iranian Psychiatrists. This leads to the possibility of the co-ordination of training and development of Iranian Balint Groups nationally. Immediately relevant is the provision of Iranian Balint Group work for trainee psychiatrists. Two Balint Groups for trainee psychiatrists are due to start soon in the cities of Sari and Kerman. In Tehran, a Balint Group for nurses led by Dr Mehdi Ghorbani, has been running now for some months, as has a group for psychologists, the Aramesh Clinic Group, co-led and pioneered by Dr Farzaneh Habibi and Mr Mohammad Azizpour. I supervise Dr Habibi and Mr Azizpour online by Skype. Arrangements are being made to establish groups for leaders to discuss their work together, with intermittent supervision, so that common themes may be identified. I have recently heard that an Iranian Balint Group for clinical pharmacologists, working in an oncology unit, is due to start, led by Dr Mozghan Amini and Dr Taha Yahyavi, both senior psychiatrists trained in psychotherapy and married to each other.

In Tehran, and for me, this is all very new, however, there is a very great interest in examining the doctor-patient relationship. The people involved in the workshops believe that it is centrally important and a necessity. Just as prior to Michael Balint, there were no Balint Groups in Britain and they had to be developed over decades, the development of Iranian Balint Groups has to find its own channel for development. I think of this as a riverlet finding its course according to the terrain. In my visits, I experienced very high motivation, acute intelligence, determination, love of work, a mastery of the use of internet to disseminate papers and hold discussions, and a very human caring atmosphere. Everyone I met felt that exploring the doctor-patient relationship was vitally important, and that is hopeful for development.

### **Reflections**

The work in Tehran has been a very meaningful emotional experience for me. I think about the people that I met and worked with fondly. I had sought involvement with Iranian culture through my work and this has developed in a way that was unimaginable when I started. "How do Balint Groups work?", I am asked frequently by Iranian colleagues. I felt in this fresh and new context, I needed to think about that anew and examine my mistakes and presumptions. I would like to share some tentative ideas to start this process of thinking.



The concepts that I now feel are important to me are unconscious to unconscious communication<sup>9</sup> and the work of Christopher Bollas focussing on the concepts of “the unthought known”<sup>10</sup>, the transformational object<sup>11</sup> and “cracking up”<sup>12</sup>. Another relevant area is the Ferenczi<sup>13</sup> -Balint<sup>14, 15</sup> axis in relation to trauma, and the suppression, neglect and avoidance of both Ferenczi and Balint’s work until recently. Ferenczi seems to be popping up everywhere at the moment, including in Iran and in new publications<sup>16</sup>. I attended a lecture on Ferenczi’s work in an Ethics and Psychotherapy Seminar, in which I took part and also gave a lecture myself on Boundary Violations, held at the Milad Hospital.

Balint Group practice is new to Tehran. Some of the attendees have now formed their own Iranian Balint Groups but what does it mean for people without a group yet, to attend an Iranian Balint Day on an intermittent basis and to have no other involvement until the next Balint Day? At the moment the interval is 6 months. However, in many people, there has been a retention of experiences and memories for over a year, in spite of the intervals. I have observed a phenomenon which I call “awakening” - others may have used exactly that word, to describe the expanded consciousness and increased experience of thoughts and emotions for the presenter in relation to the case. Others in the group experienced this too, I believe. I think the “case” can be thought of as a dream from which the presenter can’t wake up and that there is some similarity between Balint Groups and Social Dreaming<sup>17,18</sup>. Social Dreaming is an event in which participants share their dreams and free associate to the dreams and to each other’s associations. This has also similarities to psychoanalysis. In Balint Groups elements of the experience of the case remain outside the realm of conscious thoughts and feelings for the presenter, perceived and known unconsciously but unthought. Here the concept of the “unthought known” may be relevant. Linked with that, but much more perplexing and yet strangely accepted in day to day life, is the idea of unconscious to unconscious communication, advanced by Freud and referred to by Ferenczi as the “dialogues of the unconscious”, and discussed by Christopher Bollas in his book “cracking up”, with the idea of a return not to Freud but to the radical nature of the unconscious. Unconscious, in Farsi “na khodagaah” نابخود آگاه, is a strange word, defined as an “un” in relation to the conscious. The word Freud used, “unbewusste” was coined in the 18th Century by the German Romantic philosopher, Fredrich Schelling, and was brought into English by Samuel Taylor-Coleridge, whose ideas of creativity have an uncanny similarity to Bollas’s thinking. To what degree was Freud’s thinking influenced by the Romantics, and then in his rational, medical, scientific reaction to the Romantics?

The unconscious to unconscious communication in relation to the case involves everyone, leaders included, and this flows outside consciousness and is not all accessible. This type of communication could be viewed in human communications as always present, like air for living and creativity, and Bollas speaks of “Unconscious freedom”. There is a dreaming of the case in the Balint Group and in order for the “unthought known” to be thought the dream case has to be “cracked up” by the group in its associations, so that the dream material, in part, becomes suitable for thought (A Theory of Thinking, Wilfred Bion). An event does occur; there is then an Awakening. I believe subsequently a stable change in ATTITUDE occurs towards Balint Group work and communicating about the doctor-patient relationship. There are suggestions of shifts of sensibility in the way Bollas uses the term, as a capacity for intuiting other people’s feelings.

I was very grateful to find Dr John Salinsky’s paper, “Should I be saying something Now?”<sup>19</sup>. I think everyone shares the experience of the question “Should I be saying

something Now?”. The paper also refers to Enid Balint’s remark of being “well-marinated in the Balint stew”. This, in my view, is an enigmatic, highly condensed mixed metaphor. This metaphor might be treated in the same way as a Balint case or a dream, opened up by free-associations, which may include play. The metaphor stirred up questions in me like, “Who made the marinade?” and “Who is the marinator?” and “Who is the marinated?”, “Are turns taken?”. Or, Mar in aid, an association to Enid Balint coming to the rescue of her “chicks”, in Dr Salinsky’s paper. An Oxford Dictionary definition (not a culinary definition) is that “Stew is cooked by a long process of slow boiling” (Sounds painful and requiring great determination, patience and trust). With suitable marinade, are “tough old boots” tenderised and restored? Is the stew more Michael Balint, and the marinade more Enid Balint?

The etymology of words carry a history and a penumbra of changes in meaning over time. This is not the same as free-association but may be informative.

Etymologically, stew is derived before 1300 AD from “cauldron” (a vessel and container), and earlier via old French and vulgar Latin, from “heated room, bath and bathing room”. The origin of the word marinade alludes to brine, aqua marina (the mother). Brine is used for pickling (preservation), spice and flavourings bring about changes in texture, taste and aroma, in the marinated, and alteration in the essence of the dish. There are also everyday expressions, such as, “[to be] in a stew” or “to stew in [one’s own] juices’. These are ideas to do with environments or settings, interactions over a long period of time, which cause change. Relationships are involved; maternal, paternal and to the couple. The maternal aspect and the process extended over time reminded me of Winnicott’s “environmental mother”, the Transformational Object (Bollas) and Balint’s “New Beginnings”. To quote from Bollas, “The mother is not yet identified as an object but is experienced as a process of transformation, and this feature remains in the trace of object seeking in adult life, I believe the object is sought as a signifier of the process of transformation of being. Thus, in adult life, the quest is not to possess the object, it is sought in order to surrender to it as a process that alters the self, where the subject - as - supplicant now feels himself to be the recipient of enviro-somatic caring identified with the metamorphosis of the self”. Bollas in this paper gives as one of his few references Michael Balint’s book, “The Basic Fault” and explores the issue of modification of psychoanalytic technique in the treatment of individuals with disturbances at the level of the transformational object. He interestingly says that interpretations are not taken up (They disturb the flow of the unconscious communications); the relationship is with the whole environment and more important than anything said is the continuity of the environment (everything in the setting of the session) and the ‘murmuring sound’ of the analyst’s voice. I imagine there is not an individual who has escaped some degree of problem at the level of the transformational object in the mother-child interaction. Have Michael and Enid Balint developed an approach that is corrective or healing at this level so there can be new beginnings and a re-working of BEING? Transformation of Being. Is this not the result of the Balint process and psychoanalysis at its best? That which leads to a transformation of being, being with a patient, being with others, and being with oneself? Being, I believe is inherently good, as is explored by Erich Fromm in ‘To Have or To Be’. It is clear, however, that the process requires courage, endurance for the length of time required, and must occur in the right type of cauldron (The psychological container of the process).

Assuming that something useful may be found in a metaphor (What is poetry about?) and there is use in subjectivist deconstruction, what else might be further elaborated? Of course, this also depends on where and from whom the metaphor came.

One idea that occurred to me is that the Balint Group process is a series of temporally ordered unconscious communications focussed on Bollas's subject-as-suppliant, the presenter of the case. The unconscious communication is first in the presentation of the case; secondly, in the unconscious communications within the group, and this communicated to the listening presenter; thirdly, there is then the unconscious communication from the presenter brought back into the group of a sort of amalgam of his/her unconscious experience and the unconscious experience from the group discussion. There is then the first explicit focussed communication of the whole group together. This ordering is imposed and I am leaving out of this description that the group begins to communicate unconsciously from the first moment they arrive in the room, but the presentation of the case becomes a focus, and in relation to this, the ordering of unconscious communications begin. This discussion now of unconscious communications is about that only and I am excluding all the communication which is conscious. The arrangement raises the idea of a type of hall of mirrors, a process of multiple reflection, and an arrangement which augments the process of resonance of unconscious communication occurring between individuals.

Rather than a topographical model, where there is an above and below, I imagine a surface like the surface of a tympanic drum or a flat pond in a frictionless environment; imagining this as the field of the psychic and the somatic. The core origins of the individual may be pictured as being at the centre point of drum membrane or pond. This is like Winnicott's "true self" or the point of origin of Bollas's "transformational object". The earliest part of the individual, and it is this part that is set reverberating by the interactions with the ordered unconscious communications of the Balint Group. As when a pebble is dropped in the centre of a pond, or a drum struck at the centre, ripples spread out in a circle and reflected back and forth (for ever in an airless frictionless system) causing an ever-changing set of refraction patterns. There are some similarities to an earthquake. Imagine what a repeated in-put of energy over time at the core might cause in the reverberation patterns and shaking up of the surface. Would it boil or seethe? There is much literature currently on emergent phenomena and the process of kindling in neuro-psychological development and change. The idea is that these changes are from the inside out directly, accessed by group unconscious communications, not interpretations. However, the process of unconscious communication has to be allowed to flow and not be interrupted, as would occur with an interpretation. The group has to be trusted completely or people selected individually, in order to constitute a group which the leaders feel they can trust - a strong "cauldron", one that will not leak or blow up, but absorb, process, and contain the turmoil. The case serves to direct unconscious communications to the presenter in conjunction with his/her case. Ironically, I feel I am ending this reflection on a metaphor, having started with a metaphor, "well marinated in a Balint stew".

In Iran, I intend to do what work I can, that is wanted, required and feasible. The emphasis here is on the creation and development of an Iranian organisation to support Iranian Balint groups - the practice, teaching and training, so there are venues where the Doctor-Patient relationship may be explored in as much depth as possible.

My hope is that my Iranian colleagues will turn their creative minds to forging an Iranian cauldron suitable for cooking an Iranian Balint Khoresh خورش (stew). A final association comes to mind. The last two lines from the poem, "The Refusal" by Piere-John de Beranger<sup>20</sup> that introduces Edgar Allan Poe's<sup>21</sup> "Fall of the House of Usher":

Son Coeur est un luth suspend;  
Sitot qu'on le touche il resonance

The translation I have for this is:

His/her heart is a suspended lute,  
As soon as it is touched, it resonates

The Farsi translation for this is:

دلش عودی آویزان است که هر لمسی در آن طنین می اندازد

This association arose, I believe, from my memories of Balint Groups in Iran, and more likely from the accounts of a psychiatrist and Dr Mozghan Amini, of their experiences of being in a Balint Group, which are published alongside this article.

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**Meetings of Balint Groups in Iran.**



## **An attendee – a senior psychiatrist**

This was the first time I attended a Balint Group and it felt like walking in a dark wilderness. It was frightening and anxiety provoking. The case that one of my colleagues presented was about death. The case of a patient approaching imminent death and a doctor feeling helpless and guilty. I gave wings to the bird of my imagination, and allowed myself to be immersed in the experience.

I remembered my late aunt who was swallowed, in a matter of six months, by a carcinoma of the lung. My aunt expected a lot from me as a doctor and yet I could do nothing. Only in the final night before she passed away and she was in coma, I noticed that the nurses were unable to find a vein. With the help of my father, who is also a doctor, we found her vein, and this was the last gift I could give her, which in no way compared with all the kindness and love she had given me. I became deeply immersed in the waters of my imagination and remembered individuals whom, as their doctor, I had been unable to do anything for, but to see them off to the precipice of death.

The death of my grandmother, many years ago, still remains unresolved. In those days I was in my teens and growing taller and bigger [the Farsi expression for this is “breaking bones”], whilst she was becoming more ill, smaller and dying. Because of the broken femur in her leg, she was unable to move on the bed and used to ask me to move her to avoid bedsores. I was growing bigger and she was dying.

I also think about those patients who have enriched me by paying my fees when I have done nothing for them, but to see them off. And I will be seeing people off in future. People I will lose, for whom I could do nothing. The feelings of sadness, indebtedness, guilt, and helplessness clawed at my heart and intensified as I listened to what other members of the group said. It felt as if a dagger was tearing into my chest and wounding me. I suddenly remembered one of the Greek myths, and then it was as if a projector had suddenly come on in a dark cinema. I expressed my feelings in the form of sharing the myth to other group members. I told them of Charon the Ferryman of Hades who carried people from the world of the living through the river of death into Hades, the world of the dead. And the coin, they used to place in the mouth of the dead at the burial, was the payment for Charon. I said, “For us doctors, it is as if we need sometimes to play the role of Charon, though we don’t like it”. Putting these feelings into words calmed me a bit, but for a week or so I felt wounds had opened up in my heart and I really wanted to find a group of human beings and talk so much to allow my wounds to heal.

**Translated from Farsi by Merhnaz Shahabi-Sirjani**

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## **Dr Mahdieh Moin, MD**

Consultant Psychotherapist, Head of Psychotherapy Department,  
Roozbeh Psychiatric Hospital, Tehran.

It was in 2006 when the medical school of Tehran University of Medical Sciences recognised that in contrast to the rich knowledge and expertise that the medical students learn during their education, there was something lacking in “communication skills” and a deep understanding of the pain and suffering in their patients. This lack might be enough to make the whole sophisticated medical work unsatisfactory and even futile. Some colleagues and I were invited to think about this problem. The preliminary result was that our medical students, who were the best academic applicants in the country, were extraordinary in learning medicine but not necessarily the most effective in their communication and other life skills.

A series of workshops and lectures were added to the medical training curriculum. I started working on “empathy”. During the work with medical students I noticed that a serious barrier existed to the extent that our students were inclined to imitate some gestures of empathy rather than being empathic. They were fine to use statements such as, “I understand you are in pain.” My question was whether it was a real and true understanding.

Undoubtedly this inability to empathise is a multifactorial problem. Between them I could see to what extent students and young doctors felt themselves disarmed and vulnerable if they were to deeply understand and acknowledge the pain in the others, their patients. I encountered some sporadic cruel suggestions between them, like dehumanisation of their patients to feel more empowered and competent to work with them. This thinking of the patient as an inanimate object or non-human was anxiety-reducing and enabling in terms of working with the faulty or ill part of a system compared to the whole situation of a patient who suffers from an illness and probably has a mind and some other worried minds around as his family.

Why it was difficult to see the patient as a patient? Would this effort to teach empathy be fruitless? One can talk here about a need for processing and the capacity to change the beta elements with alpha functions to thoughts and so on. I found this serious barrier was due to the lack of emotional support for doctors. It is the emotional support that enables doctors to face the enormous amount of responsibility, receptivity and care for the patient. If it is lacking, it creates an urge for “detachment, emotional blackout or switching off” in them to be able to survive.

In 2016 when our department had the privilege of Dr Ray Brown taking part in the Psychotherapy Fellowship Programme’s teaching in Roozbeh Hospital, we started to think about setting up an experiential Balint work. The best place to accommodate the new Balint work at the time was The Psychotherapy Committee which is within The Iranian Psychiatric Association. After the paper work was done, “The Iranian Balint Group” was tasked to work jointly with the Psychotherapy Committee and The Psychotherapy Department, Roozbeh Hospital, Tehran University of Medical Sciences. The groups consisted four main categories:

1. Psychotherapy fellows (Consultant Psychotherapists)
2. Consultants and Fellows in psychosomatic medicine
3. Consultants in other specialties (ophthalmology, A&E, gynaecology)
4. Ethic, at least, however, we had some experienced psychoanalytic psychotherapists in the group.



The groups started to be an experiential Balint group, made of 10 people in the main circle as “the Balint group” and the rest of attendees were in the outside circle. Dr Ray Brown and I were in the outside circle observing. The individuals in the group started with an awareness of Dr Brown and the outer circle attendees’ presence there, so they talked in English at the very beginning of the experience. However, the striking quality of a Balint group happened very soon and they continued to feel cohesive as a group, distinct from the outside, and continued to talk in Farsi. We were fortunate enough that had the anticipation of this process and we had a very talented psychologist as simultaneous translator for Dr Brown. It can be claimed that all of experiential groups that we had so far which is 14 were proper Balint group leadership workshops equal to 6 Balint days by the Balint International Federation.

It was fascinating how our colleagues started to use the space which was created by the Balint group, however it came up in all feedback that Dr Brown’s dynamic way of being there had a crucial role in the creation of that space. One colleague said:

*“Dr Brown’s method of teaching reminds me of Sherpa people, who are elite and expert mountaineers, they do not need to discover Himalaya in their names but they prefer to be supporters for mountaineering expeditions, carrying the heavy stuff and being a guide for them. At the end they allow the discoverers to feel that it was their discovery and achievement.”*

It was one of the most beautiful comments about the burden and pain that might be carried and processed in a Balint group. Our Balint group experience in TUMS has been a unique space for sharing the deepest emotions and a sense of being able to process our difficult emotions while we work with patients instead of turning away, frightened of getting fragmented under the emotional pressure. We found it possible to give ourselves a space for thinking about our hidden, almost disappearing, parts of the most ordinary humane reactions as the barriers of empathy. I found the Balint work very revolutionary in the medical students and doctors training. Although now we have started our work under the umbrella of the psychiatric association for the future we are considering a link with the Iranian General Medical Council and the Ministry of Health, as well as the TUMS curriculum for medical students. We are aware that our psychodynamic psychotherapist colleagues are very competent and interested in the expansion of the work but the development will not be just on their shoulders. We look forward to a time when all general hospitals have the opportunity of a Balint group which helps them to carry the burden in the difficult path of medical work.

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## **Dr Mozghan Amini**

senior psychiatrist and psychoanalytic psychotherapist:

To write about my experience of Balint Groups is like my experience of taking part in them, full of different feelings and an experience which is full of ambiguity and which requires me to be patient and to give myself time.

As someone who practices psychotherapy, the experience of being in a Balint Group was very different from the experience of group psychotherapy sessions. In Balint Groups my emotions come very near, as if I feel them in my heart. When the group begins and one of the group members starts talking about his or her case, I feel, like water softly bubbling up from a spring, different feelings bubble up in my heart, not separated as drops but in one flow like water. Different emotions, memories and fantasies like a current of water. I don't know where they come from and how each slips behind the other and bubbles up. All I can observe, both in myself and in the group, is how each memory and each view from group members follows another and moves forward like the flow of water. Sometimes the water splashes about and erupts and sometimes like rain, which wets one's hair, with the continuous falling of droplets of water.

It is like, different individuals with different stories in their hearts, sit together, one starts a story which, which is in tune with that story, and from the heart of these stories, collectively they create a richer more meaningful story.

I felt that in partaking in Balint Groups, I got to know people differently and more deeply. Though some of them are my colleagues whom I have known previously, the experience of people becomes more real and authentic, after the experience of Balint together. I see how human emotions are shared and all of us have experiences laden with emotions we all share, and I believe it is this realisation of shared emotional experiences that brings us closer to each other. I have no doubt that all those individuals who were with me in Balint Groups had experienced different emotions in the course of their lives, but what has been so valuable for me was that in the space which we had collectively created, it became possible not only to share those very deep emotions and our personalities which brought up close to each other, but there was also a healing effect.

Another experience of Balint was when I presented the case of one of my patients ... An experience I had with another human being, who as a client, had broken my heart. This was a young man with very difficult economic and family situation who wanted to sell his kidney to be able to leave Iran and, in his mind, find happiness outside of Iran. To hear his very sad story and the feeling that I couldn't do anything to help him had overwhelmed me with feelings of pain and helplessness, such that I felt the need to discuss it in the Balint Group. Talking about him in the group was very helpful to me, in that I understood the meaning of what had happened to me. The perceptions and feelings of other members of the group about the case began to help me come into terms with my own emotions. I realised that it was possible to see some bright angels (hopeful glimmers) at the heart of this "totally dark" (in my mind) story. To present it in the group helped me create a new meaning from the grip of that experience which enabled me to psychologically digest the experience. In the meeting, my feelings about this case came to life but I was able to share them with others in whom I had trust, let them become part of the experience as if it were a collective group experience, and with the creation of the new meaning I became more able to incorporate this experience in my psyche.

**Translated from Farsi by Merhnaz Shahabi**



# The Balint Essay Prize Winner 2018

In this essay I'd like to discuss and reflect on a particularly harrowing and touching experience I had during my Year 4 GP rotation, and the subsequent experiences I encountered when bringing this case up in my first ever Balint group session. In the interests of confidentiality, I have changed the name of the doctor and my patient unnamed, as well as not specifying the specific diagnosis.

## The Consultation

I was shadowing Dr Miller, one of the doctors at the practice I'd been assigned for my GP rotation. He was very good at explaining through everything he did and would always give me a short summary of a patient's past medical history before we saw them, giving me to have a helpful preview of the person who would be entering the room. After a somewhat monotonous morning of UTIs, blood pressure checks and repeat prescriptions, I wasn't expecting anything particularly unusual for the last few consultations of the morning clinic. I was surprised with his introduction to his next patient. "He might not want you in the room," he warned, scrolling through notes on the computer.

"Oh no, that's fine," I replied. Sometimes you just don't want the extra pair of eyes and ears of a little medical student to be there, which is completely understandable. And those are the times I especially don't want to be burdening a patient with awkward glances and feeling guilty anyway. Plus, this could mean I could potentially get an early finish, a particular bonus.

He looked to me, his face void of much expression, before continuing. He explained that the patient's son had recently been diagnosed with a cruel condition, not common in young children, and one that would inevitably kill him in the coming months. "I've actually never met him, but I think he's here to talk about his son," he said solemnly. "Are you happy to stay for it?"

My heart dropped a little. I couldn't see any way this consultation was going to have a good ending. I also felt a bit guilty that even if he did consent to me staying, he'd secretly not want me there, but no part of me wanted to volunteer myself to leave the consultation. I was curious, my head filling with questions; why did this poor child have such a malicious disease? What could be done about? How was he feeling as a father? And how on earth was Dr Miller going to tackle this in a ten minute appointment? Were we going to talk about the son or the dad? Who was the patient in this scenario?

"Yeah," I said. "Though completely understandable if he doesn't want me in the room."

Whilst Dr Miller went to get the patient, I folded up my notebook, got my phone and shuffled to the edge of my seat, ready to be asked to leave the room. However, Dr Miller returned with the patient and immediately introduced me as the medical student. The patient had consented, to my surprise. The father nodded to me as he took his seat, and I sank back into my chair.

He was middle-aged and perhaps a little rugged looking, but nothing to note in particular. He was just any other bloke to a passerby, any other middle-aged dad with probably a healthy salary, living in a nice house in the leafy suburbs of the GP's neighbourhood with his wife and kids.

Within the space of seconds, I saw this very ordinary looking man in front of me crumble. He didn't need prompting, he didn't need questioning. He didn't even need words of his own to express the sheer devastation of his situation. His eyes, filled with

pain and angst, looked sadly at the doctor. A pained look which was so desperately seeking hope, but he looked defeated already. His face fell into his hands. Never had I seen such a rapid deterioration of someone's demeanour. His body language and facial expression were exposing the horrendous emotional pain he was suffering through on the inside. It seemed to me like he'd been suppressing this pain for so long it had amassed into an unbearable amount, but only now, in the privacy of the GP consulting room, did he finally feel like he could release it all. I realised this agonising journey was far from over for him. It had barely begun.

Dr Miller didn't say too much; he allowed the patient to get everything he wanted to say out of his system. The attention and priority Dr Miller had for this patient was undeniable, as he focussed on every word coming out of him. This was about him as a patient in his own right; not about his son, not about his son's diagnosis or his son's medical treatment. Dr Miller was methodical and systematic with his approach in tackling individual issues whilst still maintaining empathy and giving the patient the space and time to voice his thoughts. This horrendous diagnosis was accompanied by a plethora of other issues; the patient's home life, the relationships within the family, employment, school and maintaining his own health. The situation was dissected into a list of more approachable issues, dealing with one at a time before moving onto the next. By no means was anything definitively solved by the end of the appointment and of course nothing could take away from the fact that his son was incredibly sick, but I could see the foundations being laid in this relationship, and the trust the patient had placed in Dr Miller.

There have been many times during my clinical placements I've felt in the way, clueless and useless as a student observing, but I had never felt more like an onlooker as I did during this consultation. I could handle a consultant ignoring me or telling me off for not knowing the mechanism of action of a drug; I was used to that now, six months into my first clinical year. This feeling was nothing like I'd experienced before and despite teaching on communication skills and breaking bad news, this was completely foreign to me. This wasn't breaking bad news; the news had already been broken by someone else. This was now the aftermath of it. They don't teach you that part.

I don't remember how long the consultation was but time didn't matter in this situation. It was emotionally one of the most complex cases and delicate patient-doctor interactions I've observed so far in my medical placements. I imagine I will remember that consultation for the rest of my training and career, and incredibly privileged and grateful to both Dr Miller and the patient for trusting me and allowing me to stay for it.

### **The Balint**

I brought this case up in a weekly Balint session we had, which was embedded in our timetables as part of our GP rotation. We'd never even heard of it before or knew what it would entail. It was one of those things nobody had that much expectation for but still turned up to because of the compulsory sign in sheet.

We were in a small room, sat around in a circle. We were given a brief rundown of the structure of the session; one of us would tell the rest of the group about a patient they'd encountered during the previous week of the rotation and we would then all discuss, followed by some discussion by the group whilst the storyteller would push their chair back, out of the circle and out of the conversation.

"Has anybody got a case?" our leader asked. I immediately thought of the patient from Dr Miller's clinic, who had been mulling over my mind since the last time I'd been in the GP. Nobody spoke up, and the silence got to a point which was threatening us to

be sat there all day. It was a Monday morning and the last thing I wanted to do was put everyone into a sad mood and hoped someone else would offer to talk about seeing a delighted new mother and her baby or an endearing grandmother coming in for a chat. But with no other offers being put forward and my patient looming in my mind, I felt compelled to speak out. I volunteered.

Everyone looked grateful I'd broken the silence but little did they know what my case would entail. From the moment I started speaking, I sensed my voice faltering. Having eight pairs of eyes on me as I told a story which I strangely didn't feel like I had the right to talk about was initially intimidating, despite them all being peers I knew and had spent time with already. The story had touched me and was one I wanted to share, but I feared I wasn't doing it justice. I feared I wasn't conveying just how devastating it was and the extent of anguish, not able to give it the crushing portrayal it deserved. I continued though, speaking about the futile nature of the son's illness, the suffering of the entire family and how I saw such a presentable man completely fall apart into ruins in front of me. I tried to maintain eye contact with the group though it didn't help that every time I looked around, my eyes caught the box of tissues sat on the coffee table in front of me. I kept talking, hoping tears wouldn't get triggered from my eyes.

I also spoke about the relationship between Dr Miller and the patient. How at no point did Dr Miller rush the patient; he was the priority over anything else in that moment, and he gave him all the time he needed to express his emotions. My group agreed giving the patient this safe space to release his feelings was essential and importantly also allowed the patient to very quickly develop his trust in Dr Miller. It was also imperative for Dr Miller to learn about the patient, especially when he was so fragile, in order to properly care for him and fulfil his role as the doctor.

I mentioned about feeling like a bystander, like a stranger watching in on a very intimate conversation and the strange sense of guilt that accompanied it. My peers were very understanding, talking about times they too had felt like they were out of place in clinics. We agreed that, indeed, it was a sensitive consultation that I had been in, however informed consent had been taken before the patient had even met me and would have been able to ask for me to leave at any point. It was also a valuable experience for me to have been able to observe, one that I am very privileged to have had and one that my peers expressed they would have been grateful to have had, had the opportunity arisen. This made me even more grateful to both Dr Miller and the patient to have had the experience.

After I spoke, I took questions. I feared silence, but my peers were quick to empathise about the situation and ask questions. Some were very factual and about the patient, like his age and his job. Others were harder: did you meet the son?; how did you feel sitting there?; how long has the son got to live? It was so relieving to see people had taken interest and get involved with the discussion, and I felt discussing it together dampened down the intimidation I felt. Many of the questions they asked were ones which had crossed my mind at some point and gave me consolation that the thoughts and feelings I'd had weren't unusual or unique to me.

I was then asked to distance myself from the circle, and once again I became the spectator, like I had been in the clinic. I was a bit apprehensive, not knowing where the conversation was going to go but it went well. It was comforting to hear them discuss the case in such a sensitive manner, attesting to many of the thoughts I'd had. A key point of discussion was regarding who was the patient in this case - father or son? The general consensus laid in both, and that despite the son's illness it was imperative that the father was viewed and treated as a patient in his own right. This was incredibly comforting to hear and I could not have agreed more.

The Balint experience was refreshing; it gave me the opportunity to offload a heavy case to a group of similar peers and gain solace and affirmation about the emotions I had. It had exposed the case to different viewpoints and allowed discussion about what was a very complex and delicate case. I believe Balint is not only good as a way to offload and destress for students, particularly to prevent burnout and exhaustion, but also as a way to exchange ideas and learn about new clinical cases and scenarios. Scenarios which you can't read up about in a textbook or may not be so scriptable for an OSCE station. Scenarios which are part of the reality of medical practice. Only by seeing these types of cases ourselves and being able to discuss them in safe spaces like Balint groups will we get the valuable clinical exposure we need whilst preventing burnout and maintaining healthy minds.

