VOLUME 49

JOURNAL OF THE BALINT SOCIETY

Leadership: Looking Forward, Looking Back

NOVEMBER 2022

JOURNAL OF THE BALINT SOCIETY
VOLUME 49 2022

Leadership: Looking forward, Looking back

LEADERSHIP: LOOKING BACK

BALINT SOCIETY ESSAY PRIZES 2021

VOICES FROM AROUND THE WORLD

FROM THE ARCHIVE

Soreanu, R., Khan, S., Elder, A., Salinsky, J., (2022). Editorial: Leadership, Looking forward, Looking back. *Journal of the Balint Society, 49: 1-10.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Editorial: Leadership, Looking forward, Looking back

Raluca Soreanu[1], Shameel Khan[2], Andrew Elder[3] and John Salinsky[4]

[1] Department of Psychosocial and Psychoanalytic Studies, University of Essex: raluca.soreanu@essex.ac.uk
[2] General Adult Psychiatrist, MRCpsych, MA, Karachi: shameel@doctors.org.uk
[3] FRCGP DEd (Hon): andrewelder@blueyonder.co.uk
[4] Balint Groups Leader, former President of The Balint Society UK: jvsalinsky@aol.com

Raluca Soreanu, Editor[1]

Volume 49 of the *Journal of the Balint Society* is published at a time when the need of sitting together in a group and elaborating loss and anxiety is ever greater. The COVID-19 pandemic made its own mark on health systems, and even on the way we are imagining and experiencing our relationships with one another. There is war in Europe, and at this time memories of past loses, conflicts and catastrophes return. In uncertain times, having a *method* for approaching both certainty and uncertainty seems more important than ever. The Balint community has a method, a way of sitting together in a group, a way of elaborating difficult feelings.

In our free-associations that led to the theme of the current special issue, *Leadership: Looking forward, Looking back*, the members of the Editorial Committee converged on the necessity of the gesture of looking back at past key contributions on leadership. It is a kind of gesture of looking back that aims at revitalising the futures of the Balint method. In the pages of the current issue, by organising an archival space, alongside contemporary reflections, we aim to generate new questions on the transformations of leadership; on its continuities, as well as on its discontinuities; and on the challenges of being a Balint group leader in 2022.

In other words, the current volume has organised a space of memory for important contributions on leadership. They were written by D. L. F. Dunleavy, Michael Courtenay, John Salinsky, Valerie Parker, Anne Tyndale & John Salinsky, Andrew Elder, and Anthony Froggett between 1976 and 2017. We invited short responses to these republished contributions, which were authored by Gearóid Fitzgerald, Jeff Sternlieb, Eamonn Marshall, Judy Malone, Liz Lee, and Shake

[1] Raluca Soreanu is Professor of Psychoanalytic Studies at the Department of Psychosocial and Psychoanalytic Studies, University of Essex, and psychoanalyst, member of Círculo Psicanalítico do Rio de Janeiro. She is leading the five-year multidisciplinary project 'Free Clinics and a Psychoanalysis for the People: Progressive Histories, Collective Practices, Implications for our Times' (FREEPSY), funded by a UKRI Frontier Research Grant. She is Academic Associate of the Freud Museum and Editor of the Studies in the Psychosocial series at Palgrave.

Seigel. The short responses offer contemporary views on the archival pieces, and they reflect on some of the most stimulating questions and themes that the archival pieces confront us with. How has leadership changed from the picture that Michael Courtenay was painting in his 1986 piece, 'The Role of the Balint-Group Leader: A Critical Re-appraisal'?

This space for memory is preceded by a section on 'Leadership: Looking forward', with contributions from John Salinsky, Gearóid Fitzgerald, and Theresa Davies. The third section of volume 49 brings together the three authors who won the Essay Prize in the Balint Society competition of 2021. We first meet Maria Khan, whose essay was praised by the Essay Prize Jury for its exceptional capacity to capture the spirit of the Balint experience; for its subtle tracing of the position of medical student in the group; and for the scope of its reflection. We then meet Felix Simpson-Orlebar, whose writing was remarked for its capacity to record the progression of thinking that Balint work enables and the depth of change that it affords; for its thought-provoking use of a vignette; and for capturing the plurality of angles that a Balint group can be viewed from. Finally, we encounter Katy Mason, whose essay was appreciated for its capacity to make a complex construction starting from a Balint group experience; for illustrating the functioning of difficult affects, such as envy, in the Balint group; for capturing the complexities around attachments of members to the leader; and for gifting the readers with a fully-fledged fairy-tale transposition of a Balint group. You will read – perhaps your first – Balint group fairy-tale.

In the section 'Voices from around the World' we come across important themes, such as the medical care of non-binary individuals, or the meaning of gifts to doctors, in the writing of Isobel Austin, Natasha Khalid, Scott Abramson, Elsa Brew-Girard, Henry Jablonski and John Salinsky. In the final section, 'From the Archive', we hear Michael Courtenay's voice, in an interview conducted by John

Salinsky in 2004. I bring a short commentary on a letter from Enid Balint to Wolfgang Loch, written in 1977, with insights into co-leadership, transmission of the Balint groups tradition and the boundaries between psychoanalysis and medicine.