**Inseo Yun**  
**4th Year Medical Student**  
**University of Edinburgh**

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# **Balint Society of Australia and New Zealand Medical Student Reflective Essay Competition - The Lawrence Gilbert Memorial Prize**

This prize is open to all medical students in both countries and invites them to submit an essay recounting their experience of the student-patient relationship.

Isabel Hanson and Annabelle Hughes were awarded joint first prize,  
while Simon Chadwick was awarded second prize.

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## **Between a Beginning and an End**

Isabel Hanson

Sydney Medical School , Sydney

Desmond and I met between a beginning and an end.

For me, it was the beginning of my clinical years of medical school, the first day of my first placement. I was allocated to the respiratory medicine ward, tucked in the top corner of one of Australia's most large and well-respected teaching hospitals. I arrived with my notebook in hand and my stethoscope dangling conspicuously around my neck. I felt abuzz with nervous excitement and energy, carrying with me that powerful wide lens of attention that arises when you step into an unknown culture and environment for the first time.

For Desmond, it was an ending. He had presented late to the hospital with end stage metastatic lung cancer, and he was to spend his final days in a white hospital bed separated by thin grey hospital curtains from the three other male patients who shared his room. My career as a future doctor was beginning, but his life was ending. We met here for a moment in this sacred space of coming and going.

The first time I saw Desmond I was struck by how was painfully thin he was. The bones of his wrists and hands protruded at sharp angles, his head was all skull and cheekbone. He had a shaved head with week old tufts of grey and white hair around the rim and a neatly trimmed beard holding to his angular face. I could see from his chart he was 68 years old, but he could have been 98 from the way his skin hung and his limbs surrendered meekly to gravity. As the registrar asked her daily questions Desmond responded with an exhausted indifference, and eventually he concluded our meeting by turning away from us to face the window. We continued the ward round and moved on to the next patient. Consumed by the rich newness of the hospital process and enamoured with the idea of myself as a future doctor, I did not think of him again.

The next day when we went to see Desmond we met a different man. He sat up in bed, his deep brown eyes enormous and shining with tears, he apologised again and again. He was not himself he told us, and he was sorry to be rude yesterday. He reached out his stick and knuckle fingers and held the hand of the registrar he had turned away from the day before. Caught off guard by his magnanimity, as his behaviour the day before had been more than understandable given his condition, I shifted internally and saw more clearly the whole person in front of me. Not 'the cancer patient in bed 9', but a complex and conflicted human being, struggling with the fast and unanticipated approach of his death.

A mentor of mine had told me in the months earlier that medical students are the "last bit of fat left in the system". The time of every other person in the hospital



environment has been cut away to such a fine sliver in the pursuit of efficiency and cost saving that spending extended time with patients is almost impossible. Sitting at a patient's bedside beyond the strictly limited time required to extract the information relevant to their medical treatment is not just an indulgence, it may be an act of negligence. There are other patients who desperately need your attention and medical expertise, so to spend the time required to know a person's story and see them as whole may deprive another person of essential medical care. This is not a lack of compassion on the part of the doctors, it is the result of a health system straining under the realities of too many sick people and not enough healers and resources to help them.

But medical students are the exception. Medical students have all the access to patients and none of the direct responsibility for their care. It is a rare and astounding privilege to be medical student. So for the remaining weeks of his life I began to sit with Desmond every day. I felt powerless to help him in any tangible way so I did the one thing I felt I could do. I listened to him.

I sat at his bedside, lowered the bedrail, and listened. I had done some reading beforehand and, attempting to be a good medical student, I thought perhaps an academic approach would provide me with some guidance to bridge across my chasm of inexperience. Perhaps I could support Desmond's journey through the five stages of grief of the Kübler-Ross model (1969)? Perhaps there would be some pamphlet on palliative care resources that I could provide at an appropriate moment? I felt an undercurrent of desperation in all of this, searching to try and find some way to help.

Desmond did not want to talk about his death. He did not want to recount his regrets, or to ask questions about his condition, or to talk about himself. He wanted to tell me about Genevieve.

Genevieve had been his love. Late in life, after an unhappy marriage and a hard and long career as a labourer, he had met a woman who he had deeply loved and who had loved him in return. He told me of her tenderness, of her joy and enthusiasm for life, and with a fresh and present grief he told me how she had died from brain cancer five years earlier. Genevieve was raised as an only child by two grocers from a small rural town, who had not wanted a child and made this known to her throughout her life. Desmond told me that she had felt unwanted and unloved, and even in her death her family had treated her with indifference. But as an adult she had met Desmond, and they had shared a heart of love for more than a decade before she died.

This is what Desmond wanted to tell me. Desmond asked me to hear and hold a story not of his life, but the story of his love. In South Africa there is a term, *ubuntu*, which describes the way in which we are all connected through our common humanity. Archbishop Desmond Tutu explains this to mean that "a person is a person through other persons" (Dalai Lama, Tutu, & Abrams, 2016, p. 60). Through Desmond telling me the story of Genevieve, his story began to make sense. He had known the symptoms of his cancer long before he arrived at hospital and yet he had seen no doctors. Why had he not sought out treatment when his cough started, when his back ached at night, when the blood appeared in his urine or his muscular body rapidly shrunk away under him? Through listening I began to understand that when Genevieve had died, perhaps a part of Desmond had decided not to go on living.

When Desmond could no longer talk, I would return after the morning medical round and lower the bedrail, sometimes to hold his hand, sometimes just to sit with him in silence. I felt a sense of guilt about this, as though I was doing something wrong and unprofessional. Once as I sat silently with Desmond while he drifted in and out of consciousness a doctor from my team walked by and glanced at me quizzically through

the curtains. I leapt up and pretended I was checking some medical detail in his chart before hurrying off to another bed, hiding my embarrassment behind a shield of busyness. I felt ashamed. I was afraid that this soft part of my character was a weakness and that it would stop me from being a good doctor.

And then one morning, his bed was empty.

Vainly hoping he had been moved to a nearby room I asked the team about him, and was told that Desmond had died overnight. I felt the full body whack of emotional overwhelm. The doctor must have sensed this as she looked up at me from her paperwork, and told me calmly that he had passed at 2am and as far as she knew he had not been in any pain. The conversation felt tight and was quickly concluded. I held my tears behind a mask of rigid professionalism. We moved onto the next task, and no more was said of Desmond.

This man passed through my life for only a few weeks, but the gift of the time he spent with me has stayed with me, and continues to inform my reflections on communication with patients. Deep listening is one of the most valuable things we can offer to another human being. In the hospital environment, it is almost an impossibility to approach every patient in this way because of the lack of time and resources. But we can set an intention to try. One moment at a time.

Deep and present listening can be as deeply nourishing for the listener as it is for the speaker. When our medical treatments do not work in the way we hoped they would, when our patients get sick despite our best and most diligent efforts, when we have completely exhausted our clinical knowledge of how to heal, we still have things to offer our patients. These gifts come not from our decades of medical training but from our own raw and present humanness. From the gift of being a whole person, witnessing another person's suffering, and deeply listening to their life. To accompany someone in this way is an act of being, rather than an act of doing.

I have wondered if the threads of Desmond's life and mine had not crossed at this early stage in my training, would I have seen this man and learned all that I did from our time together? In the famous Good Samaritan study (Darley & Batson, 1973) the predictor of whether a participant would stop and help a person in need on the street was not whether they had been recently reminded of the parable of the Good Samaritan, but how hurried they felt on the way to their next appointment. Despite our best intentions, hurrying prevents helping. The hospital culture of busyness may mean we are missing these rare and precious opportunities to connect, not only to serve our patients better, but also to nourish and sustain ourselves as compassionate healers.

I would like to think that I would have taken the time and attention to be with Desmond as he died, but I fear that once I had seen and learned more about the hospital environment and how medical professionals are compelled to practice, I may have emulated this busyness as a path to professionalism and completely missed this precious opportunity to connect.

Desmond told me Genevieve's story, and through it he told me about his life, his love and what truly mattered to him. He taught me the importance of deep listening and how much we can do by bringing our humanness to the bedside along with our professional expertise. I understand now that the desire to connect and see people as whole is not a weakness. There is a power in listening and truly seeing people as whole that will not only serve our patients, but may also hold the key to maintaining our own wellbeing as healers in a hospital culture of disconnected busyness.

*Names and personal details have been changed to protect the privacy of the patient and their family.*

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# Lessons from Luna

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In the special care nursery lie 12 tiny, vulnerable newborns – born too early or with complications, and all requiring full time care. But only 11 families come to visit. One tiny baby lies in the corner of the room – sleeping, swaddled, and alone.

The morning ward round comes to a stop around her crib and the team of doctors and students crowd around her. It's a striking visual, several adults craned around this tiny fragile baby. Luna doesn't stir. I scan my eyes over the paperwork lying on the bench beside her and linger over the words 'query neglect'. As her story is told, it feels as though she's shrinking, becoming even more fragile, right in front of us.

Luna was born more than 10 weeks prematurely. The ambulance had picked her up from a 'crack house' as documented in the notes. Her mother was using drugs throughout the pregnancy, both parents 'blazed' at the time of Luna's delivery. Not a single family member has come to see her, now a month since her arrival at hospital. Family have been contacted, times scheduled for a visit, but time and time again, nobody shows.

A medical overview is tossed around verbally between doctors. It is a waiting game they say, she needs weight gain through her nasogastric tube, eventual oral food tolerance, respiratory monitoring and caffeine for her regular apnoeic spells. But despite the daunting medical milestones she must yet reach, there is much more concerning social component – where is her family? Every day that she waits for somebody to show is another day without the necessary physical and verbal contact that a baby needs for development. Nurses provide daily monitoring, bathing and feeding, but time constraints prevent the nursing staff from being able to give her the nourishing attention she needs. The consultant explains how the absence of being held or spoken to, and the deprivation of maternal contact in particular, will adversely affect Luna's cognitive, behavioural and speech development. I felt my understanding of her situation shifting; Luna was not merely unfortunate for not having visitors, she was being disadvantaged. Luna pulls a face and stretches her tiny, almost translucent hand. It was as though her little hand was pulling invisible strings and tugging at my heart. This poor little darling, oblivious as she was to her rough start in the world, was falling victim to neglect in a room full of people.

While I was busy contemplating the injustice this little baby had already stacked up in her short lifetime, the ward round had moved on and we left Luna. But Luna did not leave me. I thought about her for the rest of the day. I felt an ache to go back and pick her up, to hold her against me and protect her from the unfair lack of affection she was suffering. I replayed the morning ward round in my mind. It felt sterile and unnatural to walk past, none of us having touched or spoken softly to her despite acknowledging how that was what she needed most. 'I have two arms' I thought to myself, and I could fix this baby's current state of deprivation.

Being Luna's visitor became my new mission. It wasn't long before I became friendly with the nursing staff and with the families that were also frequent special care visitors.

My name was even written on her medical records as Luna's official 'cuddle carer'. I fed, bathed and changed her. I would put her against my chest so she could feel my heart beat and feel close to someone that cared about her. I exhausted my repertoire of lullabies, singing and humming to her. I would chat to her non-stop to squeeze as much verbal stimuli as possible into the few hours I spent with her per day. I read her storybooks and I would tell her about my day. I whispered to her about how precious and important she was. I told her that even though her family didn't come, it was no reflection of her own worth. She was loved, and I adored visiting her. I told her she would grow to be big and strong, and that despite her rough beginning, she would flourish. I would read aloud from the study books open on my lap while I nursed her in my arms.

Nearly every day I would come to visit Luna, and I became so fond of that time together. Before or after a hospital shift, or even during my lunch break, I would come to see her. Sometimes I would come to hospital especially to visit her, weekends in particular, not liking to think of her lying there alone for extended periods of time. I looked forward to seeing her, I thought about her when I was away from hospital, and I took great personal interest in her milestones. Nurses would inform me of her progress, even if we passed each other in different parts of the hospital. I battled against the onset of tears that sprang to my eyes the day she came off the respiratory monitor and the day she took her bottle from me rather than having nasogastric feeds.

Being Luna's ambassador was easy for me. I felt rewarded knowing that I was helping her and minimizing the impact of the unfair hand she'd been dealt so far. What was challenging about the situation was having to justify my actions. I was regularly questioned about my intentions, not maliciously but from curiosity. Didn't I have somewhere I needed to be? Didn't I need to go and study to pass my exams and be a doctor? The constant surprise I experienced from those around me when I came to cuddle Luna in turn surprised me! Is a doctor so far removed from the role I was carrying out? Was it that unexpected to make time for your patient and do something little, something easy, that was ultimately what they needed most? These reactions triggered me to think about the perception of doctors and the role of 'caring' in the profession.

Doctors are widely appreciated by the community for their knowledge and skill. They save lives and cure ailments. But there were no awesome heroics in my interactions with Luna. I was not resuscitating someone, performing life-saving surgery, or even writing prescriptions to ease pain and fix medical dilemmas. In fact, there was no medical knowledge whatsoever. And while medical knowledge, diagnoses and interventions undoubtedly underpin the profession; the 'care factor' ought not to be overlooked. Perhaps true patient care does not always come with the bells and whistles that we typically preconceive.

Patient-centered care is certainly emphasised in medical training and in hospital policies. It is no secret ingredient to good medical practice. And when I think of inspirational doctor-patient encounters, there is consistently a strong presence of genuine, individualized care for the patient. But there are also many instances I can think of where empathy, emotion and a personal level of care for the patient has fallen by the wayside in clinical practice. There is danger of our patients becoming a catalogue of medical conditions and a list of presenting symptoms. We run the risk of churning patients through a conveyor belt of medical management solutions, without seeing them for who they are. Perhaps I am whimsical, new to the medical world, and have not been accustomed to some of the more harsh realities of time constraints and work pressure; but I like to believe that empathy and medicine are not separate entities. I believe that care can and ought to be integrated into daily practice.

We need to shift our standpoints as doctors from purely clinical mindsets to integrate and give importance to social and emotive patient needs. And for a patient, that may be what they remember the most; not the person who wrote the prescription for the life-saving medication, not the operating staff that all contributed to their successful surgery, but the person that lends enough of their time to get them a blanket because they're shivering. The person who listens, empathises, understands. Having been on the patient side of the fence with a chronically ill and dying close family member, I can testify to the incredible difference that empathy and care brings to the patient's experience. I am privileged to have experienced the patient side of events, because, though tragic and heart breaking, it taught me the phenomenal importance of compassionately driven healthcare and motivates me to act with consideration for the patient's perspective. Luna has taught me similar lessons, but this time from the doctor perspective. I was witness to Luna's needs, and experienced the perspective of a medical person giving help that was not necessarily medically driven, but nonetheless beneficial to the patient. As a doctor, I don't want to lose that heartfelt need I had to hold and help Luna. I graduate at the end of the year, and will soon be thrown into the real medical workforce. I hope to carry with me the same strong desire to help people that inspired this interaction with Luna. Luna taught me that making time to help someone is not wasted productivity – it is the end goal.

I continued to care for Luna and had just celebrated her 60th day of hospital admission when her biological mother walked back on the scene. Luna was reaching medical milestones and was ready to be taken home. Contact was made with the mother and she agreed to come to collect Luna, though she would have to stay overnight to ensure she was safe to look after her. I made sure I was there to meet the mother, and we sat together and talked. I tried to gently impress upon her how important Luna was, and how much she meant to me. While trying not to judge this mother's circumstances, it was an incredibly difficult situation for me, having developed such a connection with Luna, to then be confronted with the woman that had put her in that situation in the first place. The mother left for a cigarette and I held Luna for the last time, rocking her and holding her a little more tightly this time. When the mother returned, I handed Luna over and had to excuse myself to seek refuge in the toilets and cry. I cried because I was no longer able to protect this little baby from what lay ahead of her. I cried because I felt like the child protection system was letting her down. I cried because I knew Luna more than anybody, and this lady, although she was her mother, was a stranger to her. She would not know that Luna poked her tongue out when she was constipated, that Luna liked the Indigenous lullaby best, and she was not witness to Luna's incredible resilience and medical triumphs in those critical days of her prematurity.

It seemed that Luna had not yet finished teaching me lessons. With time, I was to accept the limitations that come with the role of a doctor. You cannot protect, fix or control things outside the hospital walls. You can only care, then and there, with the patient in front of you. It is perhaps your only chance to show genuine kindness and to hope that your actions might positively influence them. Don't let it go.

*This is Luna's story, recalled from true events.*

*The mother failed her overnight stay with Luna, leaving for a drug hit in the afternoon and not returning. Luna was placed in foster care, though there is a chance that the mother will regain custody in the future.*

*I think about Luna often and I send a prayer in her direction, hoping that she is well cared for wherever she is. She won't ever know about me, but I won't ever forget her or the lessons she taught me.*



# Sharing the Little Lights

Simon Chadwick

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*Names have been changed to protect confidentiality.*

When I first met Alex, I was two weeks into my third year of medical school. Alex had brought his father Richard to the ED after 3 months of deteriorating health. Richard, an 85-year-old with no significant prior medical history, had become fatigued and dyspnoeic, and his loss of appetite had caused him to lose enough weight to concern his son. Richard's CT revealed a mass in his left lung, and several small lesions in his liver - he had metastatic lung cancer. From a medical perspective, the decision was simple - Richard required palliation.

I don't remember many of the details of that first meeting with Richard and Alex and the medical team. In classic medical student fashion, I was so busy trying not to miss anything that the important lesson of how to tell someone they're dying flew right past me. But I do remember the ease with which they both seemed to accept the path of least resistance. I remember Richard seemed like a kind man, and Alex smiled with the nervousness of someone who was standing tall because he had no other choice.

I also remember needing to leave the room. The image of Alex standing by his father reminded me too much of me standing with my mother, who had died of lung cancer four years earlier. I calmed down without too much trouble – a walk down the hall was all I needed. I returned to the room with the conversation about Richard's care ongoing – we would manage his pain, make him comfortable, and transfer him to a palliative care centre when a bed was available.

As his consultation finished, I asked Richard if I could return to take a more complete history; I sensed he'd be open to it, and I needed to do patient presentations for my assessments. However, the greatest motivator was a personal challenge – I refused to let the echo of my mother's illness stop me from speaking with a patient. So later that day I returned to his room.

In the hour I spent with Richard I got the impression of a strong and stubborn man. At no point did I sense he feared death. On the contrary, he accepted it with a fierceness both strange and admirable because he knew the fight was over before it had begun. Here lay a man who saw the unconquerable cancerous beast snarling at him, and he snarled right back.

But all of this is in hindsight. At the time I was more focussed on myself. The small victory was getting the history, the greater victory was sitting with a patient who had lung cancer and talking, laughing, showing no fear. But I feel ashamed to admit, that despite facing that fear, I felt tremendous relief in being able to separate myself from the familiar snarling beast lurking in that room.

Alex returned to see his father as I stood outside at the nurse's station, gathering my notes and my thoughts. We shook hands and he nervously wiped his palms on the back of his shorts. "How's he doing?" he asked.

"I think he's doing as well as can be expected," I said, mustering all the dispassionate diplomacy I could while trying to explain the obvious and inevitable in the vague yet compassionate way I believed to be expected of me. "His pain seems much better than it was this morning, so hopefully he's more comfortable".

Alex nervously shifted his weight from one foot to the other and his head turned

from me to the door of his dying father's room. When he looked back to me, he spoke in hushed and urgent tones. "Do you think we're doing the right thing?"

Of course, I knew the answer was yes. This was an 85-year-old with metastatic disease – the curative treatment would be cruelly invasive and would ultimately fail. There was no cure here. But being new to the hospital setting had made me paranoid about making mistakes. I was training to be a doctor, a very important job that required my comments to be measured and tactful and reserved. Being reserved is the right thing to do. And that was what I had firmly in my mind as I uttered my next sentence.

"Well, I'm just a medical student, but..."

Alex cut me off. "I know, but I want to know what you think."

When I look back at how I responded to this statement I can confidently say that, at best, my response was accurate. I told him his father's disease was advanced. The team's plan was the best course of action. We would do whatever we could to make Richard comfortable. When a bed at a palliative care centre was available he could move there to be supervised by experts.

Everything I said was true. Alex even seemed somewhat satisfied. He nodded, we shook hands, he went to sit with his father. I went to present Richard's case to my registrar, got my form ticked off, went home, and felt very disconcerted by the way I'd handled myself. What's worse is that I had no idea why. I knew that if given another chance, I would do things differently, but I didn't know how.

I didn't see Richard for another week, but when his medical team and I returned, the man I'd met was gone. In place of the defiant Richard I had briefly known there was a quiet shell sunken in his chair. When asked if he was in pain, he groaned. He groaned again when his abdomen was pressed. A quick look at his bedside chart revealed Richard hadn't emptied his bowels in five days, and the team decided that he had opioid-induced constipation.

As part of Richard's assessment, the consultant asked me to perform a digital rectal exam. I got Richard's consent, and as a nurse helped me lay him on his side, Alex arrived. I explained to him what we were doing, and without hesitation he knelt beside his father and held his hand. As I performed this most intimate and personal of examinations, Alex stroked his father's white hair and smiled through sadness and concern and whispered that everything would be OK.

A few days later I ran into Alex at the hospital cafeteria. As we waited for coffee, we talked about the sweltering heat, about what I was doing in medical school, and about whether his sister would be able to make it to Sydney to see their father.

Then he said, "I just hope we're doing the right thing by him."

And this time I said, "I think you are". I told him about my mum, and how the decision to place her in palliative care was gut wrenching but nevertheless the right thing to do, and how it profoundly sucks to feel like you're giving up on someone. I told him that, as much as we like to pretend we're in control, sometimes that inevitable decision to let someone die is made for us by nothing more than a cruel mistake of biology, that what we could do instead was make sure that what happened was made more bearable, that any pain Richard felt was quelled until we didn't need to quell it anymore.

Something shifted in Alex. I could call it acceptance, or maybe understanding, but all I could see was that he wasn't shifting his weight as much, he was blinking less, and when his coffee came he smiled with his eyes. He thanked me and left, and we would never speak about his father's care again. But in that moment I felt like I'd connected with someone who was confused by the paradox of doing the right thing and still feeling guilty for it. I felt that instead of acting the politician and toeing the party line, I'd been human.

I'd shared my meagre insight with someone who desperately needed to know whether the choice he'd made for his father was not only right, but kind.

To me, this is the crux of my doubt. I have insight into an experience of death that fortunately few people in my position have. I cared for a dying parent as a sole carer and watched her die before her time. I have grieved, and I still grieve. But instead of using my experience to sooth Alex's turmoil over choosing his father's death, I simply repeated a treatment protocol like a computer spewing forth an algorithm. My words were accurate but devoid of humanity. With my opportunity to try again, I allowed myself to share with Alex the frustration in our powerlessness to keep people like his father and my mother alive, that our hand had been forced by powers greater than any we could muster. I had related to him, fragile human to fragile human, and by sharing that fragility I had invited an opportunity to connect that hopefully made us both stronger.

Medical school has taught me tomes about how the body works. I've attempted to learn with intricate detail the muscles and nerves and cells and molecules that make up a human, and how we can cut up and drug up and take out what's needless or put back what's lacking. But what's missing from this are the common human experiences that a doctor needs to know about for the people under his or her care. Undoubtedly, one of these experiences is death.

The way medical school has taught me about death has been through talk of terminal illness, and a less-than-handful of philosophical lectures set between the volumes on which we'd be assessed. I learned more about death in the two weeks I spent with my mother in the palliative care setting, meeting the doctors and nurses and patients and their families and agreeing to a DNR and organising a funeral and sitting in the aftermath wondering, "What the hell just happened?"

The best suggestion I can make for how medical education could better prepare us for these conversations is by seeing them happen, by witnessing death. And the best place for this to happen is within palliative care centres, where we can see that thing which terrifies us most, where we can sit with it as the sacred and inevitable phenomenon that it is. But the lesson for me is that instead of hiding from the beast, I can use my story to help people find their way. As mum was dying I felt lost, and when she died I was lost again. Somehow, through all that mess, I found a path, and the little lights that guided me might be shared with those who find themselves where I once stumbled.

I only saw Alex once more after that. I bumped into him at the hospital and he asked for directions to the transit lounge where his father waited to be transported to the palliative care centre; the place where he would die. Alex was with his partner, pregnant with a child who would never meet his fierce and defiant grandfather. I knew there was a good chance that for Alex, the process of grieving his father had just begun. I knew there would be moments in the coming months and years where he would try to call his father and the realisation that no one would pick up would dawn with bewildering obviousness. Maybe he would read something and excitedly think about how his dad absolutely had to see it but the thought would be interrupted by the reality that there was nothing he could share with his father ever again.

These were not conversations I could have with Alex. When I pointed him down the hall my role in his life had ended. But I hope that by sharing some of myself with him, he would sit with his father and there would be no regret or fear about his decision to let his father die.

## Obituary: Dr Michael Courtenay (1923-2018)

Michael Courtenay died peacefully at the age of 95 near his home in Adderbury, Oxfordshire on 25 June 2018. As a young family doctor, Michael had joined one of the very early GP groups led by Michael and Enid Balint in the late 1950s and went on to be a member of the influential 'Six Minutes for the Patient' group. In 1969 he was one of the Foundation Members of the Balint Society in which his influence remained considerable throughout his working life. He was much admired both at home and abroad for his skilful and considerate group-leading skills and firm grasp of the principles of Balint work. The seriousness of his commitment to Balint as a unifying principle in the practice of medicine resulted in a string of important publications (see bibliography). He was a very kind man, a good friend, and an inspiration to subsequent generations of the Balint Society. For many, Michael Courtenay was the complete GP.



**Michael Courtenay**

Michael John Francis Courtenay ('Mike') was born on 14 March 1923 in Madras, India where his father was a member of the Indian Civil Service and a High Court Judge. Mike returned to the UK aged six having survived malignant malaria. He was educated at a boarding school in Eastbourne and then at Sherborne School in Dorset. He later wrote of the childhood distress produced by boarding at six and then the early death of his mother when he was fourteen. At Clare College Cambridge he studied for a two-year 'war-time' Science Tripos degree. After this he was called up to the army and served as a Royal Engineers officer (lieutenant and later captain) in North West Europe where he came under bombardment and narrowly escaped death (by diving into a ditch) just before the motorcycle he had been riding was hit by a shell fragment. In April 1945 he was given the job of supervising the delivery of a bulldozer to the notorious Bergen-Belsen concentration camp where it was to assist in the burial of corpses. The terrible sights he saw there had a profound and traumatic effect on him and it was another thirty years before he was able to speak about his experience.

After the end of the war with Japan he was sent to Burma where he supervised the rebuilding of a major bridge, and to Malaya where he was involved in further reconstruction work. Eventually he was demobilised in 1947. During a period of illness in Burma, he saw something of the work of doctors and nurses and a friend told him that a career in medicine would suit him. This must have struck a chord because, back in England, he was able to return to his old college (Clare, Cambridge) to study for a medical degree. Thus he became one of a gifted generation of doctors who had come into medicine following service in the Second World War. At Cambridge he renewed his friendship with Jane Macintosh whom he had previously met in 1942 and who was now reading Geography at Newnham College. They fell in love and were married in 1948. Michael



then moved to St Thomas' Hospital London, where his mother had been a nurse, to do his clinical studies. He qualified as a doctor in 1952 and after house-officer posts, he was offered a partnership in general practice in Battersea, South London. Subsequently he left to start a single handed practice where he was later joined as a partner by Dr Harry Dawson. Eventually theirs was one of four practices that amalgamated and moved into the new Bridge Lane Health Centre (1975). When their children were all at school, Jane worked as a teacher at Ensham Comprehensive School for Girls in South London.

After only five years as a GP (1957) Michael began to feel that he was ill-equipped to meet his patients' most pressing needs. Many were suffering from what might now be called 'medically unexplained symptoms'. He was aware that these patients often showed signs of underlying emotional disturbance, but for this his medical training seemed of little use. When he read Michael Balint's ground-breaking book *The Doctor, his Patient and the Illness* (1957), it immediately resonated and he felt that this was a man who understood the problem and knew how to help. An interview with Balint led to membership of his first Balint group (where he met Erica Jones). Later, he recalled his interview with Balint as one of the most searching encounters of his life. The group was led jointly by Michael and Enid for the first few years and later by other Tavistock psychoanalysts including Robert Gosling. From 1966 to 1971 he was a member of the 'Six Minutes' research group which came up with the idea of 'the flash' and, more importantly, mediated a significant shift in Balint work away from 'GP psychotherapy' with selected patients to a focus on what could be achieved in everyday brief consultations. The group was led by both the Balints until Michael Balint's death in 1970 and was populated by many distinguished members of 'The Old Guard'.

At the same time as Michael Balint was developing his work with general practitioners he initiated related research enterprises investigating brief psychotherapy in medical settings. In 1958 the Family Planning Association (FPA) started a training scheme under the leadership of Michael Balint for doctors engaged in their newly founded 'special' clinics for patients with marital difficulties. Mike Courtenay played a prominent part in the development of this work. He joined a group led by Dr Tom Main at the Cassel Hospital to train in marital work and then worked for two years in an FPA 'special' clinic. He was also a member of a research seminar under the leadership of Michael and Enid Balint which met for a number of years to explore this new approach to the treatment of marital problems. Mike was entrusted with the authorship of the book published in 1968 describing the research of this seminar: *Sexual Discord in Marriage: A Field for Brief Psychotherapy*. He continued to lead training groups for family planning doctors in what became the Institute of Psychosexual Medicine.

When postgraduate training for general practice was just starting Mike established a prototype half-day release course in 1972 which met in the university practice at St Thomas' Hospital (London) under the auspices of David Morrell. At the outset this included a Balint-type group for the trainees and soon this became a regular Balint group under Enid Balint's leadership. He was appointed a senior research fellow at St Thomas' and Guy's Hospital and continued in this post (and as a course organiser) for many years.

Mike was influential in shaping the early development of the Balint Society and became its second President (after Philip Hopkins) in 1973. He had an important role in the early days of the Balint Society Weekends which began in 1978, at first in Reading and subsequently every September in Oxford. The weekends offered a taste of Balint to interested doctors with no previous experience. They were crucial in opening up what had previously been a rather inward-looking Society. In 1974, he was one of the first GPs to be 'licensed' to be a group leader, and started a new group in partnership with



psychotherapist Mary Hare. Together they took the whole group to the 3rd International Balint Congress in Paris in 1976 for a live demonstration. This aroused some controversy in the audience and Mike responded with a vigorous defence of his group (in French). He took part in two later Balint research groups: the 'Surprises' group led by Enid Balint (1984-87) which produced the book of which he was one of the authors: *The Doctor, his Patient and the Group* (1993); and the 'Doctors' Defences' group (1993- 98) which he led with Erica Jones. The work of this last group was reported in *What are you feeling, Doctor?* (2000). He attended most, if not all, of the International Balint Congresses from 1972 (the first) to the 15th (Lisbon 2007) and delivered several inspiring and beautifully written papers. He also wrote a number of chapters in Balint books as well as many contributions to this journal including his Michael Balint Memorial Lecture ('Making Sense of Medicine', 1989).

Mike retired from general practice after thirty seven years in 1989. He and Jane moved to Flowerpot Cottage in Adderbury, near Oxford. Here they entertained Balint Society members and guests to wonderful lunches and from here they travelled together all over the world. At Christmas they always sent a card giving an annual account of their travels. Mike had a strong interest in education and became chair of governors of his local primary school and, in retirement, continued to read deeply and to write. In one such project he investigated the impact of different religion's beliefs on sexual problems. His exploration of this fascinating subject, *Sex and Religion*, was published in 2000. At the age of eighty-four (in the IBF Congress in Lisbon) he gave a paper entitled 'The Doctor, the Genius and his Illness'. It was an exploration of Marcel Proust's creativity and his lifelong struggle with asthma. It might well have been subtitled: to treat or not to treat? It is a wonderful example of Mike Courtenay's continuing engagement with the paradoxes and complexities of medical care; the breadth and depth of his reading; his humour; and his hope for the future development of Balint work. He was a warm and wise man and remained a witness to what it means to be fully human right into old age. He wrote a privately circulated meditation on Belief at the age of seventy-three and spoke publicly about his experience of Belsen in a Question and Answer session in his local parish church only two years before his death.

Michael lost his beloved Jane in 2014 after a short illness. He is survived by his seven children, twelve grandchildren (one of whom, James, is following his grandfather's footsteps in general practice) and seven great-grandchildren. He was devoted to his family and, in a brief memoir written towards the end of his life he quoted from Psalm 127: 'Like as the arrows in the hand of a giant, even so are the young children. Happy is the man who has his quiver full of them'.

**Andrew Elder and John Salinsky**

### **Some memories and tributes from colleagues:**

Steven Curson (GP in South London, trainer and educator) writes: I first met Mike shortly after becoming a GP in South East London in the early 1970s. There was a very dynamic group of GP teachers and trainers linked to the department of general practice at St Thomas' Hospital. We met regularly to talk about education and general practice and to support one another in what were difficult but exciting times. Mike was always a calm, gentle and thoughtful voice that wasn't caught up in personal ambition or local politics.

Mike also ran, with Enid Balint a group for what were then called GP trainees on what was to become the St Thomas' VTS. For junior doctors used to a very didactic learning style this was often a revelation. For the first time they reflected on their role as doctors and the impact of their personalities and experiences on the patient and their

health. Mike and Enid managed to challenge without frightening and were an important factor in the development of a golden age for General Practice in our part of London.

Sally Hull (GP trainee with Mike and later GP academic and one of the authors of *The Doctor, the Patient and the Group*) writes: As an undergraduate the experience of Mike's two partner practice in Battersea determined my future in general practice. His masterly confidence in holding the person in focus whatever the presenting problem helped me to understand the tightrope we need to walk between an overweening technological approach and the reflective listening necessary to hear the patients' needs.

Clive Brock (Family Physician, Balint Group leader, Charleston, USA) writes: I was saddened by the news of Michael Courtenay's death. He was known to me by reputation before I met him in person. I remember listening to a tape of a group he was leading, over and over again, to extract his pearls of wisdom.

When we met in Charleston, I was struck by his sense of self, which was unassuming and devoid of sham. It was a pleasure to watch him lead a group, where he displayed genuine curiosity about the case. This brought out the creativity in his group members. I wanted to be like him!

When I next met him, it was in his cottage, where he hosted a contingent of us for an unforgettable dinner. He will live on in all of us who had the privilege of knowing him.

Michelle Moreau-Ricaud (Psychoanalyst, Paris) writes: Michael was, for me, as was Philip Hopkins, the living link of collegiate transmission from Balint (whom I did not know), and Enid Balint. During the conference breaks I had a lot of fun talking with him, not only about his experience with the Balint and his work, but also about the theory - which has become more difficult nowadays. I was very close to psychoanalysis, and the Balint group had to remain so. He was proud of his French ancestry that I had gathered from his surname. He read French writers - including Marcel Proust - and was a man of great culture. In short, I loved him a lot.

Paul Sackin (GP, member of 'defences' group. Secretary of IBF) writes: Although I had met Mike many times over the years and always felt inspired in his company, my main contact with him was as a member of the 'defences' group, leading to *What are you feeling, doctor*. We would never have got the book off the ground, nor had such a productive group, without Mike's brilliant leadership, well supported by Erica. Mike never pushed his own agenda but steered the group with (in Oliver Samuel's words) a gentle 'touch on the tiller'. One of the main challenges of the 'defences' theme was that the 'doctor' end of the doctor-patient relationship was explored more openly than is usual in Balint groups. Mike encouraged us to do this in a safe way and many of us made revelations about ourselves that we would not normally have the courage to do. At the same time, Mike did not shirk his responsibility for safety and on at least one occasion 'called time' when the discussion seemed to be becoming uncomfortable for a particular group member. Mike had a clear vision of the potential importance of our work which made the group sessions particularly stimulating and was very important to me in encouraging me to keep going with writing the book.

Dorte Kjeldmand (GP and Researcher, Uppsala, Sweden) writes: It is sad to know that he is no longer with us. He made a great impression on me and I just loved his kind way of leading the first fish-bowl of my life. Later on he was one of the persons that I always

looked forward to meeting at Balint events, and he always received me with love and kindness. He was a firm support for me in my research on Balint-groups. For him it was important that I studied our activity critically, which was not an easy task, and to me his support was a signal that I was going in the right direction. My examiner actually visited Michael ahead of my dissertation and interviewed him about my research, video-recorded the conversation and played it for the whole audience at the dissertation as a complete surprise for me and everybody else. Michael's clear support of my results felt like a blessing.

Henry Jablonski (Past President, IBF, psychiatrist and psychoanalyst, Stockholm) writes: I first met with Mike in Sweden in the end of the 80s. He made a deep impression on me. At that meeting Mike gave a lecture about a project to help mothers to "get back" after delivery, and to deal with traumatic experiences, often severe vaginal tears. What a brave and challenging project to try to make a lasting difference for patients who otherwise would have felt ruined, joyless and damaged for life! One could sense Mike's commitment and also how a doctor had his own struggles. A couple of years later I went with a Balint group to work with him. Mike was so experienced, so well integrated. He had a fantastic capacity to grasp the psychological situation both with patients and with the group members. He was genuinely combining GP practice with a psychoanalytical understanding. Mike was such an important part of the British Balint Society who were both the custodians as well as the developers of the work of Michael Balint.

Mike was also very supportive and encouraging in his correspondence with me a couple of years later when I was in a personal crisis. Our last meeting took place at an Oxford weekend in 2010. He was tired and frail but had made a considerable effort to join us just for the opening session. It was good to see him and to be able to express gratitude and appreciation for his important contribution to Balint work.

May his memory be a blessing.

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## An interview with Michael Courtenay

Michael Courtenay was talking to John Salinsky  
on April 18th 2004

**JS:** May I take you back to your first meeting with Michael Balint. How did that come about?

**MC:** I had written to him after first reading *The Doctor, his Patient and the Illness* and said I was interested in joining a group, so he wrote back with an appointment to go and see him at the Tavi. It was the most searching interview I've ever experienced. He seemed to penetrate one. He said 'how many children have you got?' (We had four at the time) and he said: 'four children!' But he didn't seem to be very focused on what we were going to do. It seemed to me very personal; he was shining a searchlight on me as a person.

**JS:** You'd been in practice a few years by then?

**MC:** I'd been five years in practice then.

**JS:** And were you aware of some frustration with the way patients presented?

**MC:** I was aware of having no training that seemed to have any application on what I was supposed to be doing. The emotional side of ill-health certainly made itself known to me. I attempted to meet this by reading funny little books about 'anxiety' etc. But at least I knew that the deficiency was what went on in people but I couldn't find an answer.

**JS:** Did you have some background interest in psychiatry? Were you aware that there would be a lot of emotional stuff in general practice?

**MC:** No. Not at all, really. I had no idea what I was going into.

**JS:** So the book really spoke to you.

**MC:** Yes. I thought: this man knows the problems. And he indicates possible ways of approaching them. And I need this because otherwise I'm going to be thrashing about wildly as I've done for five years.

**JS:** So you arrived at your first group. Can you remember what that was like?

**MC:** I do indeed. It actually took place in the drawing room on the first floor of 7, Park Square West. This turned out to be improper later on and the Tavistock Clinic rapped him over the knuckles and said we had to meet in the Tavi itself. But we met at Park Square West for a whole year, about eight of us. It was a beautiful room with some wonderful artefacts on the walls. It was an L-shaped room with one photograph of Balint as a young man on which someone had put on devil's horns! But we were, to start with, a totally ill-assorted crew. There was a Pole, who never spoke a word for the first three months - and then left. There was a lovely GP from Malvern who used to drive up. He was very go-ahead, he actually had a radio in his boot. He was simpatico and then there was Erica, who has since become a great friend. And there was another chap who had done some psychiatry, which was not the right approach, apparently. But there seemed to be no explanation, it was quite amazing. Apart from presenting cases, and - that was the thing - if you didn't have a case to present every week, you stood in awe of great wrath. Not that you heard eight cases but you had to have one ready.

**JS:** But he didn't pick on anybody to present a case...

**MC:** No, he'd just say 'Who's got a case?' and people would raise a hand - or not - but there weren't great silences. Because he made it terribly clear at the first meeting that you would have to have a case. And of course we pulled out notes and that was utterly forbidden. Put those away. Enid was the coleader...

**JS:** So she was there from the beginning?

MC: Yes. And when he was at his fiercest, she used to protect the chicks a little bit. We were always terribly pleased with her interventions in our defence.

**JS:** What sort of fierce things did he say?

MC: He would be quite critical. Sort of: 'Why did you do that?' and 'What did you expect to gain from saying that?' It was pretty direct and pretty strong but very rarely too strong. If he became too hectoring then Enid would sort of put up a shield for us.

**JS:** Were the sessions a similar length to nowadays?

MC: Yes, it was pretty strict. They were an hour and three quarters and at the end we just departed. In my case there wasn't a moment to lose because I had to go straight to surgery.

**JS:** Two cases in a session?

MC: Two cases pretty well always. If there were follow ups - he would sometimes say: 'we'll do some follow ups next week'. So we might get three or four follow ups.

**JS:** And was it expected that you would have done a long session with a patient before presenting him?

MC: Yes. He would definitely presume that any presented case would have had a long interview. He never said, but everyone agreed that this took at least three quarters of an hour. Subsequent consultations were not so long but more than the average consultation time. Which was at that stage, you know '57, '58, pretty short.

**JS:** What sort of problems did people present on the whole?

MC: Quite a lot of them were what would have been termed psychosomatic. Questions as to why someone who was asthmatic was having more attacks and this would be viewed from the point of view of it having a large emotional component. But the main thing really was whenever you got stuck with a patient and you didn't really know what was happening; if you found you were referring the patient repeatedly to different people or there was some obvious no progress sign. There was a wide spectrum of possibilities.

**JS:** And were the patients that were presented usually someone whom the doctor felt they really wanted to help? Because these days, especially with registrar groups, the patient presented is often someone the doctor feels fed up with or annoyed with or bruised by, rather than someone he really wants to engage with.

MC: No, I think the boot was on the other foot. I think the feeling was that we, the doctors, were not meeting that patient's need and that we were sore because we felt we were professional failures, and not able to see which way to go. There were a few in which the doctor felt he had been rubbed up the wrong way, but they were rare. That was not the main focus.

**JS:** So it was very much 'how could I be doing this better'?

MC: Definitely. Here's a patient whose complaints don't make sense to me, I'm struggling to make sense of them and I need help there.

**JS:** Reading the book, *The Doctor, his Patient and the Illness*, although it's fascinating and you can see the way his ideas were developing, you don't really get a sense of what it was like to be in the group. Would you agree?

MC: I would. Actually, returning to the book, I found that even after a few years it was strangely old fashioned to read. It seemed to be quite different from the atmosphere of my first working group.

**JS:** Things had moved on, presumably.

MC: They had. It had been going seven years before I started which meant that it had probably run through a couple of groups. It was very sticky for the first three months, and then it got easier; it started to flow. The poor Pole disappeared and the rest of us had become more friendly. Perhaps the chap who had done psychiatry was not one's most close colleague, but it was treating emotional illness from a specialist's position which we

didn't really feel. We still felt that we needed more time but there was a consensus from all but two that we were on the same train. Then we moved to the Tavi and we had two new members. For those who had been at Park Square West it was distinctly a sad move. And then in the third year we moved into the Tavistock Institute. That was actually better.

**JS:** Did you get a feeling that you were being trained to be GP psychotherapists?

**MC:** That was certainly the feeling. Quite early on, before the end of the three years, there was a sort of hint of rebellion from some of us about that. Partly because, well, speaking for myself, I was aware that I was giving time to a tithe of the patients who really stood in need, and it was actually one of the most painful things that I hadn't got time to give because I suppose I did long interviews on four nights a week. But four patients a week and you had to see them for some time. And as one became more aware of the problems, the more of the damn problems were visible. So it became increasingly agonising.

**JS:** How would a group in those days compare with a group at Oxford today?

**MC:** There's a great deal more freedom in the Oxford ones. You have to remember that that group finished in 1960 and we moved on to another group. But it was rather old fashioned. Christian names were not used.

**JS:** Christian names were not used in our group (1974-78) you may remember until about half way through.

**MC:** That's true. Perhaps that was part of the old tradition continuing. We were just doing as we had done before. I must say I find that quite horrifying. I totally accept that it's true. So it was much more formal. Having said that, the nature of the work soon broke down the formality so that after a year the group was behaving much more like an Oxford group. The Oxford group seems to start *de novo* in a weekend. I can't see that happening in those days.

**JS:** Was it more difficult in those days for GPs to be open with each other and trust one another with this kind of material?

**MC:** No, oddly enough, I don't think so. That was the reason, because we were all guilt laden and everybody admitted - with one notable exception - that we were a pretty hopeless lot. And we were all floundering about on the same floor.

**JS:** The kind of way of leading a group that my contemporaries learned from you and Mary Hare - I'm curious about where that came from; whether that was present in the original groups or whether it was more due to Enid's influence. I am thinking of the sort of thing where we would deflect a question back to the questioner.

**MC:** That was always present but Michael Balint would be given to passages of didactic teaching on a particular problem - which was very useful - but you wouldn't actually find in many groups now. The other thing is he seemed to be quite directive. I think the main thing is that the reflected question wasn't as common. He would make some remark about the presentation which would not be a spot diagnosis but a direction in which to pursue the discussion at your next interview. But it was an interesting duet between Michael and Enid. She would often disagree with him. She would definitely challenge him and they would have a semi private argument and in a way that was a great learning experience. Because there was a dialogue between people who presumably knew what they were talking about. It also was teaching you that you didn't have to take the directive statements if you didn't want to. It was when there was a good deal of cross discussion between group members about something and Michael would bring that to an end by some sort of rather bold didactic statement and Enid would then say Well, I'm not sure that's how I would see it! And what about - another way? So there was in fact the model that there was always more than one way to see anything.

**JS:** I think pairs of leaders nowadays are very afraid of disagreeing with each other.

MC: I think you are right. The group that you were in which was led by Mary and myself was post the so-called Tuesday Group, the one that produced *Six Minutes for the Patient*. That was a major shift in technique. Michael and Enid's idea was to change the culture. I see that as the watershed. Because he then no longer was training us to be psychotherapists, he was no longer insisting that we spend 45 minutes with a patient... it was a sea change.

**JS:** What brought that about?

MC: I think he came to realise that a lot of us were probably not competent to be psychotherapists! I mean he didn't actually say that, but having that long interview requirement meant that a lot of patients were being neglected. And he also realised that so many 'ordinary' general practice consultations which have a strong somatic element might be just as important. I remember one of his things was: 'Can't somebody present a case with a cough?' Poor Aaron Lask was the sacrificial lamb: he produced a case. Balint appeared to be extremely angry and was really rather cruel. We all bled with poor Aaron. Michael said 'I'm fed up with these long cases which get nowhere! What about the ordinary case, the real, the case you see every day, lots of them, what about them? So that was the crunch. Then, we'd been invited to Aberdeen for a weekend. The professor of psychiatry in Aberdeen at that time was Colin McCance. So we all went up on the night train, drinking whisky and then we had this amazing weekend. In which the idea of a short case really was cemented. It had happened before. The week before, Jack Norell had presented a woman with acne and that was the first ordinary case. It was amazing. It was like peeling off layers of opaque material. In Aberdeen we had a whole spate of these cases, they weren't all acne but they were all ordinary. This was in the mid 1960s. And the group absolutely changed. Then we knew we didn't have to spend 45 minutes with all the patients we then presented. I think Christian names came in then. I think it was moving.

**JS:** Well, you'd been together a long time by then, hadn't you?

MC: We had. We'd been together four years. But that was the great change in my opinion. And he became far less didactic. He was still piercingly acute - he would say something that you had never remotely thought about that. But it was a different thing. There was much less teaching, much more encouragement to be bold.

**JS:** What about the emphasis on the doctor's own feelings? Was that there from the beginning?

MC: Not in my first group at all. It was about the doctor-patient relationship, but not the doctor's feelings, standing alone.

**JS:** Well, even the doctor's feelings as induced by the patient?

MC: Yes, that was there. You know, curiously enough, it wasn't such a democratic feeling of exchange as it became later on. It was a question of an invitation to say what was going on between A and B - rather than what A feels or B feels. It was a little bit more distant.

**JS:** Because when we are leading groups we quite often say to somebody, how would you feel if this was your patient?

MC: Yes. I don't ever remember that in the first group. Although it just so happened that at the end of three years the person appointed to lead the group couldn't do it and Bob Gosling stood in. I presented a long and impossible case, a 'pregnant nun'. He sort of looked at me and said: 'I know you have had quite a lot of experience but why have you presented this pregnant nun? And he was absolutely right. If only I'd remembered that at Oxford when that Italian doctor presented: if only I had done a Bob Gosling with him; that's what I should have done. Then we had a young leader who was very warm and simpatico, who had quite a different technique. That was leading on to a much less



charged atmosphere in the group. With Bob there was a bit of a Spartan feeling. He was very good, but it wasn't comfortable.

**JS:** Like being with a classical psychoanalyst?

**MC:** Absolutely! That's right. You've hit the nail on the head. But the other chap was more avant-garde, more relaxed. I think his name was Harding. He was a protege of the Balints and he worked at the Tavi, I think he was a senior registrar. There were people from two other groups welded on to our group of whom at least 50% remained, which was rather odd. And we definitely had to negotiate for a few months.

**JS:** Another thing leaders do today is to represent the patient: to say, if I was this patient I would be feeling so-and- so...Which can often get the group going again.

**MC:** Yes, Michael would have said: Now, the patient is in the room. The doctor is the patient. So he would invite the rest of the group, saying: you heard the story, but that's only part of the story. He is presenting the patient as a person. That would be his centre of gravity.

**JS:** So how did these subtle changes come about, do you think?

**MC:** Michael Balint had been wooed by the Family Planning Association with whom he started these psychosexual seminars. And that I think made him apply less rigidly the pure psychoanalytic approach. I joined in the second wave of those. But we were actually more psychotherapeutic in that. He felt that was reasonable because we didn't have to choose between patients. We had relatively long interviews in the marital difficulties clinic. He was interested in testing the possibilities of focal therapy. But when it came to the FPA wanting more leaders, he was prepared for GPs like myself to go and be leaders of that group because that was limited scope and we probably wouldn't be dangerous!

**JS:** How did the move to the presentation of shorter consultations begin?

**MC:** Well, those seminars made him think because a lot of the non-consummation papers had come out of quite short interviews, twenty minutes or so, in someone coming for contraceptive advice. And that's why he started off in the Tuesday group wanting to hear about ordinary length GP consultations and we all resisted it, we were all set in our ways. But he broke us down, courtesy of Aaron and Jack. But the amazing thing was, once that was broken down, the flood gates opened and we were all producing lots of cases and he didn't seem to be inhibited at all about the different level.

**JS:** What would he think today, if he were to come back?

**MC:** I think he would have approved of what we do. He was never satisfied with where we'd got to. I think he would have been very disappointed if we hadn't moved. The hardest thing to swallow would be his feeling about the qualifications for leaders. But the fact that he changed that for the FPA groups makes me feel that even that - he would have been rigorous as to selection, but Tom Main was perfectly agreeable to GPs as long as he knew who they were and what they were doing.

**JS:** I remember something he said at the second London International Conference that was printed in Philip Hopkins' book *The Human Face of Medicine*, Tom Main's line was you have to do what you have to do. And if you haven't got any analysts then you have to use GPs -

**MC:** Absolutely. He was pragmatic. I mean you've got to get the best you can. Better to have second best than none at all. Because otherwise the work can't go on. But I think Michael would have been pleased that the group that Enid led, the one that you were in when she became ill - I think he would have been very pleased with that group [the group that produced the book *While I 'm here, doctor*] and I think he would have been pleased with our last group [*What are you Feeling, Doctor?*]. He would have been critical, but constructively critical. Perhaps he would have said, we ought to have looked at the



defences in a more psychological way. But I think he would be 'chuffed' that the work still goes on. Very much so.

**JS:** And what would he think of the fact that there are so few analysts involved in this country, compared with say, France or Germany?

**MC:** I can see him shrugging his shoulders. I mean there wasn't any difference in his day. Psychoanalysis has not taken well to British soil, let's face it. With some notable, notable, exceptions. But I don't think that would have bugged him. He had sort of learned to live with it. These damn Brits! Although he was more British than the British, in some ways. I think he would have been sad, but not surprised.

**JS:** What was the attitude to Balint work and Balint doctors among GPs in general when you were doing it in the late fifties and sixties?

**MC:** Pretty negative. I used to go out and give talks and that sort of thing. By and large, a wall of rather cold semi-hostility towards these people looking at their own navels. I think Michael would be very pleased with the involvement of GP training. He would think that was a major positive outcome of his work. But I've had some pretty chilling experiences, talking to non-Balint doctors over the years.

**JS:** So we get more respect nowadays?

**MC:** We definitely do. I think after a rather chilly downturn, I think there has been a resurgence. The fact that we have had citations, I think we are taken seriously. Maybe disagreed with, but that's fine.

**JS:** They may not want to join us -

**MC:** No but we are seen as genuine research workers. It's a point of view with which you can agree or disagree, but you are not damned. The great joy of my own in Balint work now is that you can be utterly free with colleagues or patients. The openness of communication in medicine, which was not there when I entered it in 1952.

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# On Michael Balint, Cases, and Countertransference

Raluca Soreanu

## Abstract:

The article looks at the place of cases in the psychoanalytic universe of Michael Balint, while giving special attention to his work Balint groups. I argue that the case was at the heart of Balint's work of orchestrating a complicated and creative encounter between psychoanalysis and medicine. I evoke Balint's explorations and his formative years in Budapest, in the 1920s and 1930s, where he was greatly influenced by the epistemological ideas of Sándor Ferenczi. I discuss Ferenczi's lesser known idea of "utraquism" of the sciences, and his medical utopia, which puts psychoanalysis at the centre. I also look at the place of countertransference in the theories and practices of the Budapest School of Psychoanalysis. These early elaborations on countertransference constituted "the case" as a particular kind of epistemic unit and produced some mutations in terms of the contexts where psychoanalysis can be imagined to work creatively.

## Introduction

For those of us working clinically, cases emerge as epistemic imperatives: without them, it becomes hard to transmit clinical content. This near-necessity of the case-form is experienced by each of us in different ways. In what follows, I look at how the case emerged as an epistemic unit for Michael Balint, especially in his work with medical doctors. I argue that the existence of "Balint groups" – as a method of working with medical doctors in a psychoanalytic way, and thus as an extension of psychoanalysis outside its usual frame – is predicated on moments where Balint lets himself be surprised by the case-form in ways that produce consequences for the psychoanalytic method. It is almost as if the case is invented again; or as if the case returns. I focus less on how in psychoanalysis "the case" is our common epistemic unit. Instead, I will try to defamiliarise this shared-ness, which has a genealogy captured by John Forrester (2017) in his book *Thinking in Cases*. The moment of near-necessity when the case emerges as central to Michael Balint is here treated in its singularity. To not think in cases, in such a moment, would have meant to stop thinking.

In Balint's work with medical doctors, the case is the fundamental unit in the organisation of knowledge, doubly invested by medical epistemologies and psychoanalytic epistemologies, so as to allow countertransference to become thinkable and workable. In Balint groups, the nature of "the case" is radically transformed. Balint has in mind moving away from the very genealogical field of forces that John Forrester (2017) describes: the written case, the case history, the "individual description", the "dossier", the "file", the procedures of writing and registration associated to the medical examination – all the documentary techniques that make each individual into a "case" and an object of a branch of knowledge.

By contrast, in Balint groups, the case is spoken, and the presentation is free-associative. Balint insisted on doctors' not using notes when making their interventions. In fact, in one of the groups discussion transcripts I reference today (an early discussion group at the Tavistock Clinic, in 1951, actually preceding Balint groups proper), there is a note on how Balint left the room when one of the doctors started reading a case-history prepared in advance. Balint allowed himself to make a quite sharp transferential wound here, so as to demarcate a terrain outside the "dossier".

When the case is spoken, and presented to the group, the basic assumption is that there is something yet to be uncovered. Neither the presenter, nor his peers, nor the group leader know exactly what is being sought. Furthermore, as we will see, comparisons between cases are comparisons between cases of countertransference.

There is a metaphor that Balint sets the stage with: it is a productive and seductive metaphor, it captivates doctors, draws them into a game of imagination. This metaphor is that of the “doctor-as-a-drug”, or more simply, the “drug-doctor”. Already from the first meeting of the series of discussion groups I looked at, Balint states that the most frequently prescribed drug is the doctor himself and there is no pharmacology to date for this drug. This formulation will later appear in his book, *The Doctor, His Patient and the Illness* (Balint 1957).

In what follows, I propose some elements for a genealogy of the case for Michael Balint. This takes us first to Budapest; and then, to some discussion groups at the Tavistock Clinic in 1951, which precede “Balint groups”.

### **Budapest Traces**

Michael Balint’s psychoanalytic formative home was Budapest, although his official psychoanalytic formation took place during his years of exile in Berlin, between 1921 and 1924. In Budapest, psychoanalysis started with a unique robust pluridisciplinarity. In the first two decades of the twentieth century, the exchanges of avant-garde intellectuals (writers, musicians, painters, psychoanalysts, medical doctors, economists) created a number of institutions. The medical weekly *Gyógyászat* (“Therapeutics”) and the main literary criticism journal – *Nyugat* (“The West”) had an important role in popularising psychoanalytic ideas. A group of students of medicine and engineering, *A Galilei Kör* (“The Galileo Circle”), openly pursued the goal of making psychoanalysis part of the university curriculum for medical doctors. In the summer of 1919 Sándor Ferenczi was appointed professor in psychoanalysis, in the first department of psychoanalysis within a medical university. While this appointment was short-lived, and it was revoked only one month after, it did reflect the presence of psychoanalysis in Hungarian cultural life. Ferenczi was lecturing to full amphitheatres and to an enthusiastic audience.

Back to Berlin – what is notable about Balint’s time here is that he showed the initiative, in 1922 and 1923, of experimenting with the psychotherapy of patients affected by organic diseases. He saw patients suffering from asthma, peptic ulcer, thyrotoxicosis and obesity. This experiment took place at the famous Medical Clinic of the Charité. From early on, Balint’s epistemic disposition was that of enlarging the scope of psychoanalysis and “applying” it to areas where it meets the medical sciences.

Upon his return to Budapest, in 1924, he had a difficult time in obtaining the support for his project of psychoanalysis in hospitals, with patients suffering from organic illnesses (Balint, 1970). But another idea took shape, and occupied the minds and hearts of the psychoanalysts in Budapest: the opening of a psychoanalytic clinic. Ferenczi had been hoping for such a clinic since 1915. The Budapest Polyclinic opened its doors in December 1931, after years of struggle in the dire political times of Horthy’s regime, and with Balint as a key actor. The Polyclinic had the same address as the couple Michael-Alice Balint: Mészáros utca 12.

Even before the opening of the clinic, Mészáros u. 12 was a well-known meeting place for psychoanalysts, writers and musicians. With the clinic, Friday meetings became regular, and they brought together Sándor Ferenczi, Alice and Michael Balint, Vilma Kovács (Alice’s mother), and also Endre Almásy, Robert Bak, Lilly Hajdu, Imre Hermann, István Hollós, Kata Lévy, Géza Róheim, and Lilian Rotter. The Polyclinic had

a substantial autonomy from the Psychoanalytic Society: it was a fully-fledged therapeutic and training establishment. Senior analysts gave lectures, and they were followed by a seminar in psychoanalytic technique, led by Vilma Kovács. Here, cases were presented and discussions on countertransference were given a key place. It is also here that the particularities of the Hungarian training system emerged, making the analysis of the countertransference of the analyst to her patient an essential part of psychoanalytic training. This is discussed in 1935 by Vilma Kovács (1935) in her paper “Training and Control Analysis”. Balint was formed in this tradition.

In the midst of this dense psychoanalytic environment, Balint found the energies to reinitiate his project of reaching out to medical doctors. At the Polyclinic, he started a seminar for general medical practitioners. Balint was still uncertain about the most suitable format for organising this encounter between psychoanalysis and medicine. He reflects at a later point that the theoretical lectures he set up proved “fairly useless” (Balint, 1970: p.457). He had the intuition that the more productive approach would be to learn by practice and case presentations, and he experimented with a seminar where the discussion focused on the everyday work of the medical doctors.

### **Ferenczi’s Utraquism of the Sciences**

In what follows we turn to the epistemological ideas of Sándor Ferenczi, who was Balint’s mentor and analyst. In particular, Balint had close familiarity with the little known Ferenczian idea of the “*utraquism* of the sciences”. His own imaginary on the possible encounters between psychoanalysis and other disciplines was traversed by Ferenczi’s epistemologies.

Already at the turn of the century, in the 1900s, Ferenczi showed himself very hopeful about the possibilities of a less rigid and less dogmatic materialism, that would allow the emergence of a productive “psycho-physical parallelism” (Ferenczi, 1900). As I see it, it is from this early hopefulness that Ferenczi comes to develop, over two decades later, the idea of the *utraquism* of the sciences [*Utraquismus*, *Utraquistische Arbeitsweise*].

But what is *utraquism*? Derived from the Latin *utraque*, meaning “one and the other”, it is the work of establishing relationships of *analogy* between distinct elements that belong to distinct fields of knowledge or strata of reality, with the aim of discovering or going deeper into the meaning of certain processes (Ferenczi, 1924). *Utraquism* is for Ferenczi a method. It is an epistemologically consistent disposition. In “The Problem of the Acceptance of Unpleasant Ideas”, Ferenczi (1926) defines *utraquism* and makes the connection between the stages in the development of the sense of reality in any individual and the development of the sciences: “to bring some light to bear critically on the manner in which our present-day science works, I was compelled to assume that, if science is really to remain objective, it must work alternately as pure psychology and pure natural science, and must verify both our inner and outer experience by analogies taken from both points of view; this implies an oscillation between projection and introjection. I called this the ‘*utraquism*’ of all true scientific work” (p. 373). It is this oscillation between projection and introjection that constitutes for Ferenczi the highest stage in the development of the sense of reality.

Ferenczi borrowed the term from a sixteenth century Protestant group, the *Utraquists*. What distinguished the *Utraquists* among the Protestants was their belief that it is not only the clergy that should have the privilege of taking both the bread and the wine in the communion, but this symbolic reuniting of the flesh and blood of Christ should be extended to laity. As Martin Stanton (1990) notes, Ferenczi’s interest in this term is

quite a curious event in itself, given the fact that he was an agnostic Jew. I believe that Ferenczi's attraction for the Utraquists rests in his own strand of materialism, which is succinctly and poetically formulated in a 1921 essay. "[T]he symbol – a thing of flesh and blood" (Ferenczi, 1921, p.352), he writes. For him, the symbol has a physiological basis, it "expresses in some ways the whole body or its functions" (Ferenczi, 1921, p. 355).

What we find in Ferenczi is a critique of science that is much ahead of its time. Ferenczi cautions against the perils of a medical science that proceeds rigidly by looking, as if hypnotised, into the microscope (1933, pp. 146-147). Ferenczi also proposes a horizontal model of the encounter between the sciences, where each scientific discourse has the attribute of bringing insight into a particular semiotic code, while none of the codes is deemed superior. The final chapter of *The Development of Psycho-analysis*, co-authored by Ferenczi and Otto Rank, brings a utopia of the unification of the natural and mental sciences, with psychoanalysis taking up the role of making the integration. Even within this utopia, utraquism, oscillating between "one and the other" of the perspectives at hand, is central. We could argue that Ferenczi adopts a nomadic disposition in science, where knowledge is created by straying off from one point of perspective to another, from one stratum of reality to another. As he writes in his commentary on Freud's *Group Psychology and the Analysis of the Ego*, "[l]ooking at scientific advance as a whole, we see that direct, rectilinear advance keeps coming to a dead end, so that research needs to be resumed from a completely fresh and improbable angle" (1922, p. 371). This ethos of a non-hierarchical encounter between domains of knowledge influences Balint profoundly. There are reasons to believe that Balint was a close reader of Ferenczi's work referred above.

These two threads – on the one hand, the state of debate on countertransference in the Budapest School of Psychoanalysis; and on the other hand, the epistemological ideas of the Budapest School on the encounter of psychoanalysis with other domains of knowledge – are crucial in making sense of the emergence of "Balint groups" in England, in the 50s. In an interview given for a French journal, *Gazette Medicale de France*, Balint (1970) leaves a trace of striking genealogical clarity, which I would like to recapture here:

I decided to use my experience with the Hungarian system of supervision, and to work out a training in psychotherapy based chiefly on the close study by group methods of workers' countertransference. In order to be able to examine the latter in detail I had to create conditions in which it could be shown as freely as possible. I therefore did not tolerate the use of any paper material in the case conferences; the worker had to report freely about his or her experiences with the client, in a way reminiscent of "free association", permitting all sorts of subjective distortions, omissions, second thoughts, subsequent interpolations etc. I used this report – as it is used in the Hungarian system of supervision – as something akin to the manifest dream text, and tried to infer from it the dynamic factors in the client-worker relationship shaping it. Both the second thoughts of the reporter and the criticisms and comments of the listening group were evaluated as a kind of free association. The real proof of the correctness or incorrectness of the reconstruction of what happened between the worker and the client in the interview was the subsequent interview, in the same way as the proof of a dream interpretation is usually the subsequent dream.

### **The Case as Emergence**

The field of emergence that I am describing corresponds to one distinct moment in Balint's work with medical doctors. I here refer to the GP Discussion Groups, held from



April to June 1951, at the Tavistock Clinic, led by Balint and Henry Dicks. There are 10 weekly groups, with a participation of between 6 and 15 doctors (but more regularly 9 to 11 GPs are in the room). The transcripts are held at the Balint Archive at the British Psychoanalytic Society.

These meetings are a kind of laboratory for the emergence of the techniques that Balint invented and that only later came to be known as “Balint groups”. The move in these meetings is one from posing a set of questions of philosophical scope: what is gratitude? what represents an ethical posture of a GP? what is suffering? (in the first few meetings) to presenting cases (as meetings advance). The flesh of the cases emerges, somewhat as if for the first time, from the group of doctors turned onto their own practice. Balint does not make case presentations into a rule – he sometimes invites it for the next session – and the response is sometimes engagement and other times resistance and reverting to broader and more abstract concerns. The case, nevertheless, returns. The case anchors but also allows the medical imagination to work.

An equally remarkable epistemic event in these discussion groups is the alignment and intersection of utterances that make countertransference thinkable, without using the word “countertransference”. We are met with the practical emergence of a field of work on countertransference, outside the classic psychoanalytic frame, and without the need of any theoretical exposition of what countertransference is. The seductive metaphor “the doctor as a drug with unknown pharmacology” functions in this way. Also, Balint punctuates the discussion (indeed, he interprets) in a way that converges around countertransference: Do doctors select their patients? What does that mean, that doctors select their patients? What does it mean that a doctor “clicks” with a patient – to use the language of one of the doctors in the group? What is the nature of this experience of “clicking”? Do doctors expect forms of gratitude from the patient? Is there a core of guilt in this expectation?

I would like to further unpack the metaphor of “the doctor as a drug”, as I believe it is a radical epistemological construction. The reference here is not to an individual, but, surprisingly, to a substance. The doctor is a partly unknown substance. The doctor’s pharmacology is yet to be written. Here, the analyst and the doctor are not confined to an Oedipal story, they are not strictly mommy-daddy, but they can also take the place of a substance or an artefact – with reference to the scene of trauma that is yet to be uncovered. It is a kind of psychoanalysis where the physical mash of things matters as well.

In “Gratifications and Object Relationships”, a chapter of his 1968 book *The Basic Fault*, Michael Balint writes (1968, p.136):

The air is not an object but a substance, like water or milk. [...] there are a few – not many – more such substances, among them the elements of the pre-Socratic philosophers: water, earth, and fire; with some others used in present-day guidance clinics, such as sand and water or plasticine. The chief characteristic is their indestructibility. You can build a castle out of wet sand, then destroy it, and the sand will still be there; you can stop the jet of water coming from a tap but, as soon as you take your finger away, the jet is there again, and so on.

The analyst’s role in certain periods [...] resembles in many respects that of the primary substances or objects. He must be there; he must be pliable to a very high degree; he must not offer high resistance; he certainly must be indestructible, and he must allow his patient to live with him in a sort of harmonious inter-penetrating mix-up.

In the GP discussion groups that we are looking at, there are references to maternal and paternal transference and doctors hear interpretations where mother and father roles become thinkable. The word “transference” is not used as such, but Balint refers to maternal and paternal “attitudes”. But I believe the background metaphor – the “drug doctor” – pluralises the medical imagination on transference and countertransference. It subtracts it from the Oedipal (and even family-centred) imperative and it places it into a much more generous imaginary of substances. The analyst can be the soil the patient walks on, or the air the patient breathes. The GP can be the patient’s first reliable drug, and a drug that treats the whole person, not just an organ, a part.

Balint states during the discussions that there are different techniques to be adopted. One is educating the patient in responsibility toward his illness. This he will later refer to as “the apostolic function of the doctor”. The other is adopting the attitude “I know best – have faith in me”. This is the paternal function. Naming the apostolic function and working on the way it is lived in the doctor-patient relationship means opening for investigation a field of power that was compacted, foreclosed. In other words, Balint identifies a field of power.

Thomas Osborne (1993) has surprisingly interpreted Balint’s notion of the apostolic function of the doctor as being built around the idea of vocation, while the entire Balint method was criticised as a technology of power, in a Foucauldian sense, producing docile citizens, under the influence of the paternal doctor. This is a misplaced critique – what it misses is that the idea of the apostolic function of the doctor counts as a *critique* of power. The pre-existing structural and imaginary place of “the doctor” produces effects of power, which appear in many places, including in the unconscious position of each individual doctor toward the patient. Balint groups are a way to arrive at a vocabulary and at a practice of unpacking these effects of power, of becoming consciously aware of the existence of the apostolic function, and of learning to use it, nearly as a substance to be administered.

To conclude, Balint took seriously a radical politics of alliances, even untoward, uneasy alliances. He took psychoanalytic techniques and habits of the mind to a group context, constituting a plane of multiple transferences. And here we come to what Jean Oury (2009) – the director of the La Borde clinic in France, and the collaborator of Félix Guattari – called homogenisation. Homogenisation is not just a congregation of similars, but it has an incestuous dimension, it is based on the absence of symbolic inscription, and it leads to what Oury (2009) calls the “non-initiative” and to stagnation. It is the *ça-va-de-soi*, the apparently obvious, business as usual. Balint achieves an intervention in the *ça-va-de-soi* of both psychoanalysts and medical doctors.

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# **Aspects of Diversity – The Different, the Strange, the Distant, the Unfamiliar, and the Incomprehensible in Balint Work**

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## **Abstract**

Using vignettes from Balint groups, the paper concentrates on what is experienced as strange, threatening, or incomprehensible, and how defence mechanisms are being used to deal with something which diverges from the familiar. If we want to understand the different or the foreign, if we are looking for a context which makes sense, we need to include our own 'foreign' feelings. It means seeing the difference as something valuable, and not as something we need to get rid of.

## **Introduction**

In one of his latest books the writer and painter Rabih Alameddine lets his Lebanese heroine Aaliya describe herself:

"I'm a conscientious cleaner, you might even say compulsive - the sink is immaculately white, its bronze faucets sparkle – but I rarely remember to wipe the mirror clean. I don't think we need to consult Freud or one of his many minions to know that there is an issue here" (Alameddine, R. 2015).

If the author were attending a Balint group, would we expect him to present his patient Aaliya to the group? Perhaps he does not feel the need to because he considers the mirror-issue as something so minor, so not out of the ordinary, or so familiar that he does not see the need to consult Balint or one of his many minions.

But what if patient Aaliya is Lebanese, and doctor Rabih comes from another part of the world? Will he be irritated or troubled by a woman and the cultural differences between them, or will he be struggling with prejudice, or with the fact that Aaliya has had to live through two wars in Lebanon? So let's assume doctor Rabih is keen to talk about himself and his patient in a Balint group for the same reasons we go there - because we want to explore the diversity, because we want to *understand* something new. In this respect we have the same motives as John Cassavetes, the wonderful filmmaker, who is quoted saying:

"Why would I want to make a movie about something I already understand?"  
(Cassavetes, J. 1994).

But let's go back to our topic and ask: what is diversity anyway? It implies differences, greater variety, or contrast. It is about issues that can irritate, upset or frighten us. And most important, what is embodied in it is the concept of sameness – they are like dialectical twins in the philosophical sense: if we become aware of diversity, we cannot avoid realising that something is happening to our feeling of sameness. If we talk about 'the other ones', if we talk about 'them', we also have to talk about 'us'. It is not a one-way street. We can perceive someone as the foreigner, the stranger, the other, but in all likelihood we are also strangers to him or her. So we have to deal with not only the feelings of others, of 'foreigners', but also with our own 'foreign' feelings.

In our work with patients this confronts us with some questions. Is diversity something that draws or pulls us towards it, interests us, strains or stimulates us? Or do we try to keep our distance? And can we accept difference – or better even: multiple differences – without feeling the need to align, to approximate?

Our approaches or our detachments are closely related to our receptors: What are we receptive to in our interactions? And when do we – does our countertransference – block our receptors? This can be triggered by a number of things in a patient – behaviour aspects, cultural backgrounds, frightening experiences and traumas, issues of sexuality and gender identity, class differences, psychiatric disorders, or political opinions, which might make us feel uncomfortable or uneasy with a specific patient, and we might feel even more reluctant to present our ‘case’, meaning ourselves, to the group. We feel thrown into the unfamiliar, and challenged in our comfort zone. We know we will not get away with protecting ourselves, we know we will be asked the inevitable question by the ones whom we consider ‘strangers’, a question best expressed with words by Luce Irigaray, French culture theorist and psychoanalyst:

“But I, am I not a reminder of what you buried in oblivion to build your world?”  
(Irigaray, L. 1992).

### **When something becomes unbearable - is creating an inner distance easily visible?**

The presenter introduces the group to a female patient whom she has been seeing for some months now in her GP practice. With her partner, the patient has three kids, but when the eldest daughter went away to college, she soon found herself in premature menopause and developed psychosomatic symptoms, mostly breathing problems and nightmares involving the daughter’s wellbeing. The presenter feels sorry for her patient and is puzzled as to why the symptoms keep coming back although there are no pathological findings.

The whole group seems to be impressed, and almost comfortably settles into an alarming contentment with thoughts like, “looks nice and smooth”. It seems easy to understand the presenter’s and the patient’s relationship, almost too beautiful a picture. For a while they dwell on fantasies about the various symptoms of menopause and the patient’s sadness because of the daughter having moved out.

But let us be careful as facilitators. Before we are too easily satisfied, let us remember that the philosopher Francis Bacon left us a warning from way back in the 17th century in his essay “Of Beauty”. He tells us,

“there is no excellent beauty that hath not some strangeness in the proportion”  
(Bacon, F. 1612).

So, what is hidden behind this readiness to be so homogeneous, so in unison? Is it reluctance or resistance to see the ragged edges, the spikey corners? Half way into the process, however, the group begins to assume that the patient offers the

doctor some minor, less frightening reasons for her symptoms, although they may well be seen as a signpost pointing back to an underlying trauma. When the presenter is asked back in she says how the group discussion made her aware that during her introduction it did not cross her mind to mention that the patient had been the victim of rape by her stepfather’s brother when she was her daughter’s age. The presenter admitted that she had completely brushed this information aside because the mere thought of this abuse felt frightening and extremely repugnant, and the patient’s daughter and her own are the same age. Also, the patient has told her that the offender had apologised to her, and seeing him at family gatherings is now ok for her, or so she claims. Thus the doctor



decided that concentrating on the presented menopausal changes would be more important and helpful for the patient than something long gone.

We may conclude that using this rationalisation acts as a defence mechanism which helps to maintain an inner distance. And as is the case more often than not, the hidden, the repressed, the frightening, or the denied seeped into the group process.

### **Strangeness, strange words and their explosive spark**

The young doctor in her foundation year presents the case of a Romni, a refugee who had left her country of origin with her family after hate crimes against Roma people. The family's house was burnt down, one of her grandchildren died in the attack. Because of acute appendicitis she was admitted to the hospital for the operation.

The patient's first language is Romani, but she knows some of the language of the country of resettlement, just enough to get by. Being in a hospital for the first time in her life, she appears disoriented and easily irritated. On two or three occasions she asks the nurses for something to which she adds: "I eat your heart". They read it as a threat: "You better bring me what I asked for, or else...". They become fearful, prejudice against Roma people flares up, the senior doctor in charge is called, he prescribes strong tranquilisers and anxiolytics.

The doctor in training feels helpless in her position in the hospital hierarchy, she is irritated by the patient's words, and unsure whether she should identify with the young nurses' fear. She has a feeling, which she cannot explain, that there might be another reason for the patient's behaviour, like the repetition of a trauma, or perhaps deep down she is just a demanding person used to threatening people. So she takes her irritation to the group.

In Balint groups we are giving space to whatever comes to mind. This might appear at times like generating non sequiturs, unconnected elements, but only seemingly so. There is always the unconscious undercurrent, for which we have to allow time, give time and space. Things cannot be hurried, just as a Chinese saying goes: "You cannot push the river".

This can place a demand, but also questions or doubts on group leaders, sometimes even a dilemma. And as the group facilitator in this case I already find myself in one. Working for a Roma organization in Vienna I have learned some Romani, and I understand the patient's sentence: "I eat your heart". If translated back into her language, it is a way of saying 'please' in a special endearing way to younger people, like to grandchildren. It can be compared to "please, be so kind, I love you a lot", or "be a darling, please". Saying this, though, is the prerogative of someone older; young people are not to address older people in this way. Here, like in many other cases, I regret the lack of hospital translators with their ability to also introduce ethnic characteristics (Tribe, R. & Morrissey, J. 2004).

So what do I do now with this knowledge? Shall I tell the group right away? Or do I hear their clarifying questions first, or even let them start their group work? And if so, at which point do I come forward with my information? I decided to wait in order not to block their thoughts and especially not their emotions. For quite some time these concentrated on the patient. A group member's first shy remark about not understanding the phrase in question was overrun by strong words, ranging from anger, to the strongly felt need to protect oneself from the assumed aggressive attitude, to honestly admitted prejudice. The elephant in the room had 'stranger', 'fear', and 'unfamiliar' written all over him. When the heated discussion became calmer I felt confident enough to ask the group if understanding the patient's phrase would help lessen concerns, and I told them about

the translation. This enabled a shift in the way of looking at the situation of both the doctor and the patient, and it increased the understanding of how quickly the incomprehensible is rejected, especially when it is linked to a discriminated minority.

### **Passed over in silence: The issue of class differences**

On a very general basis, important issues like social equality or the access to education for everyone are widely acknowledged. On the basis of personal interactions between individuals in clinical or psychotherapeutic settings, however, the fact of class differences “is not so much excluded ... as elided and disavowed. That is to say, it is there, but not there” (Ryan, J. 2009).

This does not apply to psychotherapy only, an issue which Joanna Ryan, a London psychoanalyst and supervisor, has concentrated on in her research. It is established just the same as a widespread taboo in a liberal society and its egalitarian ideals in which it is considered not p.c., not politically correct for us to look into the topic because wishful thinking leads us to believe that there is no such thing as class anymore.

This problem of eliding and excluding class related topics inevitably has its effects on the process of transference and countertransference (Ryan, J. 2006) for psychotherapists, clinicians, and in Balint groups.

Let's take therapist A: His own background is middle class. His patient is working class and doing well in his road works job but has a problem with containing his aggression; he feels easily provoked and tries to show his superiority by starting physical fights in bars. The therapist knows that the patient's father was not able to hold a steady job, and the mother's income was not enough so the family was quite poor. The income is not the only difference; the therapist also knows that there are issues here of diverse class histories, only he does not know how to include them in the sessions out of guilt about his inherited privileges and pride in his achievements. In his countertransference he feels vulnerable and fearful of the patient's accusations and readiness to compete.

Will he bring his dilemma to the group or avoid it? He might express his uneasiness with aggression issues, but can he talk about his guilt, or his pride? Perhaps he will hesitate out of fear of being labelled arrogant, or out of embarrassment if his conceit or his need to justify himself is found out.

And what about doctor B: She comes from a working class background, and although she has worked hard enough to complete her academic training, she still experiences fear of inadequacy. Her middle class patient flaunts expensive designer products and tells her she sounds a little working class. In her countertransference she rather quickly feels the patient is frequently complaining without reason, just as the spoiled child which the doctor assumes the patient used to be – which of course is only an assumption.

In the group she might talk about her anger and perhaps her envy, but can she admit how difficult it has been all her life to deal with her own painfully felt conviction of not being good enough, and feeling ashamed?

How will it be for both A and B in a Balint group? Very probably some group members or leaders have the same class background, one or the other, but will *they* understand, or feel like exposing themselves by paying attention to, or want to even look at the issue?

It is always like walking a fine line to pick up on such delicate social aspects when only rarely has there been a good enough framework for including class issues in the respective previous professional trainings. Nonetheless, the social stratum is charged with diversity, including diverse class backgrounds. Not going further means avoiding looking

at the additional issues, like the pain of inequality or the guilt about privilege (Ryan, J. 2006).

If we acknowledge that class is not 'out there', but is part of ourselves, it will allow us to use the plenitude of experiences of patients, doctors, and psychotherapists (Ryan, J. 2009).

## Conclusion

So at the end now we are back where I began: we attend Balint groups because we want to understand more. Being confronted with an experience that diverges from the familiar, we are not automatically open to the unfamiliar. Defence mechanisms do of course not only happen in Balint groups, we witness them in everyday life. If we feel a lack of safety, a lack of control, displacement happens, a shift from what appears threatening onto something else. Our defences are looking for an object we can exert control over. The psyche might feel helpless when the banks crash, therefore it tries to make up for it by demanding punishment for the Syrian woman who wears a burkini, or for the Afghani refugee boy who steals a pack of chewing gum.

If we want to understand the not-so-well-known, if we are looking for a context which makes sense, we need to include our own 'foreign' feelings. It means seeing difference as something valuable, and not as something we need to get rid of.

In her book "Strangers to Ourselves" Julia Kristeva, Bulgarian-French linguist and psychoanalyst, states that it is all about discovering and analysing our own disturbing otherness,

"for that indeed is what bursts in to confront that 'demon', that threat, that apprehension generated by the projective apparition of the other at the heart of what we persist in maintaining as a proper, solid 'us'. By recognising our uncanny strangeness we shall neither suffer from it nor enjoy it from the outside. The foreigner is within me, hence we are all foreigners. ... To worry or smile, such is the choice when we are assailed by the strange; our decision depends on how familiar we are with our ghosts" (Kristeva, J. 1991).

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# Crossing Borders – Laying the Landscape of Balint in Pakistan

## **Introduction:**

Balint groups focus on exploring the doctor-patient relationship. Reflecting on one's counter-transference and facing emotional challenges experienced during clinical encounters requires a space where clinicians feel safe, contained and held.<sup>1-3</sup> This space is both a physical and psychological territory where clinicians come to terms with uncertainty, tolerating differences and owning otherwise disowned mixed feelings. In the absence of such a space it becomes difficult to weave the fabric of psychological insight using the thread of counter-transference. In this paper we wish to explore some of the socio-cultural challenges that we encountered while establishing such a space in a diverse society like Pakistan. Understanding these challenges provides insight into the socio-cultural variables that need considerate attention before setting up such groups in a multilingual and culturally diverse country like Pakistan.

## **Historical and geographical Perspective:**

Pakistan is the sixth-most populous country in the world with a population exceeding 200 million. Geographically Pakistan is strategically placed at the interface of the Middle-east, central and South-Asia and shares borders with China, India, Afghanistan and Iran. The social fabric of Pakistan therefore has an interesting mix of Persian, Arabic, Indian and Afghani influence. Pakistan was created in 1947 as an independent Muslim country following separation from the British empire. A civil war in 1971 led to the separation of East Pakistan and the creation of Bangladesh. Pakistan is ethnically and linguistically a diverse country. Islam is the predominant religion and religious minorities consist mainly of Hindus, Christians, Sikhs, Zoroastrians and Buddhists. More than 60 languages are spoken in Pakistan including a number of provincial languages but Urdu and English are the official languages.<sup>4</sup> Although Urdu is the primary language of communication, English remains the language of choice for educational, legal and business purposes.

## **A Psycho-oncology Balint group at a tertiary care hospital in Pakistan:**

Aga Khan University hospital is a tertiary care, private hospital located in the city of Karachi, Pakistan. Over the years this hospital has developed an international reputation for being a centre of clinical and academic excellence. In order to bridge the gap between the medical and psychological needs of patients with cancer, Psych-oncology services were set up in 2016 at the Aga Khan Hospital. As an extension of this development, hospital management requested us to start a Psychiatrist-led reflective group for oncology nursing staff. Management reported an increased burnout rate and stress in their nursing staff who they felt were getting into complex dynamics with dying patients. We decided to pilot a Balint group case-based discussion model focusing on exploring the counter-transference and the emotional exchange between the nurse and their patients. A series of four induction sessions where information relating to the basic concept and framework of Balint group were provided to the participants initially. This Balint group had 7 nursing health care staff, who met once every fortnight for an hour at a designated area of the Psychiatry department. The group was led by myself and facilitated by another psychiatrist, Dr Aisha Sanobar. This is the first Balint group to our knowledge that had ever been piloted in Pakistan. The setting i.e. Psycho-oncology and its membership comprising of nursing staff contributed further to the diversity and novelty of this group.

We are now going to highlight some of the socio-cultural and dynamic challenges that we have encountered whilst setting up and running this Balint group in Pakistan.

### **The interplay between the Balint framework, social and cultural:**

#### **The use of Hybrid Language for emotional reflection:**

People in the urban areas of Pakistan are now increasingly using a hybrid language - one that combines Urdu and English vocabularies for ease of communication. The hybrid technique helps in bridging the linguistic gap between the two languages. The nurses in our Balint group preferred using the same hybrid language for communicating their feelings i.e. neither Urdu nor English alone but a combination of both. We observed that the nurses selectively preferred English when reporting mixed feelings/affect (e.g. disgust, despair, annoyance or shame) but relied more on Urdu for primary emotions, primitive feelings and spiritual distress. When Urdu was used deliberately to translate complex mixed feelings the narrative of the group sounded too poetic and rather artificial. The group's ability to be "interlingual" created a diverse narrative in which intra-psychic and inter-personal vulnerability was expressed using both foreign (English) and native (Urdu) vocabulary. Linguistically, this may just be because of the strong historical influence of English over Urdu dating back to the British colonial empire. But from a dynamic perspective it shows how the process of translation of complex feelings sometimes can subject feelings to unnecessary censorship so much so that they may sometimes eventually lose their true identity. By no means was this just a struggle for the nurses in the group but for us too as my previous experience has always been of Balint groups where English was the sole and primary language of communication. As a leader/facilitator we realised that having flexibility in the use of language helped in creating that experimental ground where staff can safely explore and communicate their emotional states in the language that best represented their internal affect.

#### **Submission to authority and pathological obedience:**

Submissiveness towards authority is seen as a sign of devotion and respect in Pakistan. Questioning or challenging such a figure can be culturally perceived as a rebellious behaviour. Submissiveness to supreme power is further endorsed by Islam which preaches absolute surrender to the creator. If unchecked, extreme submissiveness can affect one's capacity to think freely, independently or critically and can create a state of pathological obedience. It is important to understand how this cultural submissiveness can interfere with the Balint matrix as the task of exploring one's counter-transference requires rebelling against traditional ways of thinking or being "curious." Group members may develop a peculiar cultural transference towards the leader/facilitator whose task they see is to encourage freedom of thought. Members might initially view "free thinking" as culturally forbidden as if there might be something quite blasphemous about being curious. The theological perspective becomes important to hold in mind here,<sup>5</sup> based on which the Prophet Adam was expelled from the heavens because he dared to think and act differently to what he was instructed by God. Adam's descent from the heavens to Earth is therefore seen as a divine punishment, the fear of which still hibernates in the society at large. Such paranoid anxieties relating to being "singled out and exiled" can be projected into the Balint leader too when he/she attempts to encourage freedom of thoughts and speech. It is therefore important that the Balint leader understands these cultural limitations as he/she could be perceived in the transference as a spiritual, religious or tribal leader who is expected to adhere to a traditional or divine script. The



leader's wish to create a free-thinking space could be perceived by the group as a liberty too much to digest. They may equate this granted freedom as something quite forbidden and try to maintain a silence of pathological obedience. In order to develop separateness from the cultural submissiveness, a closed rather than an open Balint group works better in a setting like Pakistan. This is because shame and doubt may precede or follow healthy curiosity and a closed Balint group offers a safer setting where members can explore their genuine counter-transference without feeling overwhelmed by either the fear of being divinely punished or culturally exiled.

### **Divisive splits in the society and its impact on Balint:**

Pakistan is an economically developing country which is moving on to become a progressive and democratic society after years of rule under different dictatorships. There remain multiple divisions within the society based on gender, class, caste, religion and political affiliations. The patriarchal nature of the society, lack of social integration between religious sects and sharp class divisions have created an atmosphere of social paranoia with a fear of disintegration by the more powerful. This fear has possibly heightened following the geo-political changes post-9/11 and the subsequent impact of terrorism on the psychological landscape of Pakistani society. Because terrorism silences freedom of speech and attacks differences in a hope to achieve pathological sameness, the society has become split into multiple islands of paranoid schizoid communities. The "vulnerable self" of these communities remain socially quarantined and hidden from each other due to a fear of being consumed by the more powerful. Expression of one's vulnerable self can be very challenging in such an atmosphere as it requires laying down one's defences which is culturally seen as a sign of weakness rather than strength. Understanding these social splits is important as it helps to comprehend the challenges one might face when assembling a heterogeneous Balint group in a divisive society like Pakistan. When doctors/clinicians belonging to different communities, classes and sects are aggregated in a group, the purpose of which is to reflect on feelings, lay down their defences and own their vulnerability, then Balint could become a social experimental playground. Although the task of Balint will never steer away from understanding the clinician-patient dyad but indirectly this experimental space also provides the opportunity for social integration and a marriage of emotional differences.

### **Power Hierarchies:**

In our Balint group the majority of the members were females with only three men. The preference of male members to sit next to each other reflected the underlying cultural anxiety that they might either get singled out or their masculinity might come under attack by engaging in a process of emotional reflection.<sup>6</sup> Women were quite often expected in the group to take the lead in disclosing feelings and they often became the voice for other male members who struggle to own or disclose their vulnerability when dealing with dying patients. The leader/facilitator should keep a check on this as otherwise there is a risk of patriarchal divisiveness within Balint. It is our view that in a country like Pakistan it helps if the co-facilitation for Balint groups is undertaken with the opposite gender. This helps in setting up a dynamic of co-dependence between the male and female facilitators. The group views this as a non-traditional yet symbiotic relationship where roles and power can be shared between opposite genders without necessarily losing one's identity. Our Balint was also peculiar in a sense as there was another power imbalance between the nurses (members) and the doctors (leader/facilitator). Historically the power struggles of the doctor-nurse relationships date back to the times of Florence Nightingale<sup>7</sup>

and can resonate within Balint too. As a Leader/facilitator we were mindful of this challenge and tried to promote a democratic and shared ownership of the Balint group within the members in order to dissolve such power splits.

### **The risk of Pseudo-countertransference:**

The anxiety in relation to exploring one's counter-transference is perhaps universal but in a society like Pakistan this anxiety can sometimes have a phobic quality. This is due to the profound cultural dissonance that clinicians may experience when exploring their genuine feelings towards patients. The class and religious divisiveness between clinicians can heighten the fear of being socially or morally judged by others. This creates a space for pseudo-countertransference i.e. clinician's feelings towards patients that are either thoroughly intellectualised, rationalised or perhaps not genuine. An example of this can be the range of counter-transference which nursing staff may experience towards a patient who engages in social drinking or has a liberal take on pre-marital sex both of which are punishable offences in an Islamic country like Pakistan. The liberals or clinicians from a relatively higher socio-economic background may have a very different approach to dealing with their feelings compared to those from a more traditional background. Metabolising a range of complex countertransference, helping the clinicians use this as a tool to broaden insight and enabling them to own their socio-cultural bias requires sensitive handling of information by the Balint leader/facilitator. It is imperative that the group should never lose sight of the patient as a HUMAN whose interaction with another human (i.e. clinician) should be analysed, unbiased by class, caste, moral or other differences.

Handling pseudo-counter-transference can be a potentially explosive business in a Balint group where religious and other patriarchal divides operate within the rich matrix of the group. Defusing such emotional landmines by the group leader requires patience, courage and tolerance of polymorphous and ambiguous projections from other group members. What is morally objectionable verses what is morally acceptable can potentially transform the Balint group into a court room where the leader and the facilitator may suddenly find themselves as ethically policing the sacred space of Balint. Pseudo-countertransference can be one way of maintaining political correctness in the group through which members try to avoid a potential conflict between their own socio-cultural values and those of the patient. It creates, what we would call a "synthetic zone" where emotions and feelings lose their organicity and develop a processed flavour.

It was initially difficult for the nurses to digest and absorb genuine counter-transference as it involved sharing a mentally intimate space not just with their patients but with their own unconscious too. In Pakistani society, closeness and intimacy with feelings follow a certain ritualistic and often controlled pattern of display. Death, marriage, childbirth, loss and other important events in life often get coupled with cultural rituals of mourning or celebration. The function of these rituals is often to give a cultural license using which the member of society can progressively become close and intimate with their feelings and vulnerability. We initially felt that pseudo-countertransference in our Balint group was a defence but we later realised that it may perhaps be a ritual which the group feels compelled to engage in before a genuine catharsis of feelings can take place. As a ritual it might therefore have a protective or adaptive function which the leader and facilitator need to be mindful of. Any attempt to fracture the apparatus of pseudo-countertransference completely can trigger a premature tsunami of anxiety and uncertainty within the members.

Exploring one's genuine feelings towards a patient who might be an alcoholic, atheist, sexually promiscuous or even an elite brings along with it a facing our own racist judgements and prejudices towards certain group of patients. It creates a space within the Balint group where clinicians become curious about their own as well as others' internal belief systems. In a country like Pakistan such discussions have the potential to turn rapidly into confrontation as these beliefs are often shaped by religion, culture and other social influences. Our role as a leader and facilitator in such a situation is to tolerate the synthetic flavour of pseudo-countertransference until the group has evolved to a point where it begins to question the lack of organicity in their discourse. It is at this point when an intervention by the leader or facilitator helps in creating that "curious mind" using which members themselves begin to doubt the authenticity of their manifest feelings.

Interestingly in this respect the technique of the Balint group actually helps in a culture like Pakistan to become intimate with our feelings but from a distance. For example the separation of the presenter from the group while he/she watches others talk about the material being presented allows the presenter to come into contact with their vulnerability in a self-quarantined zone. Its like watching and understanding your own feelings through the prism of others and then later realising that there is perhaps a reflection of self too in others people's account.

### **Death anxiety and spirituality in Balint group:**

The nursing staff in our Balint group worked closely with people diagnosed with cancer some of whom eventually received end of life care. Staff very often discussed cases (including children) where death and dying came up as existential questions. Identification with one's own mortality, fear of uncertainty and becoming non-existent were some of the many anxieties which surfaced in their counter-transference. Quite often the staff located such vulnerable feelings entirely in the patients or their families with relative disconnection from their own vulnerability as clinicians and humans. In this context it is important to understand the significance of spirituality in a culture like Pakistan where life and death are treated as spiritual transitions. It is not uncommon in Pakistan for God to become a focus of clinical discussion between the clinician and patient to provide hope and alleviate despair, especially when breaking bad news. This triangular relationship between the clinician, patient and God can replicate itself in the form of a spiritual counter-transference within the Balint group. The simple act of praying for a patient in the group sometimes enabled the members to engage in a mystical catharsis which helped them overcome their own fear of death and dying. Spirituality, we believe, provides a license for psychological catharsis in Pakistan using which even the most defended clinicians are able to lay down their defences and own their vulnerability.

It was interesting to note in our Balint group that members quite often talked about deceased patients as if they were still alive. Memories relating to bedside care, family conflicts and how nurses became an integral part of their patients care produced a very rich narrative in the group. The concept of afterlife is a deeply entrenched component of one's spiritual identity in Pakistan. The nurses very often found themselves embroiled in dynamics where they had continued to provide care to a bereaving family member for a number of years. The concept of providing extended and often intensive aftercare to the family was an accepted norm very much like their belief in the afterlife of the deceased patient. In some of the cases nurses had become surrogate objects for these bereaving families whose emotional demands they found compulsory to attend, sometimes well after the death of the primary patient. These behaviours ranged from attending the funerals of patients, receiving calls from families on the anniversaries of patient's death

and (on one occasion) attending a wedding in the family of the deceased patient. The Balint group provided these nurses with that space where they started to explore their own loss and other mixed feelings when caring for terminally ill or dying patients. They became cognizant of how these unprocessed feelings can influence a range of compensatory behaviours that they otherwise saw as routine aftercare. For example the need to maintain prolonged contact with bereaving families was sometimes driven by their own guilt and loss when dealing with death and dying. Their struggle to separate from these families and on occasions becoming overwhelmed by their demands was often discussed in the group as a common theme.

As a leader and facilitator we observed that the nurses had developed a 'survival kit' of defences when dealing with terminally ill patients. Use of dark humour, concrete preoccupation with policies/procedures as well as locating the blame in the setting i.e. hospital were some of the ways that they had learned to distance themselves from death and dying. The Balint group provided them with the space where it was possible to talk about death from a multi-dimensional perspective and allow episodic connection with their own vulnerability as clinicians. This we felt was important to address as pervasive disconnection from our own mortality can create malignant alienation from the patients who we care for.

### **Conclusion:**

Balint like any clinical group is a micro-fraction of the society at large in which it operates. It is therefore important to understand the social, cultural and spiritual fabric of the society in which it is dynamically administered. Socio-cultural variables can resonate within the matrix of Balint and can influence the technique with which it is executed or navigated through. Our Balint group was novel in certain aspects as it involved nurses (rather than doctors) providing cancer care to patients some of whom were receiving end of life care. The fact that this Balint group was led by two doctors added a further interesting dimension due to the hierarchical differences between doctors and nurses historically. Ongoing qualitative and quantitative research is imperative to understand how socio-cultural variables can interplay with the Balint technique and contribute to enriching its framework in diverse ways.

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## 20th IBF Congress 2017

Wednesday, the 6th September 2017 finally dawned. The organising committee, myself, Ceri Dornan, Caroline Palmer and Martin Tilling had been at Keble College, Oxford since Monday evening preparing. Also, there had been those from the Balint archive, laying out the exhibition space. With reasonable but not wonderful weather people began to arrive after lunch. Despite knowing the numbers, we were amazed by how many people that really was. There were 212 delegates, plus some accompanying persons, from 29 countries. As the home country there were 50 from the UK, 27 from Iceland (all their GPs in training), 19 from Germany, 17 from Israel, 14 from the USA, 11 from Australia and 10 from Sweden, as the biggest delegations.

We really needed the Society administrative assistant, Helen Lycett, to help process the registrations of the delegates who then thronged through into the O'Reilly theatre for the introductory session of speeches, followed by a presentation by the Irish poet Padraig O Tuama, "Where there is silence, let there be story". Inspired and thoughtful, we then marshalled everyone for a brief walking tour of Oxford. Groups of 10-15 people departed every 2-3 minutes, on a planned route! Drinks in Liddon Quad followed by dinner in the hall got everyone back in good time. It was really when the conference entered the hall, sat down, and filled it, that we, the organising committee, realised that we had achieved our aim - to show traditional British hospitality to the world, alongside a world class scientific congress.

There were four paper presentation sessions and one workshop session addressing the theme of the conference, "Balint Theory and Practice: Exploring Diversity". Five small Balint group sessions ran throughout the four main conference days. The scientific committee, headed by Paul Sackin, had chosen wisely and were able to take papers and workshops only relating to the conference theme, which had produced a big response. The papers were published in advance to enable people with English as a foreign language to follow them better and are also available online now. There were 17 small groups, some leadership, some ordinary and one psychodrama. We were grateful to the IBF Leadership Task Force, led by Tove Matheisson, for organising the leadership and the membership of the groups; also, for running the groups for those leading groups at the weekend. It was done excellently, as was our intricate task of finding the rooms for them! Some were a little cramped, but once the leaders realised many were in exactly the same style of room design they were happy!

There was also a session on Saturday to hear the Ascona Student Prize essay winners, invited by the IBF. It coincided with our student Saturday, an afternoon of groups for medical students, attended by about 10 UK medical students, as well as the prize winners, and organised by Caroline Palmer and Helen Sheldon. The UK students had also attended the morning lecture session with the whole congress.

Posters were displayed in the ARCO suite, alongside a marvellous exhibition, organised by a team led by Andrew Elder, Esti Rimmer, Raluca Soreanu, and archive staff from the Balint archive which has recently come back to England from Switzerland. It was a documentary display on "Balint the Internationalist", showing letters, official documents and photos. Also present on the Thursday were physical items, such as his briefcase, actual passports and other items. Everyone wished that this could become something permanent somewhere-the display boards have been stored by the archive for possible future use.

There was a free afternoon on the Friday to give people a chance to recharge from



all the ample meals served in the hall, and the intellectual work. Also free for many was the Saturday afternoon, though many of the delegates did attend the IBF General assembly. We also provided a social programme, alongside all the work! There was a wind ensemble concert in the beautiful chapel on Thursday evening before dinner, live music and dancing in the bar on the Friday evening after dinner, and of course the traditional communal singing after the Saturday conference dinner. There was also the chance to see feature films, chosen and displayed by Jane Dammers and John Salinsky, on Thursday and Friday in the Pusey room.

The Congress ended on Sunday with a plenary session. For our organising committee, a relief, the sadness of saying good bye, and sincere thanks from the IBF and the floor. Feedback afterwards confirmed our positive feelings. Amazement that we had stuck to a theme, and made it work and that the theme was so relevant to all at the congress. Compliments on the venue, Keble College, where we accommodated everything-the old college education tradition. Affirmation for the IBF that the four day congress is worthwhile, giving so much more than a weekend.

I look forward to the next, the 21st IBF Congress which will be in Porto, Portugal from 11th to 15th September, 2019. I hope to see many UK Balint Society members there.

**David Watt**

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## **Blooming Balint (after James Joyce).**

Bag-pipes lead the foot soldiers  
To the crest of the hill.  
Drum tattoo punctuates the staccato of  
of a case presentation.

We sit inside our 17th century mansion.  
The 1st international Balint Brigade.

'What's going on here?', is the question  
which gets asked.  
With Balint we are barred from  
arriving at an answer.

'Eaten bread is fast forgotten' was a phrase  
my mother gave to me to describe the dynamic  
of the fading or loss of appreciation.

But, on Bloom's day here amidst  
our brigade I realise  
that we have all been Leopold Bloom of a type here.

Still on our extraordinary journey  
through our own geography spread  
over an intensive weekend  
rather than his one spectacular day.

Like Ulysses, we yearn for home-  
and dare say at times  
we found it with each other here.

Patsy Brady

June 16th 2018

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# Talk on Silence

Balint Weekend, Whalley Abbey, March 2016

A talk on silence- I'm sure the irony is not lost on you. It's a bit like inviting someone to their own surprise party or sharing recipes with someone on a fast. People seem surprised that such a talkative person as myself loves silence, but for the last thirty years I have experienced many silent retreats, at first just for a weekend. Then, for eight days and finally, once a thirty day retreat. In fact, the older I get the more I value, not to say crave, silence.

Maybe if I were a shepherd or a lighthouse keeper it might be different, but as a psychotherapist my whole working life is about words: listening to words, helping people to put things into words, speaking words. In fact I offended my husband the other evening, after a long day, when he was going on about something and I just said, very quietly: "Will you stop talking now please: I just can't listen to another word."

Why, I asked myself, was I asked to do a talk on silence to this particular audience? I'm guessing that the context of being in what was once a monastic foundation may have influenced the choice of subject, but I also think it might be to do with how we use or don't use silence in our Balint groups and in our work in general.

My husband is a former BBC sound engineer so I asked him about sound versus silence. He told me about anechoic chambers: spaces where there is absolutely no sound and it can drive you mad. So maybe what we mean by silence is not a complete absence of sound (as in the dictionary definition) but a deep quietness that enable us really to hear- as in the stillness exercise I began with?

I asked my twenty-something year old daughter what she thought of silence and she told me it was boring: "I feel I'm not being productive." She likes to have the radio or the television on because she says she needs stimulation. Then I asked her boyfriend -a very different character- what he thought: he likes it because it gives him space to think. Both of them are actors, which got me thinking about silence in theatre: they told me it builds tension and is really important in drama and gave me some quotes from Howard Barker:

'How hard it is to sit in a silent theatre. There is silence and silence, like the colour black. There are colours within silence.'

'The silence of compulsion is the greatest achievement of the actor and the dramatist.'

'It is such a powerful thing when speech stops, when very highly wrought speaking stops. The power of silence is huge.... It can be quite chilling, it's a stop of the flow. Sometimes an audience requires room to breathe.'

People don't tend to like silence much: if you phone a company they feel the need to play you 'musak' while you are waiting, and people often feel awkward when there are pauses in conversations. If there's a silence in the media it means something's gone wrong.

In other traditions, silence is viewed more positively. In the Old Testament, the writer of the book Ecclesiastes says:

*'There is a time to be silent and a time to speak'*

And in the book of Job:

*'No-one said a word to him because they saw how great his suffering was..'*

Later, the friends get a bit chattier, and Job says:

*'If only you would be altogether silent: for you that would be wisdom. Keep silent and let me speak.'*

We tend to think we have to have a plaster for every cut, but sometimes silence is the most appropriate response, especially, as in this case, in the face of great suffering, or simply to allow the other person to think and form the words they want to say. The first an empathic silence- a kind of deep being with someone in the silence, the second a permissive or freeing kind of silence to allow the other the space they need.

I guess that with practice you come to know what kind of silence you're in. Is it heavy and stuck, so might need a gentle interpretation to get things moving, or is it a pregnant silence, which will produce something fruitful if left?

Is it an awkward silence when no-one seems to know what to say, or an eloquent silence where people are quietly reflecting in a peaceful, contented kind of way on what's been said or done? In analytic psychotherapy, there is a real art in knowing how long to let the silence go on.

Generally speaking, the longer I keep my nerve, the more fruitful the results. If I'd spoken, I'd have blown it and lost something really important.

In Balint work it is similar: a case can be presented that is full of pain, suffering, complexity, or sadness, and silence at those moments can be just what is needed. At other times, the group may be stuck and need a helping hand to get the wheels rolling again.

So I hope I've given you some things to think about, and we're going to open it up now and have a conversation, ironically, about silence.

**Linda Mary Edwards**  
**Psychoanalytic Psychotherapist**

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# **Emotional Wounds - The Healing Process of Dissection**

by Dr Claudia Calciu

Having run Balint Group for psychiatry trainees for a number of years now, it feels like my role as a leader has been safeguarding my confidence and my unshaken self-esteem. But I only came to realise that when I participated in a workshop for Balint leaders where I switched roles to being 'the presenter'. Not that I had not been a presenter in a Balint Group until then, but this time the experience seemed to be so different. Maybe it was because I had not spoken about this case before. Maybe it was the pressure of emotions waiting to be talked about. I saw this opportunity and I took it. I talked about my patient. I am now writing to record my experience as a way of reflection and future recollection. People were assigned to groups and they were organising themselves in each group. My group was doing the same; the two co-facilitators were talking about how to lead the group and how to structure the session, who was going to be the presenter and who the observer. Before they ended their conversation, I said: "I'm going to present a case". It felt like I had to ensure the presenter role was mine. I remember quite well my presentation and I shall try to reproduce it as accurately as possible:

"This is a patient with a long history of psychosis and alcohol misuse. She is in her 40s. I went to see her at her home for a medical review. I have known her for two years, during which we had a very good relationship, with no issues at all. At that review, as I was doing the regular interview for mental state examination, she suddenly started shouting at me saying that I was an awful doctor, rigid and doing everything by the book. She said "you made me fat by giving me all these tablets". She was angry and was getting even angrier. She went on and on and I was startled and could not understand where all this came from. I took all in and I realised that there was no way we could continue the meeting. She was not threatening but was angry and clearly not willing for me to be there. I acknowledged her distress and I told her I felt sorry if I made her feel this way. Then I asked whether she would like to finish off and offered her the option to meet again at a more convenient time and talk through what happened or to see another colleague. She chose to see another medic. And I left. I was shocked, confused, could not get my head around it, frustrated and left with the feeling that I was not the doctor she expected me to be".

My presentation was shorter than 10 minutes. Someone said it was powerful and it came like a punch. I had managed to give very few details about her personal history or current circumstances and clarification questions were not allowed. Then I pushed my chair backwards and listened to the group discussion. So many ideas, feeling and thoughts were expressed. I felt blamed and supported at the same time. They were enacting what I experienced.

It felt so sad when one of the participants remarked that I left with no chance to get an explanation, not knowing, in doubt or with a chance to fix the relationship. I was left wounded. It was exactly what I had been thinking of for so long.

We do carry around so many ambivalent emotions. As much as I felt sad and willing to be liked and valued, I was angry and willing to retaliate. The anger was picked up on. They talked about the patient's anger projected onto me, her anger and frustration at being ill and helpless. She wanted me to know the way she was feeling. One of the leaders reflected on the patient's reaction as an attack on me to which I retaliated by allowing her



to be seen by someone else; like a punishment. How interesting....and true! The more I was listening, the more I could put things into a different perspective. I started accepting what happened. And suddenly someone said they had a strong wish to bring the presenter and the patient together and allow them to talk and fix the problem. And in my imagination I did that. It felt like having a wound dressed and starting to heal.

Powerful emotions were evoked. There were some members annoyed with 'the presenter' because of the lack of reaction. Feelings like fear, shame, doubt, anger, frustration, sadness, abandonment, losses were being talked about and were out in the open, now. The patient might have felt abandoned and shameful. I was feeling the same. I understood that she needed to be valued and to have a meaningful existence. I saw how she needed reassurance and she was maybe pushing boundaries to test my reaction. Would I abandon her to shame and desire to hide away by seeing someone else? And yes, I gave her the option to feel comfortable seeing another medic but, without knowing, I might have taken myself out and away from her emotional pain.

It was so strange having my experience being talked about and not being able to say anything back.

The time came for both the observer and me to join the group. I started giving clarifications without being asked to do so as I felt I needed to fill in the gaps: "She was living alone in the house. Just before the day we met, her two sons had come to live with her as they were jobless and having committed some criminal offences. She was thinking to find some paid work as she had to provide for them. She said she would not want to see me again".

The discussion went on. Clear. Nice. Someone identified a similar personal experience. It was reassuring; until then it seemed like I was the only one having had that experience. Being not good enough...being not good enough.... A torturing thought accompanied by an infinite feeling of hopelessness. How easy it is to question your abilities as a medic when a patient implies that you are not good? Someone in the group asked this question. You do start doubting yourself if you get on well actually with all of your patients.

The whole experience was like an epiphany. I could look at my emotions being dissected by the group. Embarrassing but at the same time so helpful. As if I was in the theatre under anaesthetic and I was being fixed. My emotions were being dismantled, patched over and put back together but in a nice order. And as if by magic, the whole skein of intertwined emotions started coming together in a coherent story.

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## **“Is There A Doctor On Board?”**

Amos Ritter, MD, MPH

“Is there a doctor on board?” – This call always brings up some fears. Who is the patient? What is the problem? Will I know how to handle it? Are there other doctors in the airplane who can handle it better than me? What if I do something wrong – can the patient/traveler sue me? Does my malpractice insurance cover me here?

I was travelling with my wife, returning home from Paris. The trip started 2 weeks earlier, in a “Balint” conference in Metz, where I co-led a Balint group for 5 sessions, during the 4 days meeting. The group was superb, most members had some experience with Balint groups and some were leaders themselves. We had interesting discussions on issues related to doctor-patient relationship, dealing with difficult patients, coping with emotional burdens of the therapeutic encounters. After the conference, my wife Michal and I went for a relaxing vacation in Alsace. We went back to Paris by train the night before our flight, and spent the night in an airport hotel. A text message notifying us of a 2.5 hour delay in our flight enabled us to enjoy a morning swim in the hotel’s swimming pool. After breakfast we took the shuttle to the airport, where everything again went smoothly and without delays. Some of the other passengers, who were not notified of the delay, came early, and were angry about it. We boarded and took off, after the pilot apologized for the delay. The cabin crew began the usual routine of walking along the plane with refreshments and then lunch trays. I was just finishing my lunch when the call came over in the loudspeakers: “Is there a doctor on board? Please come to the back of the plane”.

I didn’t hesitate, even though the fears I mentioned earlier were causing my heart to accelerate. I had to clear my way to the back through all the lunch trays of the passengers near me, and the trollies in the walkway. When I finally arrived at the back of the plane, I found an elderly man, dressed in a white shirt and a jacket, sitting near the aisle with a young woman trying to take his pulse. “I’m a doctor, can I help” I called out. “Please take over, I’m just an intern” said the young woman, stepping aside and letting me approach. “Does anyone know this person; can anyone tell me what happened to him?” I asked the passengers sitting near him. The only information I got was that he was travelling on his own, and had complained of headache and heartburn from the start, even before takeoff. He was very upset due to the delay. I tried to communicate with the passenger, but there was no response. A quick check of the carotids revealed no pulse, and there was no sign of respirations. I realized that I had to begin CPR. I have not taken part in resuscitation since my residency, which was about 25 years ago. Even then, my memories were that most CPR’s fail. Of course, they were all “in hospital” CPR’s, which are known to have a much poorer outcome than “out of hospital” CPR’s. “Can I still do it?” was the thought that must have crossed my mind in the second before I started. Luckily, my employer insisted that I take a “CPR refresher course” last year.

I tore off the buttons of his shirt, and started cardiac massage, right there, on the airplane seat. It took only a few seconds for the crew to understand what was happening. The patient was quickly put down on the floor and taken to the back “station” of the plane. A face mask, airway and Ambo appeared from nowhere. A full CPR by a team of 4 (myself, the intern and 2 of the cabin crew members) was performed, within 30 seconds of the patient’s cardiac arrest. After another minute there was a defibrillator near the patient, reading his pulse and initiating defibrillation as needed. After about 10 minutes of CPR and several electrical shocks, one of the crew members called out: “I can feel the radial

pulse!" I asked for a stethoscope and listened to his heart sounds. A few more seconds have passed and he started breathing, and then moving his limbs, in involuntary spastic movements. I couldn't believe that this was happening. Somehow I was sure that this CPR was going to fail, like all those I remembered from the hospital. But there I was, kneeling at the side of a person who was almost dead, and who came back to life due to our actions. "Take care, the plane is landing" I heard the call from a young and efficient crew member who had participated in the CPR. I understood that while we were busy performing CPR, the crew had informed the pilot of the situation, and he decided to perform an urgent landing in Sofia, Bulgaria. I held on to something and felt the wheels touch the ground. Later on my wife told me that all the passengers were horrified and afraid that something was wrong with the plane. The crew members were so busy that they did not have the time to announce what was happening, until the pilot finally spoke and briefly explained the situation.

The plane came to a complete stop, and an ambulance with an EMS crew came in and took over. I tried to explain to the doctor what had happened, but we couldn't find any common language. The patient was still unconscious, but with a good pulse and spontaneous breathing, pupils not dilated, moving his limbs and making unrecognisable sounds.

I started to make my way back to my seat. The floor was filled with food that had fallen down from the trays during the sudden landing. All the passengers were looking at me with admiration. Some blessed me; others called me "a hero" or "saviour". All of a sudden, I was transformed from being an unknown passenger to the hero of the day.

After some reorganisation, the plane took off again, and took us safely to Tel Aviv. Passengers kept coming up to me, congratulating me and thanking me for what I had done. A thought came into my mind: for 28 years as a family physician I have spent so many hours teaching patients how to change their lifestyle, I have managed patients with chronic illnesses such as hypertension and diabetes – I must have prevented many cases of heart attack or stroke. But nobody ever called me a hero for that. And now, after 30 minutes of CPR, I became the hero of the entire plane...

The next day I was back in my office, dealing with the everyday issues of primary care – treating patients with acute minor illnesses, managing others with chronic conditions, relieving stress and anxiety, helping patients cope with losses in their lives. And of course – lots of administrative work – filling out forms of all kinds, requesting pre-approval for laboratory and diagnostic tests, writing hundreds of prescriptions etc. But the case of the CPR on the plane remained on my mind. Who was this person? What is his condition now? Will he be able to return to his everyday routine? What will his cognitive function be? The only information I had was his name, his age (67) and the fact that he had double nationality, French and Israeli. My thoughts also wandered to the conference I had just come from, dealing with the doctor-patient relationship. Even though I had had no personal communication with this patient, I felt that there was a strong relationship between us. Can one have a relationship with a person one saw only in a state of unconsciousness?

A few days later, I received a phone call from "El-Al" thanking me for what I had done, and offering me a free ticket. To their knowledge the patient, upon arrival at the hospital in Sofia underwent an urgent cardiac catheterisation with intervention. Another week went by, my phone rang, and on the other side I heard the shaking voice of a man using a mixture of French and Hebrew languages, introducing himself as the passenger whose life we had saved. We were both so excited! The patient, for speaking with the person who saved his life, and myself, speaking to a person who came back from certain

death due to the actions of an experienced team which I happened to be part of, without any advanced planning whatsoever.

This feeling was new to me, since in my daily work I do not encounter life threatening situations on a regular basis. Being constantly under the burden of the routine, demanding and frustrating primary care needs, this feeling brought me back to the reasons why I decided to become a doctor. To be there for the patients, when they need me, to know what needs to be done and how to do it, by listening, examining, understanding, and acting according to what I find. This is the doctor-patient relationship which is the basis of our profession, forming a therapeutic bond of a unique and lasting nature.

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## **Balint work and the institutional setting** **- on Balint groups for medical students by a leader who** **thought himself unfit for the task**

*An abbreviated version of this paper was presented at the Annual Meeting of La Société Médical Balint in Bobigny-Paris, September 9-10, 2016, immediately succeeding the presentation of Dr Philippe Heureux, Belgium. The author would like to thank Andrew Elder, Judy Malone, Paul Sackin and John Salinsky for their reading, commenting and constructive criticism on this paper. The author assumes responsibility for the interpretation and contextual use of their viewpoints.*

I would like to begin my meandering on this subject by quoting two colleagues who have dedicated themselves to Balint work with medical students, Dr Heureux and Dr Torppa<sup>(4,18)</sup>:

*Being a doctor is not only about savoir-faire but equally about savoir-être.*

and

*In the medical education it is important that the students gain not only knowledge and skills but are supported in the metamorphosis from layman to a medical professional. ....the process of professional and personal growth should not be left to rely on a « hidden curriculum ». It should be explicit and open.*

The French experience of Balint work at medical schools is longstanding and was well represented at the SMB Bobigny annual meeting, whereas the title of my presentation suggested that I am poorly qualified. In fact I have had no personal experience at all of leading student Balint groups, partly due to circumstances and partly due to how I see my limitations as a professional and as a Balint group leader.

Why this title for my presentation? Years ago I was leading two parallel groups at the Karolinska Hospital for specialists and specialist registrars who were more than half way into their specialisation. Through the grapevine five students in their 6th year heard about it and were inspired to ask for a Balint group for themselves. I met with them and their director of studies and concluded that they did not need a psychoanalyst, but rather someone that I was not: an independent experienced somatic doctor in regular touch with the teaching, mentoring and supervision of medical students and inexperienced doctors. The person I had in mind had been a member of a Balint group. She had a psychodynamic orientation through inclination and her own therapy, but she had no Balint leadership experience of her own. I brought them together and they worked excellently for a year and a half.

In short about my professional background: I am a psychiatrist and psychoanalyst in private practice which after 32 years closed down in the autumn of 2017. For 10 years I worked night and weekend shifts in an ambulatory emergency GP service in the 1980s, making more than 12000 home calls. So I did not entirely lose touch with basic medical clinical work. I have led Balint groups continuously since 1986, between two and six parallel groups, at the moment four. These groups are voluntary, generally bi-weekly and go on for two, six or even nine years. So the number of 90 minute-sessions for the



participants ranges between 40 to more than 120 or more. For many years Balint work attracted GPs only but in the past 15 years hospital groups have also been organised and maintained. The median individual attendance in my groups is 70-80% for the GPs and 55-65 % for the hospital doctors. I usually work alone, not by virtue, but for practical reasons.

### **What psychological stuff are doctors made of?**

This paper aims at drawing your attention both to the individual and the institutional vicissitudes of running Balint groups, particularly compulsory ones.

Firstly, do we know anything about the psychological make-up of medical students and doctors? Engellau<sup>(3)</sup>, made an extensive study of the psychological attachment patterns of doctors at his Department of Oncological Radiology. He found that a large number of them had considerable personality limitations with regard to capacity to relate. Some of them could probably even qualify for a diagnosis of emotional disturbance. Nevertheless he concluded that in spite of their personalities, in many ways they did a good job with their patients. In my view his findings raise a strong warning finger particularly to those within and even more outside of the Balint ranks who have made it their mission to train people to feel and to relate. You may well have personal qualities that make a difference in your work with patients without being particularly good at relating. Many patients will sense the trustworthiness of such a doctor and feel secure. Some may even prefer such a doctor to one who tends to over-identification with his patients with difficulties in maintaining an adequate professional distance.

### **Balint work and the institutional setting**

I certainly favour reflection groups for medical students. Salinsky (private communication 2016) with his vast group experience ranging from trainees to GPs has pointed out that Student Balint groups are different from traditional Balint groups, mainly because the students do not generally have clinical responsibility for the patients they present. Their contacts may be transient and they may just be observers of what their teachers are saying and doing – at times horrified observers! Usually the students are more concerned with their own emotional trauma than the feelings of the patients. However, there are examples where the student has gone out of his way to get to know the patient and try to provide emotional support that is otherwise lacking. The student may over-identify with the patient and this can cause problems..

He states that student groups in the UK are voluntary and furthermore that those schemes are very popular. The Balint groups at University College Hospital London, the birth place of Balint groups for students, have been overbooked for many years. They compete with a psychotherapy training scheme which is the first choice for quite a few of those students, who ultimately will have the Balint group. Though thought of as second-best beforehand, many of them afterwards hold their Balint experience in high esteem (Sackin, private communication, 2016). I would think that the spill-over from the psychotherapy scheme provides a positive selection for the Balint groups. Salinsky states further that the student Balint groups are providing a valuable service in offering students a safe space where they can talk about the way their feelings have been disturbed by encounters with sick people and emotionally incompetent professors. If it has to be short, it is still better than nothing.

Yet one has to recognise that

- there are huge differences in motivation and inclination between individual students, and

- that there are fundamental differences between such groups and Balint groups for doctors who come together voluntarily to discuss their professional experiences in strict confidentiality and on a regular basis for many years.

These differences will constitute one of my vantage points, the other being reviewing some earlier reports on student Balint groups in the UK, USA, France and Finland. I will from time to time take the role of the devil's advocate discussing the difficulties making Balint groups work for students.

My impression is that the student Balint group is a label for a diversity of group projects that at their extremes have little or no resemblance with each other. This also holds true for Balint group work generally. I do not view each and every one of these varieties as consistent with the essence of Balint work. Thus generally I view the development and appropriation of "Balint" as a label or trade mark for educational schemes as problematic<sup>(8)</sup>. It could be expected that followers would interpret the Balint heritage in different ways. The comparison with Freud elaborated by Leonard Shengold<sup>(16)</sup> in "Our Freud" is not far-fetched. It has frequently crossed my mind that "Balint" is used consciously or unconsciously as a trade mark for other schemes and agendas. Is such development unavoidable when a "gospel" spreads? This issue of dilution and alienation was raised internationally already in the 1990s by Frank Dornfest and published in this Journal. I agree with him. My plea is not for orthodoxy but for a certain measure of informed rigour. So it seems essential to discuss the contents of those various designs in order to get a better idea of what they are about and in which way they derive their ideas and methodology from the explorations of Michael and Enid Balint and their followers.

Also, apart from groups which claim to be Balint, but are not, we will in many places find other courses and seminars focusing on the consultation situation and communication with the patient. These schemes both resemble and differ from the Balint student setting of the kind you will find exemplified below, and they are competing for the same space in the medical curriculum<sup>(8)</sup>.

As Balint work promoters, because of the substance we deal with, we will, alas, usually have difficulties to argue our case in a 'savoir-faire environment'<sup>(4)</sup>. Here I want to point out a finding which favours the Balint approach in competition with the behaviouristic approaches to training students in clinical communication skills which is becoming part of standard training at many medical schools:

*Within Northern American medical education it has been observed that explicit commitment to traditional professional values of empathy, compassion and altruism, conceals a tacit commitment to behaviours grounded in ethics of detachment, self-interest and objectivity, promoting a culture of emotional detachment from patients (Coulehan and Williams 2001 quoted in<sup>(12)</sup>)*

Thus, training students can even be counter-productive!

In contrast to such schizoid and Golem-like endeavours there are some very good US schemes in Family Medicine Programs where Balint groups are well integrated and part of the culture of those medical schools, i.e. in Charleston and Santa Rosa.

### **To structure or not to structure?**

I spontaneously approve of what Dr Heurreux has outlined (4): When you only have a very limited number of sessions and a very heterogeneous student group both with regard to motivation and gift for relatedness, the leader(s) must design the seminars and take on a lecturing and structuring task. As regular Balint group leaders we would rather tend to minimise those aspects.

Elsa-Lena Ryding and I did something similar for a six-session voluntary trial Balint group offered to specialist registrars in Obst and Gyn (2009) defining themes for each meeting such as abortion, perinatal death etc. Elsa-Lena started each session with an introduction. Only in the final 6th session we opened for the participants to bring whatever case they wanted. The evaluation was positive and the department decided that a continuous Balint group should be offered which went on for another 2.5 years<sup>(11)</sup>.

But then again, the experience of student Balint group leadership in the UK raises the question: 'Who needs the structure?' (Sackin P, Elder A, Salinsky J private communications 2016). Sackin states

*Does the introduction of some structure into the groups maybe help the leaders more than the students? I often get anxious when students have finished their presentations and I wonder what there is to discuss, given it may have been a very fleeting encounter. But all but one of the six or so groups I have led, I have generally found enough to discuss and that the participants have shown considerable insight. But I couldn't have tolerated this "hands-off" approach without the support of my therapist co-leader, who is equally quiet but brilliantly insightful when she does contribute.*

This is a reminder that the good cooperation between the Balint-experienced somatic doctor and the sensible and psychoanalytically trained therapist by itself, as it were, creates a secure space for group work (holding and containing functions in the psychoanalytical vernacular). Then again, Salinsky challenges the slogan 'Trust the group process!' and advocates that a more active stance by the leader might often be needed. Both these views call for a more detailed exploration into the interaction between the leader(s) and the student group. 'The leader as a drug' seems a suitable title for such an inquiry.

One of my concerns is that a very limited number of Balint group sessions offered to the students will be too many for those who lack motivation and they will be fed up, whereas those who find them beneficial for their professional development will not feel appropriately fed. Has anyone tried to offer an optional group to interested students as a continuation of the time-limited compulsory Balint course?

### **The Balint group as a drug?**

Balint taught us that the doctor is a drug that needs to be carefully prescribed to the patient, a drug that is potent, and as all drugs, has side effects. The same can be said about the Balint group in relation to medical students, medical schools and hospital departments.

For this reason it is interesting to learn and analyse how institutions have come to adopt and include Balint work in their curriculum. On the whole I think one is justified to state that, in contrast to the forming of voluntary GP groups, which is mainly up to the motivated individual GPs, it is mainly the initiative and determination of the management of hospital departments and medical schools that will decide if a Balint group will stand a chance to function efficiently. My experience over the years is that Balint work must be allowed a relative independence. This is only possible if there is a mutual trust and respect. The Balint leader has to feel fairly safe that the general attitude of the teachers and of the institutional leaders is not actively opposed to patient-centredness and relatedness, and that his relative independence from the institution is accepted. I think it has been consolidating for Balint work that I, as an externally recruited leader, had meetings with the management and the entire staff of doctors to present and discuss what Balint work is about, and to listen to their objections and questions. Sometimes concerns are voiced

that the discussions in the group could undermine the institutional climate. I think of such concerns as the tip of an iceberg, where the Balint group is equated with the Freudian 'unheimliche/uncanny'. Certainly the management needs to feel secure in order to grant the Balint leader this kind of independence. If not, knowing (or just the vague premonition) that sensitive issues, even 'the family secrets' and fragments of the psychohistory of the institution may be brought up though this is not the aim of group work, it will be surrounded by an atmosphere tinged by paranoia. It is crucial to minimise such suspiciousness. Patient work is always more or less affected by institutional skews and to illuminate the case those aspects should be allowed for reflection. The Balint leader will be trusted not to act out on institutional conflicts but to help group members to reach a deeper and fuller understanding of situations which demand a critical attitude in all directions including self-scrutiny. When it works – the hallmark of a good Balint group as well as of a "healthy/normally neurotic" institution – the group discussions will be helpful to tolerate and manage complicated and difficult issues in a constructive way.

### **The complementary and conflicting values inherent in medical training**

Let me elaborate and continue my devil's advocacy discourse

Torppa<sup>(18)</sup> opens her presentation on student Balint groups in Finland by stating:

*The centrality of doctor-patient relationship in medicine is undeniable*

I am not so sure. Is this not wishful thinking representing our own standpoint which is consistent with what Michael Balint and others introduced as patient-centered medicine in contrast to illness-centred medicine or organ-centered medicine? These approaches are partly complementary and partly in conflict with each other. Missenard<sup>(10)</sup> makes a valid point about the impact of the Ideal du Moi (Ideal Self) on the future doctor and its reflection into the imago of the Ideal Medical Doctor. This imago is usually prominent in the *hidden curriculum* of the medical school<sup>(18)</sup>. No doubt, the ideal of a doctor, who can even-handedly manage any calamity be it corporal or emotional, and who can successfully fight and defeat illness and death, simultaneously attracts and puts a heavy burden on both students and on many of those hospital specialists, who are their teachers. This imago is difficult to challenge, because – again using the voice of the devil's advocate – the impact of the unconscious on daily clinical work is so deniable.

To rephrase what I already said: for long-term survival, student Balint schemes have to accommodate to that tension and take the mainstream mentality of each particular university hospital into consideration. Though it may sound disappointing to those Balinters who eagerly look for proselytes, I think it is essential for a prospect Balint leader to assess whether those tensions are surmountable or not. If in doubt a trial period could be suggested to the administrators or declining altogether explaining the reasons, if circumstances allow. It takes a long time for Balint work to recover from failures due to various kinds of defect frames and settings – the 1970s and 1980s can provide us with ample examples. And those Balint settings which survived physically seem to lack the sincere and at times painful inquiring aspects of Balint work, doing the integrative work required to make free associations meaningful. Often they are appreciated for their warmth, tolerance and entertainment.

I think it is also crucial to recognise that regardless of Balint groups, the institutional setting at the medical school functions as an important auxiliary professional ego for the students. In other words teachers function as role models to imitate and incorporate into the emerging professional ego of the students, see Sackin<sup>(12,13)</sup>. For example, the *sense of responsibility* is a parameter that I believe is not sufficiently recognised, partly because it is taken for granted and partly because it is so enmeshed in the potent (and mainly

super-ego derived) Ideal Medical Doctor imago<sup>(10)</sup>. This obscures its *professional ego quality*. ‘The hidden curriculum’ is also very heterogeneous and contradictory at many medical schools. Even illness-centered doctors demonstrate a variety of attitudes with regard to this hidden curriculum – from arrogance and daredevil to mature respectful judgment. I argue that in the doctor-patient relationship the sense of responsibility is equally important as *empathy and psychological-mindedness*. Empathic capacity and capacity to relate without the sense of responsibility has a very limited value in medical practice. Such doctors unfortunately exist. They are unreliable partners for their colleagues but even more so for their dependent patients.

### **Evaluation of Balint work is needed**

I think it is crucial for the continued development of student Balint work

- to systematically evaluate Balint group work so that we internally can learn more and adapt, but also provide the management and the teaching staff with some feed-back, which in turn might facilitate their feed-back to us as leaders!
- that the evaluation should show the contents of group work, and account for positive and negative experiences. I agree with Kjeldmand<sup>(7)</sup> who recommends a special focus on drop-outs and on those participants who evaluate the Balint experience negatively.

Although I consider myself a Balint apostle, though one with boundaries, I am a sceptic with regard to the above quoted statement by Salinsky:

*If it (the student Balint group experience) has to be short, it is still better than nothing*

As a general truth that remains to be demonstrated. I would think that very much would depend on the institutional circumstances and the personality of the leader. In view of what Engellau<sup>(3)</sup> found in his survey of the psychological make-up of the doctors at his department, one would assume that his findings carry certain relevance for medical students as well. So as an evaluation aspect I would add:

- to assess the perception of the Balint group in its institutional context

### **The Leader, his students and the Balint approach**

Do not Balint leaders, teachers and mentors at the medical schools, thinking about and tending for their group members/students, somewhat resemble parents? If so, how then do we as leaders account for our own projections and projective identifications?

There seems to be a consensus, that for most medical students, who generally come from a fairly safe and protected environment, the encounter with medical reality will in a variety of ways bring them out of their comfort zone. They will meet aspects of life previously unknown to them. They will lose their innocence. They will move from a prolonged adolescence inherent in their long academic studies into adulthood. This is reflected in a poem ‘Male anatomy in Hospital life’ by my Balint colleague Elsa-Lena Ryding<sup>(5)</sup>

*What good is a man in formalin  
to a nineteen-year old virgin?  
I had to dissect his head  
I prefer not to talk about  
the rest of the training  
The damage is done*

I think many of us in retrospect can relate to similar experiences and appreciate the emotional hardships becoming a doctor. It is often argued, that the loss of innocent



sensibility and the need to develop defensive modes against anxiety during medical training, will decrease the empathic capacities of the future doctors. One explicit purpose of student Balint work would be to foster empathy with the patients.

But another purpose would be to provide the students with a platform to discuss their discomforts, awkwardness and anxieties, and with the help of the group leader to re-experience and assess that such personal concerns are legitimate. Discussing them may facilitate future professional development. Meeting and sharing, and learning from each other is possible! As a future licensed doctor you will know that you have the option to not be alone. *If student group work can achieve that, it is good enough!*

### **Idealising students?**

We also seem to idealise the innocence of youth forgetting that innocence is an expression of a wide range of unconscious motives in the students which are to surge and merge into their future medical professional identity.

As leaders and teachers we have to be cautious. We may appreciate and care for the innocent sensitivity of youth but should not idealise it, or be *too* apprehensive. I have seen such a tendency in the Balint movement many times – a nostalgia for our own lost youth and innocence projected on the young colleagues-to-be.

*In Heidelberg 2013 at the Ascona Student Writer's competition one emotional presentation moved many in the audience, a presentation which in my reading could be understood as the emotional abuse of an old lonely patient by a sentimental medical student intoxicated by her self-image of goodness and her careless innocent 'on-off'-like affective connection to this old lady. She told that she had been in a Balint student group where this relation had been discussed. The student as a drug was apparently not on the agenda.*

*A very experienced GP sitting next to me whispered:  
'She will not be able to be the good GP she strives for'*

I am not so sure. After all, medical students get older and most of us mature too. But to me this points at a special Balint variety of an Ideal de Moi reflected into a medical subculture hailing a particularly feeling-prone Ideal Medical Doctor<sup>(8)</sup>.

### **In the midst of savoir and savoir-faire, how to promote savoir-être?**

Now, leaving the devil behind, student Balint leaders must recognise that many medical students are burdened by the heavy task of assimilating all the medical savoir and savoir-faire. It can be too much and premature, to simultaneously push the development of their medical savoir-être.<sup>(1,4)</sup>

Particularly in the context of obligatory student groups, we have to consider the potential creative space for Balint work. The students see each other daily. The medical school is a workplace with a lot of interaction. How does that work? How and by whom are the groups composed?

Again, not every student has the inclination, ability and courage to expose him/herself even in an optimal group setting. The leader has to respect and adjust to the diversity of personalities and developmental phases of the students much more than if it were a group formed voluntarily. Structure could provide more security. Some students with a capacity to benefit could be considerably inhibited by those who are strongly prejudiced against group work or just lack motivation. But also the constructive use of a group can vary between members. Some will present and discuss a lot, others may benefit from just listening. This unevenness may be an obstacle – or not.

*I recall one very young and insecure specialist registrar participating in a hospital Balint project who did not make one single voluntary comment during the first seven sessions but who repeatedly reassured me that she found the discussions very important. Ending the 7th session out of the total of 13, she announced: 'Next time I will present'. And from then on she took a very active part.*

I will just reiterate the importance of the general institutional mental environment for Balint work, how the group leader is accepted in the academic institutional context without having to abdicate from the essence of his Balint inquiring perspective.

### **How it started**

Let us have a look at how Michael Balint started the student groups. Here I will lean on Michael Balint's 1969 paper<sup>(2)</sup> and on the account given by Paul Sackin<sup>(13)</sup> who participated in Balint's student group for a year and a half. Participation was voluntary. The students spent two full years at the hospital and were divided into a junior group for the first six months and then a senior group which could be joined after those first six. They met once a week for 90 minutes. They were informed that

*participation might even be a bit unpleasant at the beginning but that they would gain a lot in their work with patients.*

It was not only about bringing the experiences from the wards and from the clinics. The students were encouraged by Balint to expand on their duties at the ward by spending extra time to talk to the patients about their concerns, their life situation etc. This brings Balint's long interview to mind. Free associations were encouraged, and Balint took an active part in them himself. He had an uncanny way of sensing the psychological realities on very scant material, and had them often confirmed at the follow-up on the case. Balint encouraged the exploration of both psychological and medical issues, whereas many Balint group leaders today tend to ignore or exclude the medical aspects. Initially these student groups attracted great interest, but over 3-4 years the interest for Balint's project faded. Fewer and fewer students signed up, and the absence rate increased.

*A suicide by one of the group members led to long and soul searching discussions to deal with the aspect feelings of guilt and probably hastened the demise of the group<sup>(13)</sup>.*

The air became thinner and thinner for those few who like Sackin showed up. The group that succeeded the group Sackin was in, set off as an integrated junior and senior group in order to reach the numbers, but it soon faded out. Sackin reports that Balint felt *almost paranoid about the consultants of the hospital; ( that they ) were completely against his approach*

Sackin<sup>(13)</sup> comments that this might be true but not altogether since there were consultants at the hospital who definitely had a holistic approach to their patients, and who made an even greater impact on the young Sackin than the group work with Michael Balint<sup>(12)</sup>. Don't we all, like Paul Sackin, remember some of those doctors from our student days, like beacons in the darkness? But no Balint leader has this 'hands-on' clinical position to inspire the same identificatory process as a clinical consultant teacher can do. We know from first hand reports by Michael Courtenay that Michael Balint himself filling in for Courtenay had that quality as a clinician. Sackin's account indicates that this partly came through the way he led and participated in his group. Yet it was not until later, when he sat in with Phil Hopkins, that Sackin came to appreciate the full value of the student group experience. This indicates both the difficulty with Balint groups for medical students and that the Balint experience has a delayed 'après-coup' -like effect that appears at a later stage in the professional career. This is not unique: it also holds true for a lot of savoir and savoir-faire experiences during the medical studies too!

My critical reflection would be that Balint took his position at the UCH too much for granted and surprisingly un-analytically did not recognise the conflict between patient- and illness-centred medicine and maybe other latent issues at the UCH, which would call for continuously maintaining a dialogue with the firms and the administrators of the clinical training. It is not difficult to imagine that Michael Balint and his approach provoked both personal and ideological opposition. But he was not unique in pursuing a holistic and patient-centred mission at the hospital<sup>(12,13)</sup>. Paul Sackin has interestingly added in a private communication (2016)

*Talking with the patients was encouraged by all our teachers and at that time each medical 'firm' had an attached psychiatrist who met with us students regularly (maybe also weekly) to discuss the patients though I have little memory of the details of these discussions. So, I remember feeling at the time that the ethos on the medical firms was patient-centred.*

Allowing for (too?) much soul-searching into the suicide could probably be understood as a shift of aim/paradigm, turning the group from a Balint into a therapy group. Was Balint's group the only place at the medical school to deal with the suicide? Was there a feeling that the group process might have triggered the suicide, and if so, in whom? Balint's own experience of the suicide of his parents could have cast a shadow and made this issue larger than required by group reality. But these are reflections about the group process. The groups were vanishing in any case and medical students sadly commit suicide for personal reasons regardless of Balint group participation.

Balint very carefully had his co-leader document what went on in the groups. But he did not evaluate or document what went on around it. Nor does it seem that the students themselves evaluated the group work. Was the group dying because of lack of integration with the rest of the training program? Did Balint think that his apostolic mission in his psychoanalytic object-relational patient-centred approach - although it was really down to clinical earth in comparison to the apostolic mission of some other psychoanalysts - would be palatable and digestible without resistance? After all, once a week for two years, and demanding students to do homework in between by interviewing patients at length on the hospital wards is a considerable extra burden for the student, though Sackin (2016) says the discussions with Balint and the general climate of the 'firms' he trained in stimulated students to relate to the patients. I still think that Balint group work would have to be very well supported by most doctors and the hospital management if not to cause friction.

I am also struck in Sackin's report by Balint's helplessness at revitalising the dying group, so that in the end only he and a few others showed up mainly out of loyalty and respect.

With all this said, the fact remains, that in spite of Michael Balint's misgivings he left a long-lasting imprint on the training of medical students at UCH. 40 and 50 years later we still have the reports on ongoing successful Balint student groups at the same institution!<sup>(17a,b)</sup> Those schemes, while preserving the essence of Balint work, are more adapted to the hospital environment and the predicament of the students, their 'areas of urgency'<sup>(17a)</sup>. A number of evaluation tools are used today.

### **The Bristol scheme**

The Bristol scheme<sup>(9)</sup> offers another model for student Balint work. The first few sessions are compulsory and students then choose to continue or not. They are offered up to 9 sessions within usually 6 weeks or a somewhat longer period. Leaders are recruited from appropriate core and advanced psychiatry trainees in the same university area who are

*psycho-dynamically orientated and have been to Balint groups themselves* (40-120 sessions - once a week for 1-3 years). Balint groups are compulsory for core psychiatry trainees. The leaders to be have demonstrated their motivation as Balint group members as well as in their own teaching of medical students (Here I must confess, I am deeply envious: such species do not exist in Sweden.) These leaders have a continuous supervision every fortnight. Supervision starts before the leaders take on their groups and continues after groups have finished to offer support, containment and learning for these novice leaders. The psychiatrists themselves also find leading Balint group work very rewarding. Thus, the evaluation is favourable and the scheme is expanding. The 'near-peer-relation' between students and leaders seems a positive factor.

To sum up the success:

- the Balint group is voluntary, and attractive to the students in its own right
- the intensity (once a week up to a fortnight), the timing and the limited number of sessions (9 sessions at the start of their clinical training)
- the Balint background of the leaders, their supervision and their own institutional connection, not to be underestimated
- The project itself is well seen and supported by the administration

Also, as a spin-off, imagine what this project will do to the cooperation between future somatic doctors and psychiatrists, the liaison psychiatry and the adequate use of referrals to psychiatry in this region!

Re-introducing the devil's advocate, temporarily exiled by my enthusiasm, I was wondering about inherent weaknesses/skews in the Bristol scheme. By using psychiatrists as leaders - would one run the risk of pushing the discussions on the cases towards a "psychiatrisation" rather than allowing for the free reign of clinical associations and fantasies? Another issue would be the lack of Balint-experienced GPs or other "body-doctors" as co-leaders of these groups.

I raised these issues with Judy Malone. Together with Ami Kothari (9) she is the founder of the scheme, and she does the bulk of the supervision and training of the trainee psychiatrist group leaders. She emphasised that the groups are not directed towards helping the students to learn the psychiatric aspects of the cases.

*The leaders, students themselves not so long ago, are very attuned to the students and their experiences within their clinical training and are generally sensitive to the variety of students in their groups.*

Malone has not seen any tendency towards "psychiatrisation". The leaders through their recent medical training are close to the realm of somatic clinical experience, which is maintained through Balint and liaison consultancy work. Malone agrees with the benefits of Balint-experienced doctors as co-leaders. Attempts have been made but the budget of the project does not allow for it. Then again, there is so much interest in leading groups that with the surplus of trainee psychiatrists there now are some groups with two leaders. Also motivated and gifted medical students who participated in the previous year are now on a small scale invited as co-leaders.

In the long run I imagine the Bristol Balint scheme would gain by including Balint experienced GPs or other "body-doctors" in the co-leading of groups, and it seems likely that the dynamics of the project - given it will continue a few more years - will gradually find those leaders among previous students and other doctors in the region who are attracted to leadership training through the scheme.

With regard to the institutional setting of student Balint groups, Malone confirms what I suggested above:

*We do and have done a lot of talking and presenting to all those around the medical student groups – with those with authority and administrative staff and we have found that where we have the best relationships the groups also flourish best.*

### **The Bobigny/Paris scheme - compulsory groups for medical students**

As an advocate of voluntary groups also I run into difficulties presented with the extraordinary work of Philippe Jaury at the Bobigny University in the Paris outskirts. He gave a preliminary presentation in Metz 2015 (6) and a follow-up at the Annual Meeting of the French Balint Society in Paris in September of 2016 to be published. These compulsory student groups are led jointly by Balint-trained doctors and psychoanalysts/psychotherapists. The results show a considerable increase of empathic capacity in the Balint group participants in stark contrast to those in the control group. The outcome is remarkable in view of that any student Balint project would be regarded as satisfactory if just any decline of empathy could be prevented. This project begs for bench-marking to learn about the elements of its success.

Again, to look for a deeper understanding of the gap between a productive and counterproductive group, it seems important to make a distinction between using *the group as training* (in a “tool-orientated” behaviouristic sense, compare Coulehan and Williams 2001 quoted above (12), my remark) *and offering students an opportunity to think about their clinical experiences in a different way*. *The Bristol experience is that most of the students who attend and keep coming back love the groups. Others find them difficult. They certainly do not suit all (Malone, personal communication 2017).*

Yet 85% of all medical students carry on through the nine sessions, as reported by Kothari and Malone<sup>(9)</sup>.

### **“Balinting Balint” to resuscitate a Balint group**

To end, I wish to mention a fascinating report about the difficulties managing a group because I think it is relevant for any group, be it compulsory or voluntary:

The Californian Balint leader Richard Addison<sup>(1)</sup> described the resuscitation of his compulsory once-a-week Balint group for hospital residents. When sensing the increasing lack of interest in the participants, arriving late and being numb during the sessions, he had the courage to allow open criticism of the working model. They complained it was rigid, predictable, boring, rule-bound and injurious to their sense of spontaneity and creativity. He then empowered the group members to assume responsibility for the format and contents of work. He called the process ‘Balinting Balint’. I will not reveal more in order to tease your interest to read the full paper for yourselves. But what happened makes wonderful reading about how to re-establish a true working alliance which made the group work close to our perceptions of both an ideal Balint group and a good psychoanalytic process.

Addison shares the issues that have provoked him, and rephrases them into questions which I think are highly relevant for student Balint groups:

- *Do we (in the traditional Balint setting) give enough attention to the residents’ (read students’) developmental needs? Some are so worried about gaining enough medical knowledge and learning procedural skills that they have difficulty engaging in Balint work.*
- *When we require residents (read students) to attend Balint groups, are we putting our own needs to teach the traditional Balint method and format before their developmental needs?*



And he poses a final question which I think is crucial to discuss:

- *Would resident (read student) Balint groups be better if they were optional or voluntary or open to variation of method?*

So after these meanderings and the exchanges with experienced colleagues that I have tried to account for in this paper, I would preliminarily conclude that an optimal scheme for Balint work for medical students should contain three steps

- a short compulsory introduction for a couple of sessions
- an offer to participate in a time-limited group meeting for say a semester with a frequency no less than a fortnight, and
- for those interested, an offer to continue Balint work over a longer period during their studies.

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# **An account of a nine-week pilot Balint Group for medical students at St George's University of London Medical School**

## **Introduction**

In the spring of 2016 the authors co-led the first Balint Group for medical students at St George's University of London Medical School in southwest London. The eight students who enrolled opted into the pilot as the Student Selected Component (SSC) of their first clinical year (T year) of training.

The group ran for nine consecutive Thursdays from 17.30 to 19.00 between March and May. A quiet and private room had been arranged in one of the buildings on the Springfield Hospital site, now the home of clinical and administrative staff working for South West London and St George's Mental Health NHS Trust (originally built as the *Surrey County Pauper Lunatic Asylum* and opened in 1840).

## **About the Leaders**

The first of the two leaders was, at the time, a medical doctor specialising in Psychiatry – more specifically in Medical Psychotherapy and General Adult Psychiatry. She has a long-standing interest in psychotherapeutic work and is a general member of the Balint Society. The second leader is a UKCP accredited psychotherapist and supervisor and Balint Society Accredited Leader with extensive primary care experience, both as a manager and clinician. He is now working in private practice and has been co-leading a GP Balint group in Lewisham since 2013.

## **Group demographics**

The group comprised eight medical students, all in their first clinical year of medical training. There were two female and six male participants, ranging in age between their early 20s and early 30s. The majority were graduate entry students (commonplace in SGUL medical training) with a range of backgrounds from social work, pre-hospital care and arts degrees. They originated from many countries around the world including Australia, Canada, India, Iraq and the UK.

## **Overview from a psychotherapist perspective**

Having only worked with qualified and experienced GPs until now I was interested to have the opportunity to work with students at the point at which their enculturation into the medical profession had only just begun. At certain times during the life of the group it was possible to see how quickly a culturally enforced etiquette was being established, albeit often unconsciously, in which speaking out about one's personal struggles with very human dilemmas would soon become more difficult, if not taboo. The window of opportunity during which they could still articulate their worries and dilemmas was already beginning to close as they described the sometimes blunted and more stereotyped reactions of more experienced staff and colleagues. What marked out these students for me was their willingness to make themselves vulnerable, and their ability to talk relatively freely about their conflicts and difficulties. I was often moved at their heart-felt commitment to their patients and the humanity they demonstrated in the process.

One particular theme, that of supposed 'lack of empathy' came up often, a subject of course that exercises more experienced doctors too. Not surprisingly perhaps the

subject of death and dying was very early on brought into the material presented. It felt incredibly important to be able to explore, and to some extent normalise reactions to the unexpected deaths of patients they said they 'hardly knew', patients that they had however come into intimate contact with, and often for extended periods of time.

### **Overview from a 'medical' perspective**

Having experienced my own journey through medical school training I found this experience in equal parts fascinating, challenging and disturbing. My own difficult early experiences were mirrored back to me with sometimes overwhelming persistence and intensity. My overriding sense, however, was one of privilege – to be an indirect witness to these students' earliest 'doctor'-patient interactions and the impact these were having on them emotionally. My position as 'elder medic' in the group allowed for some interesting and often times playful interactions but at times also made it quite difficult to step-back into a more objective Balint Leader role. I was thus very grateful for the co-leading of an experienced Balint Leader and found his presence invaluable in channelling and interpreting my sometimes wayward interjections!

Another lasting impression is just how vulnerable medical students are in their early years of training, faced as they are with a constant onslaught of some of the most challenging interpersonal human experiences imaginable. As I try to summarise in pithy sentences the sheer magnitude of their encounters I'm left with just a string of words: mortality, insanity, power, integrity, incarceration, sexuality, impotence, faith, intimacy, boundaries, pretence, lies, kinship, belonging, jealousy, judgement ... the list goes on. It is no wonder, as Leaders, that we left the early sessions feeling emotionally tired and carrying the weight of their worlds. And equally heartening to feel, as the weeks progressed, that that weight began to ease as their confidence in using the group grew.

### **Some significant themes**

#### *Dehumanisation of patients and the student's guilt*

From the outset the subject of 'using' patients to learn from was presented as an uncomfortable fact of life for medical students. Almost daily they were doing something '*for the first time*' with all the potential for clumsiness and error and embarrassment (or shame) that that entailed. What was interesting to learn (at least, for the psychotherapist co-Leader) was that there was a hierarchy of kudos to be earned depending on what kind of procedure was being performed, with those involving needles or scalpels attracting the most (interestingly, it was the men in the group who seemed to react most to this comment, and we wondered about the gendered aspect of this overtly competitive behaviour). Linked to the guilt evoked in taking a utilitarian attitude towards their patients was the necessary encounter with their own sadism, particularly during procedures that inflict pain or discomfort. This of course flies in the face of more idealistic notions of being potential saviour figures, or the ones who have the power to cure or relieve suffering. These conflicts, conscious and unconscious, were never very far away in much of the material presented.

#### *"Who is the doctor?" – being in – or out – of role*

This was the very first case presented in the group:

Whilst on placement with a female GP the student had been allowed to do a breast examination of a 28 year old female patient, something that he was clearly still getting used to. During the course of the examination he had felt a '*bump*' and he felt a dilemma about who to address this finding to: the patient or the GP. His feelings were compounded

by having initially been asked to leave the consulting room by the patient, who then suddenly changed her mind in the time it took him to turn on his heel and open the door. The patient explained that it was because ‘he had asked so politely’. *‘I felt like I’d lost the patient’s trust and then regained it again, all in a very short time’*. Upon examining the patient herself, the GP also felt a lump.

Here is a powerful example of the rather unique vulnerability of the medical student out in the real world. He suddenly becomes aware of the disturbing responsibility of having to announce a potentially serious negative finding. We could argue that the student was somehow unprepared for the responsibility he had been – somewhat indirectly – given. The ‘granting of trust’ seems key. In the moment that the patient changed her mind and allowed this student to examine her she effectively endowed him with the trust she normally reserves for her GP. She also engaged his gratitude, for not excluding him, and for allowing him to learn – all in the context of an intimate examination.

His gratitude was quickly overtaken by his anxiety in finding a possible pathology, and his (accurate) finding became an unexpected, and perhaps unwanted responsibility, so much so that he registered it as a ‘betrayal’ of her trust (*“how could I do this awful thing to her?”*). In this moment, the student discovers that he is out of role and to whom he directs his findings takes on an unusual significance. If he directs his findings to the patient he is in danger of usurping the GP, and in turning away from the patient to address the GP he literally and metaphorically turns away from the patient (a kind of abandonment) and leaves her isolated and alone with her pathology. This consultation became a veritable rollercoaster of emotion for this young medical student and was immensely useful in showing us something about the power dynamics inherent in the uniquely privileged position that doctors find themselves in daily.

### *The vagaries of empathy*

From the outset group members would touch on their discomfort in encountering patients whom they considered were somehow ‘responsible’ for their own illness or poor physical health. The obvious examples were people misusing drugs and alcohol, but once or twice group members were brave enough to voice other ‘prohibited’ thoughts about what might otherwise appear to be a tragic accident or a random misfortune.

In one particular case, a male student on GP placement had been given a good amount of time to interview a female patient alone before then presenting the patient back to the male GP who, it was emphasised, was incredibly diligent (he was clearly somewhat idealised in the eyes of this student). Try as he might, the student was unable to elicit from the patient what she wanted, and his frustration with her was palpable. In the group discussion that followed this presentation it became clear that some rather simplistic ideas were operating about the need for the student to ‘demonstrate empathy’. Whether it was the aim of their trainers or not, the students had come to the idea that the absence of empathy was something less than ideal and therefore reflected badly on them.

In this particular group we tried to elicit a definition of empathy, with only limited success, and went on to reflect upon the ubiquity of the problem, even in the working lives of very experienced doctors. These normalising interventions were fairly common throughout the life of this group and seemed to be received as welcome relief from the ‘tick-box’ approach to medical education they were experiencing outside of the group.

### *Health, disease and illness – and the ‘right distance’*

Our students consistently struggled to evaluate their boundaries with patients. Having the opportunity to spend extended periods with patients they would often end up feeling

a degree of confusion about the nature of their relationship; with older patients, some felt like their adult children, with peers a sibling (or friendship) relationship was sometimes evoked. On balance these factors seemed to serve a positive purpose that afforded certain bonuses; a greater satisfaction in their work, valuable extra information imparted or an initially refused investigation later agreed to.

However, one particular case brought into sharp focus the powerful and unconscious conflicts evoked when the patient and student are at the same time quite similar, and yet separated by the chasm between the student's health and the patient's disease.

A female student was assisting a nurse in the changing of dressings for a young woman of a similar age who had suffered the loss (amputation) of parts of both feet after the onset of a post-operative infection. Not only was the patient quite physically impaired (she was in a wheelchair) the wounds were offensively pungent, and the smell extremely difficult to tolerate. The student's evident disgust was something she felt she should have been able to manage (as she explained, she had '*worked with the homeless*' before her training).

How *does* one align oneself with a patient whilst at the same time managing the disgust and alienation evoked by the smell of a festering wound? However much the student tried to alleviate the patient's obvious emotional discomfort she seemed to make it worse, becoming clumsy in her attempt to identify and then choosing inappropriate examples of conversation (like the wearing of 'skinny jeans' which, of course, was highly alienating rather than comforting). In contrast to the theme of an absence of empathy, this case seems rather more to do with an excess of empathy. As she was later to say in her own written account of being in the group, this student was only too aware of herself as a '*symbol of health*' relative to this patient.

What is one to do with the privilege of feeling physically intact and robust in the face of one's contemporary who is isolated, diminished and prematurely dependent? The medical student (and the qualified doctor too for that matter) will have to contend with these conflicts and the guilt and shame that they evoke on a daily basis.

As was often significant in many of the cases presented, as medical students they are in the relatively privileged position of having more time on their hands than their harried and more senior colleagues. As much as this seemed to be a source of satisfaction, it did of course cut both ways. We were often struck with the poignancy of hearing the painful lesson that the students were learning: that the closer one gets to one's patients the harder it is to lose them or let them down.

#### *Intellectualisation, emotional literacy and humour*

From the very early groups, in fact even from the students' application emails, the word '*interesting*' was used a disproportionate number of times and immediately highlighted one of the key defences being employed: intellectualisation. Repeatedly, when asked for their emotional responses to a case, students would share their thoughts and invariably describe the situation as '*interesting*' - clinically, morally or even, in one case, medico-legally. As the weeks progressed we became more explicit in our directions to address feelings and emotions but still they struggled until we explicitly named the difficulty in an attempt to explore it more fully.

Their struggles appeared to stem from a mixture of limited emotional literacy, needing permission, a fantasised fear of reprisal and lack of positive role modelling. One group member commented: '*... you (the medical leader) are the first doctor I've heard talk about their feelings*'. Both leaders were pleased to observe a gradual improvement



and increased freedom of expression as the weeks passed and in the final debrief session group members felt that this increased confidence would likely have continued had the group run for longer.

Another favoured, and slightly healthier, defence mechanism amongst the students was humour – often dark and subversive in nature; from the mocking of domineering and powerful alpha-male (usually) Consultants to frequent self-depreciation and occasional sarcastic comments directed towards us a group Leaders. Neither Leader felt this behaviour as intrinsically problematic, more a manifestation of the students attempting to manage their anxieties as they began to put words to emotional conflicts that, outside of the group, felt too risky to articulate. The most significant manifestation of their sometimes paranoid anxieties about our position as representatives of ‘the authorities’ surfaced in a fantasised notion that we were covertly ‘monitoring’ their behaviours in the group.

#### *Initiation – the medical culture*

Another recurrent theme throughout the life of the group was the position of the medical student as ‘apprentice’ in their chosen vocation. They were often asked to assume the role of doctor, performing the same tasks and even enjoying being recognised (perhaps omnipotently) by patients as ‘the doctor’ – whilst simultaneously not wanting to overstep an invisible line that actually marked them out as ‘the uninitiated’. They coveted NHS lanyards and the ‘uniform’ of the junior doctor (for men: ‘*chinos and a pastel shirt with the sleeves rolled up*’) as if these were the spoils of their victories over their training. A perhaps more unconscious process was one named by a group member who said they ‘*felt like they had joined the club*’ after their first patient died. There appeared to be an unspoken list of initiation rites one must traverse before becoming a ‘real’ doctor. It was our impression that the students generally suffered these emotionally impactful events in silence with little or no opportunity for acknowledgement or discussion.

And all the while during the lifetime of this group the first Junior Doctors strike in over 40 years was making headline news. The leaders wondered how this was impacting on the initiation processes that the students were describing. Was there now a further blurring of the line between *initiated* and *uninitiated* as the proposed new contract loomed? Could the fear of annihilation (of their profession) be intensifying their emotional experiences? Was the resulting increasing camaraderie safeguarding them against such fears? These aspects of the socio-political environment remained mostly unexamined, and unconscious.

#### *Grief, and fleeting intimacies*

Grief was never very far away in many of the cases discussed in the group. Sometimes more overtly, in the case of a patient with a terminal illness, other times more subtly in the loss of previous identity, loss of trust in a colleague or loss of an expectation being met. But universally it appeared a difficult set of emotions to express within the group – often fragmented and only pieced together by the Leaders in the fullness of time. Expectations around grief were explored too as many group members expressed a sense that it ‘didn’t make sense’ to grieve for someone they ‘didn’t know’.

It seemed clear that the most useful intervention to make at these times was to name the various component emotions of grief, and to validate that a ‘doctor’-patient interaction, however brief, can often evoke incredibly powerful emotions in both parties. Students are often in a position to spend far more time with a patient than other members of the healthcare team and consequently can share a powerful intimacy with patients that

is denied (or avoided) by their busier colleagues. Patients also seem to understand this imbalance of role and benefit from sharing intimacies that they would never consider imparting to 'the doctor'.

### **Closing thoughts**

We were extremely impressed with the capacity of this group to enter into the spirit, and demands, of Balint work. Their capacity to speak from the heart was very powerful, and refreshing. Not yet overly identified with a professional culture that has to employ various defences to manage the daily emotional and psychological strains of the work, their openness with us, and with each other, was exemplary.

Often times there is a feeling that Balint work would be more effective, or valuable, offered later in medical training, but with this cohort we definitely felt that they were at a uniquely raw and vulnerable point in their medical education, and in considerable need of a safe enough space in which to talk about what they were experiencing at the coalface. Indeed, in the closing group (in which we conducted a more informal conversation about the experience of being a member of the group) there was a strong feeling that the reflective space opened up in Balint work was of considerably more value to them than those spaces offered as a matter of course within their mainstream training. This was of course a self-selecting group of students who, by definition, will already be that much more invested in examining and exploring their responses and motivations in the work.

For our part, we ended the nine weeks having felt that we had been afforded the very great privilege of being allowed to participate in and witness a brief moment of this extremely complex process of 'becoming' a doctor. Negotiating the disappointments and conflicts inherent in the process of deconstructing an idealised fantasy of the doctor they have always wanted to be, whilst reconstructing the more limited (and human) doctor that they are *becoming* is a humbling business, and one that must be carefully supported and protected. A Balint group seems to us to be an eminently good place to do a valuable piece of that work.

**Eamonn Marshall  
Dr Caroline Walker**

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# What's So Special About Balint Groups?

John Salinsky

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It may surprise you to learn that Balint groups are not the only kind of small groups for doctors. You may say, well, maybe so, but I doubt if they are anything like our groups: they probably just discuss guidelines or problems in clinical diagnosis. I don't suppose they talk about the doctor-patient relationship. We'll come to that shortly. But there certainly are many other small groups where family doctors meet for *case-based discussion of individual patients*. They are similar to Balint groups – yet different. We are not alone in the Universe. But there is no need for Balint supporters like us to feel threatened. They come in peace and are not trying to replace us.

These groups, like our Balint groups, provide a safe and confidential space for doctors to talk frankly about their work; they also offer continuity which helps to develop friendship, support and trust. Like the Balint group, they focus on a particular patient, starting with listening to a story or narrative. Many of them were based on the Balint group model. Some of those who started them have had experience of Balint and still speak highly of it. But it wasn't quite what they wanted. They wanted a medical input as well: to discuss diagnosis and treatment of a physical disorder as an option as well as a discussion of emotions and relationships.

While the Balint group's chief concern is to explore the doctor-patient relationship, these other groups see their task as seeking to manage uncertainty in medical practice.

I observe that we Balint group leaders rarely mention these somewhat distant cousins, if indeed we are aware of their existence. I feel that we should not only talk about them but talk with them.

## Case-based supervision groups

These Case-based peer supervision groups exist, to my knowledge, in Canada, Denmark, Ireland, Scotland, Sweden and the USA. They are groups for primary care physicians and trainees as well as other clinicians. Although they tend to be more clinical in focus, they will often use the Balint method, or something close to it, when it seems more appropriate to the problem in hand.

## EXAMPLES:

1. **Peer Supervision groups in Denmark.**<sup>1</sup> These began 30 years ago and have been part of Continuing Medical Education (CME) since 2007. Typically, eight to ten doctors meet once a month, under the guidance of a designated 'interviewer'. The session starts with a case history from one of the members, after which the interviewer questions the presenter. The other members ('the reflecting group') then discuss the case, after which the interviewer resumes his conversation with the presenter, making use of the input of new ideas. After a further brief group discussion the interviewer and presenter end the dialogue; and the presenter describes what he has learned and how he intends to proceed. Finally the interviewer evaluates the process of the session. The interviewer may be a group member or, in some groups, a paid facilitator. Many cases will be about trying to resolve clinical uncertainty; others will engage with ethical problems or feelings and relationships.

## 2. Practice Inquiry in the USA<sup>2</sup>

These workplace case discussion groups were started for family physicians in the San Francisco Bay area in California in the 1990s. Subsequently ongoing groups were started for family medicine residents at the University of Virginia, Concord, New Hampshire, Martinez, California and elsewhere. Like the Danish groups these have a rather more formal structure than the Balint group.

A Practice Inquiry group will also meet regularly to discuss individual cases. One of the members will offer an *Uncertainty Statement* summarising the problem and then proceed with their *Uncertainty Narrative*. Next, the facilitator asks the group what further information they will require. After supplying this, the presenter formulates an *Initial Question* for the group to consider. In the next phase, called *Inputs to Judgement*, the group considers the situation in terms of clinical experience, evidence, the contexts of presenter and patient and the relationship between the two. The facilitator then refocuses the discussion in the light of new ideas that have emerged, in a process called *The Blend*. Finally, presenter, facilitator and group members contribute to a summing up. The discussion is rigorous but allows space for the expression of feelings as in a Balint group. Follow up of the case is encouraged at future meetings.

## 3. USA Bible Study groups<sup>3</sup>

OK, I'm cheating here. These are not medical groups but they are included for a reason. I came across Bible Study groups while searching for material on 'small groups' on the Internet and was immediately struck by their resemblance in many ways to medical peer-supervision groups. The article I found was called '5 Mistakes that Ruin Small Groups' and it enabled me to look at the medical groups through a different lens. The author, Carter Moss, is clearly an experienced group facilitator; to avoid ruining your group he offers the following advice:

1. Provide a safe environment.
2. Don't move too quickly. Don't feel you have to complete the curriculum.
3. Don't get together only for group meetings
4. Don't kill the group discussion:
  - Don't be the first to answer.
  - Let the others know you are OK with awkward silences.
  - Ask open questions.
  - Pick some fights.
5. Don't stick together too long. Don't get stuck in your comfort zone. Welcome new people. Encourage people to become leaders themselves.

I think you will agree that, while this is not a group discussing patients, there is much that is familiar to us. We might agree with most of the recommendations while finding some that pose an intriguing challenge.

### **There is something special about small groups.**

There seems to be something very special about small groups of 8-12 people, provided they are well-managed and facilitated. The size allows for diversity of opinion and personality while remaining sufficiently small for members to get to know and trust each other well.

The other medical peer supervision groups that I have mentioned are all of this size and they are also to be found in other fields of education and study; the small group naturally fosters and encourages the working environment that Balint people value. We might summarise the virtues of small groups as follows:

- They provide a safe space to say what you feel.
- They have serious respect for confidentiality.
- People will listen to you and respect your views.
- There is mutual support from colleagues.
- The continuity and regularity of group meetings helps to build trust.
- If you are having a difficult time you can be sure that everyone else has been there too.
- You can talk about mistakes without being made to feel stupid.
- They are chaired by well-trained facilitators who nurture the group and protect the members but are not afraid to challenge the group.

So we can say that Balint groups share the values of all successful small groups to a large extent. All such groups are supportive and they encourage constructive working together.

However, each kind of group will add something of its own which it offers in the small group context.

### **What does the Balint group offer that is different?**

If we compare the Balint group with other clinical supervision groups we find that, while the others will quite often discuss the doctor-patient relationship, the Balint group has this as its main purpose. This is our speciality. It is true that most GP groups spend time at the beginning of the discussion talking about diagnosis, treatment and referral; maybe they will go on with this for a bit too long, until they are recalled by their leader or one of their leaders, to the proper Balint agenda.

So we start in the same clinical space as the other GP groups, but we are aware (or at least our group leaders are aware) that we are really there to look at the patient's feelings and the doctor's feelings – especially those aroused by the patient. We need to do all the right things for our patient, including intervention and referral if appropriate. But we try to be aware that the GP (or psychiatry trainee) continues to have a role however many specialists, super-specialists, social workers and even psychotherapists are involved. Referral doesn't mean we can forget about that patient; he or she is still going to need us as a companion on what may be a difficult journey. The relationship may still need some attention from the Balint group.

Dr Balint also hoped that we would be capable of a *limited though considerable change in personality* - and that seems to imply some greater insight into our own psychological underworld. But are we all able to use this kind of experiential, very personal re-education? Does everyone want it? Should we be encouraging all our colleagues and trainees to join one of our groups? Can we really say that a course of Balint will benefit everyone? This is even more of a problem if Balint groups for doctors in training are mandatory for everyone.

### **Can everyone benefit from being in a Balint group?**

In the early days (1950s) Michael and his colleagues worried about this. True, their groups were for qualified practising GPs and you had to apply to join but too many people were



dropping out of their groups after only one or two terms. So they introduced 'Mutual selection interviews' with the aim of excluding those doctors who would clearly not be happy with the Balint method: unlikely to benefit and likely to leave early.

This was described and discussed in a book called *A study of doctors* (1966)<sup>4</sup> which was written by Michael and Enid Balint with their colleagues Robert Gosling and Peter Hildebrand. During the preliminary interviews, mainly conducted by Michael Balint and Robert Gosling, candidates were 'shown a sample of what is likely to happen in a seminar' so that they would have some idea of what they were letting themselves in for. As a result of the interview, some doctors spontaneously decided not to join. There were very few who still wanted to join despite being rejected. However, there was a second problem. The fact that a doctor stayed in the scheme did not mean that he or she was a 'success'. And yet, this did not mean that the time they spent in the seminars had been entirely wasted.

To explore the question of who benefited and by how much, the Balints and their colleagues developed a Rating Scale on which to map the doctors according to their degree of participation and subsequent enlightenment.

'Some were willing, even enthusiastic, to try out new solutions to their problems; their performance, however, seemed to prove that they have not really grasped the problems with which the group was grappling.' Another subgroup showed some slight, not very great, change in their handling of patients' problems. 'They are pleasant members of the seminars who created no disturbances.' (What a relief!)

Other group members, placed lower down the scale, actually left the seminar at varying intervals, for various reasons. The details of how the doctors were evaluated and their performances scored on a grid are all in the book and make fascinating reading from today's perspective. In the final chapter, Michael Balint concludes that 60% of doctors either did not see the need to join a Balint group or, if they did join, would be unable to tolerate it for long. Of those who stayed, 20% were 'able to make some use of the experience'. This left only 20% who 'will be able to acquire a commendable amount of diagnostic and therapeutic skill.'

Of course things have changed. All doctors (or most doctors) are more psychologically aware and sensitive to feelings but could it still be true that only a minority can truly benefit from the whole package? By making Balint compulsory in some training programmes (as in the USA) have we declared that everyone can benefit?

I think it's obvious that some group members become much more psychologically aware and effective than others. And if most people benefit to some extent, that might be good enough for us, if not for Michael himself.

### **Benefits of being in a Balint group.**

Thinking about this in the year of the London Olympics (2012) I was minded to construct my own rating system. This would rank the possible rewards of being in a Balint group into three levels of benefit or achievement: bronze, silver and gold. Or perhaps it is more like the scale of rewards offered by theatre companies or airlines for different levels of 'membership'.

So it goes like this:

#### *At the Bronze level*

You receive all the benefits of the *generic small group effects*.

You are a member of a group of really nice, congenial colleagues, doing the same difficult but often rewarding job as yourself.

You have a safe, protected space to talk about work, your feelings, even your mistakes.

You are treated with warmth, and respect.

You are able to off-load unpleasant experiences at work to sympathetic friends who have been there too.

You can get advice from colleagues. You feel it's a great help to learn what others would have done.

You feel that, now that you have the group to go to, general practice (or psychiatry) is not so bad after all.

#### *At the Silver level*

You receive all the above benefits – but in addition:

You develop more *Interest in the patient as a person*.

You have learned to risk taking a bit of time to explore their life history.

You have learned to be a better listener.

You are more relaxed at work, with a greater tolerance of difficult patients.

You find work more satisfying, patients less persecutory.

You are less likely to suffer premature burn out.

In the group you still present the same sort of patients with whom everything seems to go wrong. Each time you feel better. But, a few weeks later, oh dear, here we go again. Why didn't I learn from the mistakes I made last time?

You find the leaders contributions very interesting, if sometimes a bit fanciful. But they don't really change the way you deal with your problem patients.

*Finally the Gold level.* Maybe only 20% of all doctors are open to this level of personal change. In addition to all the benefits of bronze and silver membership, you are:

Aware of projected patient feelings

Willing to accept a share of painful feelings: helplessness, anger, irritation.

With a little effort, you are able to contain the bad feelings, without retaliating angrily.

You have developed greater self-awareness. You recognise why some patients disturb you. These patients may remind you of a part of yourself you would rather not acknowledge.

You are sometimes able to 'identify' with a patient – and then withdraw to regain objectivity.

Maybe your clinical practice changes for the better?

I should say, in qualification, that that it's not really as clear cut as that. Most of us, I guess are around the silver level with periodic lapses into the bronze – or below – and occasional glorious moments of gold.

#### **What do group members think?**

I would now like to share with you some work I have been doing with my own groups to try and find out about the way they view their participation in Balint activity.

I am a leader in two groups, one of established family doctors (with a sprinkling of psychotherapists) and the other a group of GP Trainees for whom I am also a programme director.

1. *A group of established GPs plus psychotherapists from my local area.*

This group has had a stable core membership for several years. I lead it together with a GP colleague (Tessa Dresser).

## 2. *A group of GP Trainees*

This is one of three groups in our GP training programme. Each has a single leader who is also one of the programme directors. The groups meet during three academic terms for a total of about 20 sessions. Each trainee stays in the same group for three years.

### *Aims*

I wanted to use a qualitative method without questionnaires or rating scales or any kind of numbers. My aim was to get an idea of what the members thought about the group, its method, its purpose and its effects on the way they thought about themselves and their work.

I also wanted to know how they saw the role of the group leader; whether they thought we had an 'agenda' and whether they found our interventions helpful.

### *Methods*

I asked each group to act as a focus group and have a discussion about the Balint group experience. I was present also; just to prompt them with a few general questions aimed at directing their attention to aspects in which I was particularly interested, as outlined above.

The sessions were recorded (sound only) and later transcribed. I then went through them, coding what I thought were the more significant sentences and phrases and looking for predominant themes. The transcripts and the analyses were circulated to those who had been present and also to those members who had been unable to attend the focus group so that everyone concerned would have an opportunity to add their comments.

At all stages I obtained their consent and took steps to maintain confidentiality.

In the results, I have set out what I thought were the main themes to emerge with a few quotations to illustrate each one.

### *Results: themes from the focus groups*

#### **'THE GROWNUP GROUP'**

##### **1. Appreciation of the group**

Very supportive

You (the leaders) allow it to happen and yet it feels contained

It can be challenging as well

There is a depth and detail we don't normally get elsewhere

##### **2. Leaders**

You nudge us back on track

I think these interventions are very important

You want people to imagine how someone else is thinking

##### **3. Help with patients and change in self**

It doesn't necessarily change what you do: it makes you more aware of what's going on.

You see the patient in a different light.

Sometimes when I'm struggling with a patient, it's this shift in the mind...

I used to present the same cases...the same hopeless, depressed person

I think we all notice how everyone changes.

## **THE GP TRAINEE GROUP**

### **1. It's an outlet to speak about cases**

It's a nice sort of outlet to have.  
It's good to get differing opinions.  
Helpful even if it's not your case  
Insight into the patient but also into yourself  
Can detach from the emotional side – or realise that there is an emotional side.

### **2. What sort of cases?**

Ones where you have worked really hard.  
You've expected something to happen and it doesn't.  
Cases that have irritated people... want to iron that out and understand better.

### **3. Group Leader's role: steering?**

You just get us back on track...we get distracted.  
You bring us back to what is their history, what's motivating them?  
When we ask too many questions, you bring us back to what the patient is thinking and feeling.  
Or how is the doctor feeling?

### **4. Curiosity (mainly questions to me)**

#### **a) About Balint**

I don't know much about the origin of it.  
Are you going to tell us?

#### **b) Other groups in this and other programmes**

Is there a different style of doing this?  
Would it be different with a different group leader?  
Do similar cases always come up?

#### **c) 'Grown-up groups'**

Do our sessions differ very much from 'grown-up' Balint?

## *Discussion*

Both groups seem to know what the aims of the Balint work are. This includes an awareness and appreciation of the leader's role in 'steering' the discussion back to the doctor-patient relationship when it has strayed for too long. The 'Grownups' were more appreciative of the mutual support in the group, possibly because GP trainees already get a lot of support from programme directors and each other. Trainees are curious about other groups, other styles and wondered what they might be missing! Both groups seemed to have a reasonably good grasp of Balint group aims and method.

*Limitations* The study was conducted quickly in order to capture data before the residents group changed in composition. Ideally the focus groups should have been conducted and analysed by independent observers. The group members may have been influenced to some extent by their wish not to disappoint me.

*Future study.* It would be useful to do a further study to see if the findings of this one are confirmed and to explore ways of estimating the level of benefit (degree of change) achieved by individuals.

### **My reflections:**

Both groups seem to know what the aims of the Balint work are.

The 'Grownups' are more appreciative of the mutual support in the group.

The 'Grownups' have a deeper knowledge about changes in themselves.

Trainees are curious about other groups, other styles.

Perhaps we don't tell them enough to begin with.

### **In conclusion**

Let me remind you that we started by looking at two other kinds of regular, continuing, case-based discussion groups for doctors. And a third group, not for doctors, but for bible students.

They all have in common certain contexts and processes which, I have suggested, add up to the 'generic small group effect'. This is something all well-run small groups share and, when you think about it, that is rather wonderful.

But the Balint group offers us something special in addition: the study of the doctor-patient relationship: including its hidden, subterranean elements. We committed Balintees rejoice in this specificity. GPs and psychiatrists in training seem to value it too. And yet it is quite clear that our groups are not greeted with fervour and enthusiasm by the majority of qualified doctor in practice. It may be that some of our colleagues would be happier in groups dealing mainly with clinical uncertainty rather than their own and their patients' personal uncertainty.

We may believe that our Balint groups are the only ones to deal with the fundamental problems. But we should at least be aware of the other doctors' groups and not regard their approach as heretical. If you get the chance, try and sample one. It will be different, but I think you will still enjoy it. And, if you are looking for it, the doctor-patient relationship will still pop up.

### **Thanks**

I wish to thank my colleagues Tessa Dresser, Caroline Dickinson and David Price for their support and advice.

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## President's Report 2018

I have to admit that it was with great trepidation that I took over the Presidency from David Watt, in September 2017. He had, in addition to being President for the last 3 years, 3 years vice-presidential experience and 22 years as the Society's Honorary Secretary under his belt. He is clearly a hard act to follow! It has also been a time of big changes, not only with David's retirement from Council, but also Ceri Dornan's as Honorary Secretary after 6 years of unstinting good-natured hard work. However she has continued to offer support to Richard Pannett, who kindly stepped in to the Secretary role at the last minute, literally on the day of the AGM in September. Both David and Ceri remain very active members and ambassadors of the Society, organising study days, weekends and training events, for which we are most grateful.

I have been a member of the society for 35 years, since being a GP trainee in the East End of London. The Balint way of trying to understand my relationship with patients has been crucial to my sustained interest in Medicine and for my remaining in practice as long as I did. I've also served on Council for very many years, too many according to our newly rediscovered rules, but was encouraged and recruited to stand as a then slightly younger GP. Also, as the voice of the provinces as by that time I was living in Lancashire. I had also established a regular Balint weekend in Chester for a few years, so this gave me a little kudos with the elders of the society and I felt honoured to be asked to join Council. I rarely managed to attend meetings which were always in London on midweek evenings, a pleasant but productive evening discussion held over a meal at one of the council members' homes. However, I showed interest and contributed occasionally by phone and then email as the years went by. Since then, the Society and society as a whole have both changed, with Council meetings more formalised and often held at a hired daytime venue in London, or attached to a residential Balint weekend around the country. The Council remains committed to ensuring that Balint work is not forgotten and is still regarded as relevant to current medical practice. After all, the dilemmas that practitioners face in their work remain essentially the same. Balint group work is as engaging, enlightening and as helpful as ever. The Balint Society through its activities continues to nurture the interest of practitioners in their patients, as well as curiosity and understanding about the emotions that are engendered between them.

The UK Society is continuing to grow both regionally and across various health disciplines and there are moves afoot to plot what kind of groups are running where on a map of the UK on our website. This should make it easier for interested people to make contact and find an accessible group.

At the Oxford IBF Congress last September we held a Student Saturday initiative, and although small, it has since sparked further interest. As a start there is a meeting planned for October when medical students from London are going to get together to see what they want to achieve, and how we as a Society can help them. The RCPsych and their student working party have been pivotal in getting the majority of medical schools to take up the idea of Balint groups for students, and the majority of medical schools now include a Balint group experience as part of their training. We believe that encouraging students to think about their patients holistically and recognising the emotions within the student-patient encounter, will be helpful in retaining their empathy and their long-term engagement in medicine.

It is a shocking and sobering fact that about 50% of junior doctors quit working in the NHS after their FY2 year, and the provision of Balint groups to this group of

particularly vulnerable doctors is being seen by the Society as an emerging priority. Sadly often consultants don't understand, nor appear to want to understand what Balint Groups are about, and so don't allow their juniors the time to attend. The investment of a bit of time set aside for a lunchtime group every 2 weeks might help prevent the haemorrhaging of junior doctors from our embattled NHS. However there are some groups running across the UK with more success, sometimes run during their Psychiatry attachment, alongside core Psychiatry and GP registrars, and we need to learn from them and how to replicate this in the future. The Psychiatry trainee groups that have been spearheaded and supported by the RCPsych are now often led by accredited Balint leaders. We are keen to retain them as active members of the Society, and especially help newly-accredited leaders develop their expertise and group leadership skills further. The leadership accreditation team led by Jane Dammers, Gearoid Fitzgerald and Shake Seigel are also helping to expand and normalise group leaders' supervision.

At a Balint Council awayday in March 2017, kindly hosted at a society member's house, we decided that re-engagement with both our parental roots in General Practice and in Psychoanalysis was important. We keep trying to reforge links with the RCGP whose very inception was largely due to Balint-trained GPs, and to this end have invited the past three Chairs of the college to be our after-dinner speakers at recent annual dinners, including the present incumbent, Prof. Helen Stokes-Lampard this year. Yet there still seems to be resistance by the College to embedding Balint groups in the training of GPs, in stark contrast to the RCPsych's attitude. To encourage better links with the RCGP, I and a fellow GP and course organiser Suni Pereira, along with Doris Blass, a former GP and current psycholanalytic psychotherapist are providing a session at the RCGP national conference in Glasgow this October. I have also made overtures to the



**Good company by a cosy fire at Whalley Abbey.**





**Whalley Abbey.**

Practitioner Health Programme as many of us believe that Balint work would help prevent burnout, and there is at least one new Balint group run as a PHP initiative on Teesside, instigated by Amanda Smith, one of our Balint leaders in the North East. On another front, we are also collaborating with the RCGP Heritage Committee over the hoped-for installation of a Blue Plaque on the premises near Regents Park, where the Balints held their first seminar groups. This we hope will form part of a 50th anniversary celebration of the founding of the Society, scheduled for May 17th next year, but there are many planning and other consent hurdles to overcome first.

On the ground, it does feel that there is a slight resurgence of interest amongst GPs for Balint work with increased GP uptake of Balint weekends and more asking about on-going groups too. Links with our Psychoanalytical roots are also being strengthened with Gearoid Fitzgerald, a Psychoanalyst from Leeds, now acting as our vice-president; and another Psychoanalyst Anne Patterson, from Imperial in London, also agreeing to stand for election to Council in September. The Society has also been asked by members of the Institute of Psychoanalysis to help run a half-day session, at the Anna Freud Centre on December 9th during their ‘The Balints and their World’ conference; so gradually I hope that we can pursue a fruitful cross-fertilisation of Balint work and activities with them.

The Society is still running at least 4 residential Balint events each year: at Oxford in September, Whalley, Lancashire in Spring, and either in Sligo or Newcastle in June, with either Belfast or Leeds/Sheffield in November. There are also several study days, leadership training days, and peer supervision days so we are quite busy with a calendar of regular and growing number of events.

We are of course also interested in the International Balint Federation (IBF) and its work, and have close ties with them. Paul Sackin, a UK Society member, is their

Honorary Secretary, and we hosted the last IBF congress in Oxford only last year. I had the pleasure of co-leading an international Balint group at the IBF meeting in Reims in May with Andrew Elder, a past President of our Society, and had a group which included French, Belgian, Brazilian, British, Hungarian, Israeli and Serbian members. They of course, much to our shame, spoke excellent English. We eagerly await the next IBF Congress in Porto next year from 11th to 15th September, and their leadership conference in Helsinki this September.

I also received a very warm welcome and enjoyed a great time at the Dublin Balint Event in June, to which 5 UK leaders were invited, including Glenda Mock from Northern Ireland. It was an authentic Balint experience attracting a mix of psychiatrists, therapists and a good number of GPs. Many of them are now keen to join the UK Society until they have sufficient interest in the Republic to form their own. It was also interesting to have some head teachers included in some of the groups. They clearly felt helped by the group work process but this is a departure from our tradition, and may be an interesting point of discussion and perhaps difference between the UK and the Irish proto-society.

As I finish this piece, I have just been listening to the news which headlined the fact that continuity of care by clinicians is important and that patients who see the same GP over time have lower death rates. The findings from Exeter University revealed the importance of 'interpersonal factors' despite technological advances in healthcare. This effect applies across different cultures and is true not only for primary care doctors, but also applies to other specialists such as psychiatrists and surgeons. "The human aspect of medicine has been neglected. Our study shows it is potentially life-saving and should be prioritised" said Prof. Phillip Evans of Exeter University. As Sir Denis Periera Gray said "Patients have long known that it matters which doctor they see and how well they can communicate with them. It is literally a matter of life and death". This may not be at all surprising to any of us in the Balint movement and should give us hope that our time has now come!

**Caroline Palmer**



**Dining at Whalley Abbey.**



## Regional reports 2018

*It has been another busy year for the society with several leadership training days, Balint weekends including the first in Sheffield which was well attended, and the very successful IBF Congress in Oxford. We have been keen to bring together our accredited leaders to think about what sort of continuing support and development they would value, and how they can contribute to developing Balint work – personally, locally, regionally and nationally. To do this we have organised two study days – one in London in February which focussed on starting groups, keeping them going and supervision, and a second day in Birmingham in May to look at developing leadership skills further, supervising and being supervised, establishing peer supervision groups and getting involved in leadership training. Both were very well attended and led to lots of ideas to take things forward. It was very encouraging to see so many people coming and participating in these two events with lots of ideas for the future of Balint work. Also, that we have increasing numbers of accredited leaders in the Society.*

*The following are accounts from most of our regions. Names and emails of whom to contact if you would like further information are included at the end of each section.*

*We look forward to seeing you at many more of our events in the coming year and hope that you will be in touch if there are things you would like to develop locally or nationally.*

**Jane Dammers May 2018**

### Balint groups in South Yorkshire

Balint Groups for Core Psychiatry Trainees with GP Trainees happen in three localities:

- Weekly group in Sheffield lead by Alex Pavlovic, General Adult Psychiatrist and Medical Psychotherapist, and Jenny Jack, General Adult Psychiatrist.
- Weekly group in Rotherham lead by Grace Warren, General Adult Psychiatrist.
- Weekly group in Chesterfield lead by Joanna Carley and Amy Hereford, General Adult Psychiatrist.

Monthly multidisciplinary Balint group for occupational health professionals lead by Kerry Hicks, Clinical Psychologist in Sheffield. Kerry is supervised by Alex Pavlovic.

Monthly GP Balint group in Sheffield at St George's Community Health Centre led by Alex Pavlovic and Harriet Fletcher, General Adult Psychiatrists and Medical Psychotherapist.

Monthly multidisciplinary Balint group at Share Psychotherapy Sheffield led by Steve Delaney, Group Analyst and Libby Kerr, Psychodynamic Psychotherapist. Steve and Libby are supervised by Alex Pavlovic.

Sheffield Medical School organises Balint-style masterclasses for third year medical students.

Sheffield hosted a very successful Balint weekend in 2017, organised by Alex Pavlovic. There were three groups, including leadership training groups and many new people, including medical psychotherapists, attended. A very warm and friendly atmosphere was created. We enjoyed watching the film 'La Fille Inconnue' directed by Jean-Pierre Dardenne and Luc Dardenne in which a young female GP gets obsessed with





**Delegates pictured at the successful Sheffield weekend.**



the case of a dead woman, after learning that the woman died shortly after ringing the surgery doorbell for help late in the evening when the doctor was too tired to respond. It is a very interesting portrait of some of the stresses and isolation a GP may feel.

**Dr Alex Pavlovic**  
**Alex.Pavlovic@shsc.nhs.uk**

## **Balint in the North East**

### **Newcastle upon Tyne and Gateshead, Tyneside**

We have four mixed Balint groups on Tyneside, including GPs, Psychiatrists, clinical psychologists and others. They are all monthly and co-led by accredited leaders. Another group for GPs in South Tyneside may be starting soon, supported by the GP Health initiative.

There is one group for Psychiatry Trainees in the whole region, and two groups for Foundation Doctors during their rotation in psychiatry. There are hopes to extend foundation Balint groups to all doctors throughout their two foundation years – this will require considerable leadership resources and training and will start with a pilot in one trust.

There are some initiatives to get Balint groups going with medical students at Newcastle University, though this is quite slow. The University of Sunderland is starting a new medical school with a remit of training more GPs and psychiatrists; this may well be fertile ground for medical student Balint groups to develop.

We participate each year in the GP Educators conference where we run Balint groups for GP trainers, often discussing a trainer/trainee relationship in a Balint group format. These groups always attract interest and have good feedback but have not led to any longer term initiatives of re-establishing Balint groups for GP trainees unfortunately.

**Leaders' Peer Supervision group** meets once a term. It is open to all Balint leaders who are invited to bring their groups for discussion. It is also an opportunity to catch up on what is happening in the region.

**Newcastle Two day event June 28/29th 2018** We are hosting a two day event, instead of a weekend, to see whether this appeals to those who may find it easier to come during the working week. We are looking forward to Jean Pierre Bachman joining us to facilitate a Balint Psychodrama group with Esti Rimmer, as well as having a leadership and ordinary Balint group.

### **Teeside**

A new group for GPs has recently started on Teeside, supported by the GP health scheme. Some GPs have signed up to travel considerable distances to join this new group.

**Dr Jane Dammers**  
**jane.dammers@outlook.com**

## **Balint in the NW**

### **Generally**

It seems to have been a busy year for us individually in the North West of England, but the different districts feel quite separate and distinct, almost along tribal football club

allegiance lines! Writing this I have the dawning realisation that it would be helpful to have more regional meetings and dialogue in the future. Re-establishing the NW leader peer supervision group which has not met for a while might well help reduce the sense of dislocation between us. The geographical spread of potential members remains a challenge and the possibility of an internet group using Zoom is being considered.

### **Around Manchester**

Two Balint groups continue in south Manchester. One is for GPs, mainly younger practitioners, led by Simon Henshall, a practising GP and now an accredited leader and Ceri Dornan, a retired GP. Although there are eleven people on the list for this group, attendance is sporadic and often the topic of conversations between the leaders and their supervisor, Andrew Elder. The second group is a mixed GP and psychiatrist group led by Louise Ivanson, a medical psychoanalytic psychotherapist and Ceri Dornan. The mixed disciplinary contributions are welcomed by all and show how much we all have in common. Simon has also introduced some Balint sessions into the Salford and Trafford GP VTS years, assisted when possible by Ceri.

Helen Sheldon, a psychotherapist, who has returned to Arsenal territory in the last couple of years, and Ceri ran a leadership training workshop in October 2017 which attracted people from Manchester, Liverpool and Sheffield. They had one group where questions were allowed after the case presentation and one where they were not. This provided interesting live material for discussion. We agreed that we might use such contrasts again in future workshops.

### **In Lancashire**

The 'Clinicians in Practice' group based near Burnley was dwindling in numbers and commitment until an email was sent out by the leaders warning the members that it was in danger of extinction. Since then we've had an honest discussion at which the idea of meeting three-weekly was mooted and agreed. Since then there has been growth in attendance, with recently renewed commitment and an influx of new members. There is a good mix of clinicians, including several GPs, several Consultant Psychiatrists, a Nurse Practitioner, a Medical Oncologist, and an Osteopath with a degree in psychology, which proves very interesting, and demonstrates our often shared common experience of the consultation. The group is lead by Cheryl Williams, an established Psychoanalytic Psychotherapist, previously a mental health nurse, and myself, a retired GP. We now feel that this group has reached capacity with eleven fairly regular attendees, so we are now forming a waiting list and hope that a nucleus of another group may form, perhaps based in south west Lancashire, possibly near Wigan.

Groups for Psychiatry trainees working with Lancashire Care Trust continue with many co-leaders now working towards leadership accreditation having attended study days, weekends, or on-going groups, as well as co-leading with already accredited leaders. The lack of core psychiatry trainees in some districts has hampered some groups from running successfully but the amalgamation of the Blackpool and Preston groups has produced a pretty lively, engaged group of committed members.

Groups for medical students are now well-established for Manchester medical students undertaking their clinical years of study at Preston, so all students there have the experience of a Balint Group for three consecutive weeks during their Psychiatry attachment, while those that are keen can opt to attend an on-going evening Balint group which they could in theory attend for two years. Plans for medical student Balint groups at Lancaster University, which have been very slow to come to fruition, are now fully



developed and are planned to start in September. Plans to provide Balint Groups for the international medical students and post-graduate Physician Associate students at UCLAN are now under development too.

### **Merseyside**

Spurred on by recognising my ignorance of what is happening in Merseyside, I have made enquiries to Simon Graham and am told there are Balint Groups for junior Psychiatry trainees as well as an on-going group for fifth year medical undergraduates at the Medical School, but am unaware of any groups for practising GPs/community staff in the area.

### **Cumbria**

Again, reflecting on my ignorance about Cumbria, my correspondent further North, Andrew Morgan, tells me that there is a Balint Group for Allerdale Community Mental Health Team staff and also one for Psychiatry and GP trainees during their Psychiatry job, run by Cumbria Partnership Trust, but probably no GP groups out in the community.

### **The Whalley Abbey weekend**

Near Blackburn was again a restorative but stimulating experience for the thirty five or so participants that attended, including some from Wales, Scotland, Greece and Austria, as well as all four corners of England. It attracted a pleasing number of GPs, indeed, nearly a third, as well as a consultant neurologist and a geriatrician. It was interesting to note that no students applied to attend the weekend, perhaps because there are increasing opportunities to attend Balint groups in their own medical schools now. The welcoming



**Delegates relaxing at Whalley Abbey.**

Abbey staff and special ambience worked its magic on us all and the intensity of the group work was balanced by a free afternoon for local exploration or rest and the roaring log fire to relax around in the evenings was especially welcome since it was bitterly cold and snowy outside. The Abbey conference house has been booked again for a Balint weekend from April 5th to 7th, next year, due to popular demand.

So we in the North West can look back on a year of consolidation and some growth, but also look forward to some exciting developments and hopefully collaborating further with Balint colleagues in the wider region in the near future.

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

## **Balint in the Midlands – Birmingham and surrounding area**

### **Leadership**

There is ongoing interest across the region in Balint work. More people are proceeding to accreditation for Balint Group Leadership, and a number of groups are coming into being.

A Balint Peer Supervision group now meets in Birmingham at the Edgbaston Golf Club every two months on a Thursday evening. It has eighteen potential members. The group supports accredited leaders as well as those on the pathway to accreditation or considering applying. There are clear signs of growing interest in establishing Balint groups in the region and for leaders to get together.

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

1. The Telford group is now well into its fourth year and well supported. It is a mixed group of GPs, Palliative Care consultants and psychiatrists led by Chris Brown, Psychotherapist who is now an accredited leader. The group meets at Severn Hospice on the second Monday of the month. This group could accept new members.
2. The longstanding Burton-Lichfield-Tamworth group still meets monthly after thirty four 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 Debbie Williams and another in the south of Birmingham facilitated on a rotating basis by members. There is a possibility that these groups may amalgamate this year.
4. Sandwell Hospital has a group, facilitated by Dr Diana Webb. This group consists of mixed hospital specialities.
5. A Palliative Care group has started up based on the regional training days led by Dr Miling Arolker.
6. A group has also been established in Nottingham facilitated by Dr Bertram Karrasch. This group is open to new members. A GP VTS trainee in Nottingham has run a research project on the potential benefits of being in a Balint group. Watch this space.
7. 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.



8. A mixed membership group mainly drawing from members of the West Midlands Institute of Psychotherapy (WMiP) has been meeting monthly at the Friends Meeting House in Edgbaston for the past three years. This group is currently facilitated by Shake Seigel and Sandra Harrison.

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

## **Bristol**

### **Psychiatry Trainee-led Balint group scheme for Medical Students**

The scheme is now in its fifth year and continues to offer all third year medical students at Bristol University the opportunity to participate in Balint groups. We have welcomed Eva Bowditch and Melissa Buckley to join the project management team - Ami Kothari, Clare Trevelyan and myself which has been a good development. Project sustainability is in our minds and we will be continuing to approach others to join us. We were pleased to involve medical students in our planning group this year which worked successfully.

We had more core and advanced psychiatrists interested in the scheme than were needed this year and took the opportunity to offer co-leading experience for psychiatrist leaders and we had two medical students co-leading groups with more experienced psychiatrists. These developments worked well with leader pairs attending supervision together. We are hoping to attract more students to take up leadership opportunities.

Mostly the scheme continues to work well and feedback is still mostly good from students who choose to attend. We were sad not to be successful in being supported by the medical school to offer additional introductory Balint group sessions in years one and two of the new medical student spiral curriculum which started in September 2017 and offers clinical experience for students at an earlier stage. We were enthusiastic to be invited to relevant curriculum meetings yet the university was not keen to include more Balint, and earlier Balint experience, or indeed add anything into an already packed and new curriculum. We hope to try again at a later date. We are hopeful that we can support the development of Balint groups for GP trainees in the future

We face ongoing challenges with the medical student Balint group scheme in terms of poor attendance to some student groups and ongoing difficulty in some areas around scheduling regular times and rooms for groups with busy administrative staff and a busy student timetable. Another challenge involves some of the psychiatrist leaders not attending regular supervision despite our offering a range of sessions and the possibility of phone supervision. We are working creatively with these challenges.

We continue with recording and monitoring our own evaluation from questionnaires and trainee and student reporting and took part in a six city pilot evaluation of various measures and scales this year. We have continued to share our model and link with interested psychiatry trainees across the UK and again delivered training in Birmingham over the year. We are very pleased that Birmingham has developed a scheme for ongoing medical student Balint groups on psychiatry placements.

Our funding from Health Education England and RCPsych has sadly all been used up and we are pleased that the Severn Deanery has agreed to fund the biannual training sessions for the psychiatry trainees and medical education in the AWP trust will support those trainees on the accreditation pathway attending Balint society events. Ami Kothari and I continue to be involved in the Balint in medical schools strategy group (BIMS)

discussing issues around Balint and supporting medical students with colleagues from the UK, Australia and New Zealand. We also continue our involvement with the Royal College of Psychiatrists Medical Student Psychotherapy Schemes and Balint groups working group

### **Leadership training**

Psychiatrists leading groups attend regular supervision with me. Clare Trevelyan, Eva Bowditch and Melissa Buckley have offered peer supervision groups this year. Ami Kothari will be returning to work in the autumn after maternity leave and will also be able to offer supervision. We continue to support trainees to gain wider experience in Balint group and are currently supporting eight trainees towards leadership accreditation. Psychiatrists have been supported to develop Balint groups for Foundation Year doctors, doctors in a forensic unit, staff in a psychosexual clinic and there is a proposal to set up a group for paediatric trainees. Trainees previously involved in the scheme are setting up a group in CAMHS and there is a possibility of a group starting in both oncology and occupational health services. It is good that we have a range of supervision opportunities available to support all of this work. Some more experienced trainees have set up a peer supervision group for leaders who are running core trainee/GP trainee and Foundation Year groups. We continue to offer trainees biannual leadership training days and had a successful day led by Gearoid Fitzgerald September 2017. We had to cancel the day planned for March because of snow.

The third Bristol Balint leadership study day was held in December 2017. 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 have a further day booked for December 2018. We offered a morning presentation by Gearoid Fitzgerald at the Severnside Institute for Psychotherapy in Bristol which was well attended and received excellent feedback from the ranging clinicians attending. Eva Bowditch and I have both been involved in offering an introductory talk to the Balint peer support group South Wales. We are pleased to be supporting Balint leader colleagues in South Wales working towards accreditation.

### **Balint groups in Bristol and the South West**

Balint groups continue to run across the AWP Trust and trainees who have gained experience on the medical student scheme have been involved with leading and co-leading such groups. I continue to lead a Balint group for GPs in Bristol and since January have had a GP co-leader join me which has been a great development for the group. Attending supervision together has been very interesting. We have made links with people interested in Balint leadership training and developing Balint groups in Cornwall, Somerset, Cheltenham and Bristol and are pleased that we have more leaders available to help with such developments.

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

# London and the South East

## **Oxford IBF Congress**

The year began at Oxford, September 6th to 10th with the International Balint Federation Congress, replacing the usual Balint weekend. It filled Keble College, attended by 212 delegates and more accompanying persons. There is more about the Congress elsewhere in the journal.

**London Study Day and Annual Dinner** In February at the Medical Society of London on the theme of 'Starting Balint Groups and keeping them going' was a great success, both the day event and the Annual Dinner were full to overflowing. Dr Helen Stokes Lampard, Chair of the RCGP, spoke at the dinner about her own commitment to retaining personal care within the panoply of guidelines. Unfortunately the RCGP as an organisation is not so favourable to the Balint Society. After granting accreditation for the Whalley Abbey and Newcastle weekends, they have reverted to asking us to apply in their regular way, which is prohibitively expensive for us.

**London Leadership training day** in June was well attended with two groups, led by David Watt, Helen Sheldon, Doris Blass and John Salinsky. This has become an annual event.

**Balint Groups.** There are a number of Balint groups for GPs and others in and around London.

Wembley	Leaders Tessa Dresser and John Salinsky
Brockley	Leaders Eamonn Mitchell and Paul Julian
East London	Leaders David Watt and Joan Fogel
Brighton	Leaders Anne Tyndale and David Watt
Physician Health Programme	Leaders Andrew Elder and Anne Tyndale
Whittington Hospital Gynaecologists	Leaders John Salinsky and Doris Blass.
This is a new group	
Whittington, Tower Hamlets, Hackney and Northwick Park VTS schemes all have groups	
GP Practices	Three large GP practices in London continue to have Balint groups

**Balint group Leaders Workshop** at the Tavistock Centre continues three times a year, and has been well attended, with plenty of leaders wanting to present the groups. It works both for new leaders or leaders in training to get experience, and as supervision for longstanding Balint leaders.

We do get asked to do occasional work in London, which may help spread Balint in the long run. I ran a group for the Child Protection team at Kings College Hospital early in the spring and am waiting to see whether they will ask for more. Paul Julian ran one group for trainers in south east London at their residential – they tend to touch base every year. We hope that a Balint group will start up in north west London in the future.

## **Medical Student Psychotherapy Schemes**

The Royal College of Psychiatrists working group for developing medical student psychotherapy schemes and Balint groups continues to meet on a quarterly basis. A further symposium on medical student Balint and psychotherapy schemes is taking place on Friday 25th January 2019 at the Royal College of Psychiatrists and all Balint Society members would be very welcome.

### **London Medical Student Balint groups**

UCLH – Balint groups are well established for students in their first clinical year. Unfortunately the groups are no longer offered as an SSC and therefore student uptake has decreased slightly

Barts and the London School/Queen Mary University – unfortunately last year's new project offering Balint groups to first year medical students as part of the Medicine in Society module has been discontinued.

Imperial College School of Medicine - Balint groups for medical students in their psychiatry placements continue to be offered, organised by Dr Anne Patterson

Kings College London School of Medicine – From September 2017 weekly Balint groups were offered as an SSC. Six groups of 10 sessions each were co-led by higher trainees in psychiatry. These trainees participated in leadership training days organised by Dr Barbara Wood and Dr Helen Sheldon who also offered weekly Balint style supervision. From September 2018 all first year clinical medical students will participate in fortnightly Balint groups for fourteen sessions whilst doing their fortnightly day placement in psychiatry. These groups will be co-led by consultant and specialist trainee psychiatrists who will receive leadership training and regular supervision.

St George's Medical School - Eamonn Marshall continues to lead a medical student Balint group with Dr Ross Campion.

### **Pan-London Medical Student Network**

An interesting development is taking place on Saturday 13th October 2018 with an inaugural meeting of the pan-London medical student Balint network at St Pancras Hospital. This is being organised by Eamonn Marshall and Helen Sheldon in response to continuing interest expressed by medical students who have participated in Balint groups.

### **Foundation Year Balint groups**

The FY1 and FY2 groups at Newham run by David Watt and Paul Julian, ended in March this year due to removal of funding. They will continue as a group meeting but not Balint, though Paul has been asked to supervise the leaders. At UCH there is a FY1 group which meets weekly during the surgical rotation. The groups are co-led by psychiatry trainees who have participated in leadership training offered by Amy Jebreel and Helen Sheldon, and regular supervision with Helen. This work consistently receives positive feedback from the FYs and is strongly supported by the FY educational programme director.

**Helen Sheldon and David Watt**  
**david.watt7@nhs.net**

## **Northern Ireland**

### **Multidisciplinary Balint Group**

A new multidisciplinary Balint group opened in Belfast in March 2017. This is co-led by Christine Christie, psychoanalytic psychotherapist and group analyst, and Glenda Mock, sessional general practitioner. The group currently has eight members and includes general practice, psychiatry, dentistry and educational psychology. It meets monthly in the evening. It is many years since this type of ongoing Balint group was run in Northern Ireland and we are delighted that people are interested and enthusiastic. Christine and Glenda would also welcome expressions of interest from anyone else who might like to join in future.





**Delegates pictured dining at the Dublin event in June.**





### **Balint in Belfast Weekend**

We are holding another Balint weekend in Belfast on 16th-18th November 2018 and look forward to welcoming colleagues from all over Ireland, the UK and further afield. There will be leadership and ordinary Balint groups in the usual format of a Balint Society weekend.

**Glenda Mock**  
**glenda.mock@doctors.org.uk**

## **Republic of Ireland**

Balint activity in Ireland continues to advance. There has been an enormous amount of activity around Balint over the past twelve months. The emergence of blended groups consisting of multi and interdisciplinary professions in Dublin is of note. We all look forward to the first Balint Symposium in the east coast of Ireland hosted by Dr Emma Nelson, Ray O Donnachada and Dr Hugh Nohilly. This will be on 14/15th June and dovetails neatly in with the upcoming winter gathering with our colleagues in Belfast.

GP education in Ireland is currently in flux as a transfer of training is currently being negotiated between two bodies. However, the news on the ground is that the Balint activity is gaining purchase. An example of this being the Sligo region where there are two groups operating in the community and four others within training programmes.

**Patsy Brady**  
**padraigob@hotmail.com**

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**The Balint Society**  
(Founded 1969)  
**Council 2018/2019**

President:	Caroline Palmer	Hon Secretary:	Richard Pannett secretary@balint.co.uk
Vice President:	Gearoid Fitzgerald	Members of Council:	Jane Dammers Ami Kothari Eamonn Marshall Shake Seigel Sharon Warden
Treasurer:	Ann Evans		
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## **Guidance for Contributors**

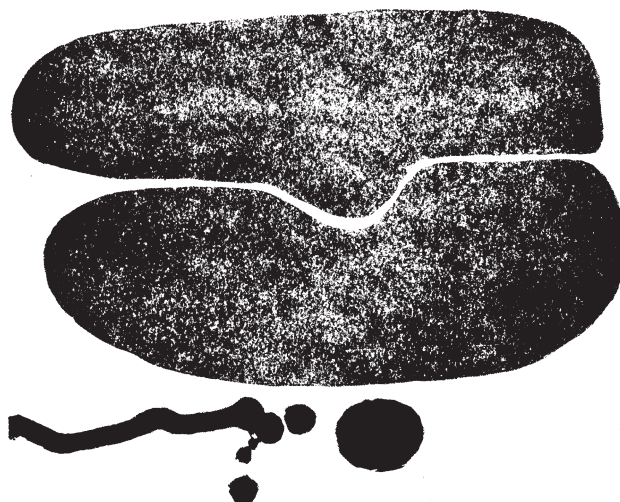
All manuscripts for publication in the Journal should be submitted to the Editor, Dr Tom McAnea by email as an attached word file. The address is *tomcmc@doctors.org.uk*

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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## Vol. 46

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