You will discover in the pages of the Journal seven still images from a film. They too are part of the gesture of looking back. They are images I took from the *Balint Groups* short film, which I prepared together with psychoanalyst Judit Szekacs-Weisz in 2018, based on BBC footage on Balint groups produced in 1970. The short film shows the atmosphere of Balint groups led by Michael Balint himself, in the 1970s, and it contains selections from three case discussions.

The cover image transports us to the Château de Kernuz, in France, in August 1968, when Balint was leading an open-air group (photo credits: Guy Lavellée).

In what follows, the Deputy Editor of the Journal, Shameel Khan, and two of the members of the Editorial Committee, Andrew Elder and John Salinsky, write their reflections on leadership. A third Editorial Committee member, Anne Patterson, also contributed to the conception of this issue.

Shameel Khan, Deputy Editor[2]

From technique to technology: Leadership at times of change

While recovering from the shell shock of pandemic and beginning to grapple with the reality of living in an increasingly polarised world, I am reminded of the labour that Balint leaders have undertaken over the last 2 years. The transition from room to zoom and then back into rooms, has been like a surreal navigation from dissociation to association to re-integration. Whilst dealing with the adversity of novelty and change, leadership has yet again become open to exploration through the trifocal lens of past, present and beyond. There is a pressing need for an ongoing discourse in this fermenting environment of change regarding what truly constitutes the core of Balint leadership today.

In my previous job, I was given a book as a farewell gift by psychiatry trainees titled *Governing the Ungovernable* by Ishrat Husain. Although the subject matter of the book was economic cum political context of Pakistan, the title, I felt, had a coded meaning covertly handed to me as a present. The title made me think about the challenges of Balint leadership I had encountered with these trainees at times of unprecedented change during COVID. It also made me think about how social, political and anthropological schemas of leadership (relevant to each geographical region) can interplay with the schema of Balint leader as our community continues to expand across continents.

The space between a clinician and patient creates the stage for *emotional happenings* evoked in our day to day clinical encounters with patients. Such

[2] Dr Muhammad Shameel Khan is a consultant general adult psychiatrist with an interest in group work and physician wellbeing. He has a Masters from University of Essex in Foundations of Psychoanalytic Psychotherapy (Tavistock and Portman NHS foundation Trust) and a Postgraduate Diploma in group work from Institute of Group Analysis. He is currently involved in supporting and developing the practice of Balint groups within the contextual healthcare systems of Pakistan. He has also previously worked as a faculty and postgraduate training programme director for psychiatry at Aga Khan University Hospital, Pakistan.

emotional happenings by nature are like a cosmic meteor that can't be *'governed'* but can be processed, contained and regulated within the safe orbital spaces that our leaders create. The frame of Balint group (leader being part of that frame) provides that essential safety needed for such holdings and containments. The challenges that lie ahead for Balint leadership are partly inherent in the ever-increasing demand and pressure on this frame today, as we adapt to a world of changing social interactions and technology. There is a need for qualitative research on the experiences of leaders (belonging to different clinical disciplines and diverse socio-cultural contexts) who are trying to adapt to these technological changes while also preserving the tradition and technique that we have been long familiar with.

For me, technique is dependent on the situation and the medium in which humans encounter novelty or a problem. Room and zoom are different mediums where access to the unconscious, body language or the unsaid is differently available to the leaders. We as leaders need to realise our vulnerability at times of such change, where generalisation and/or over-simplification can sometimes impede our true understanding of this hybrid existence that most of us are now faced with. For example, questions like 'Where is the empty chair' in online groups is not a critique of the medium but an invitation to discuss the absence of something symbolic in a frame. My hope is that as a community we continue to engage in sharing our lived experiences as leaders as we expand beyond borders and dimensions of time and space.

Andrew Elder, Editorial Committee Member[3]

Our Society is at a time of considerable change. In relation to leadership, many more people are interested in training as Balint Group leaders. The majority come from psychiatry or the psyche-professions. Whereas previously becoming a leader depended on being a member of a group for a considerable time this is no longer possible. There are now many more groups for students in medical schools, for junior doctors during their training posts, for psychiatrists, hospital doctors and some for non-clinical professionals such as teachers or lawyers, as well as for GPs. How can leaders gain enough experience before being accredited to lead groups in these many different settings? How flexible are leaders in adjusting their approach to different groups? Is the temptation 'to teach' stronger when a psychiatrist leads a group of psychiatrists? How do psychiatrist leaders in training get experience of GP groups? As a Society, how do we encourage and support the growth of a leadership culture in which we continue to develop our understanding of Balint Group Leadership in the many different settings in which it is now practiced?

Enid Balint used to say: I am a psychoanalyst in whatever I do – conducting a consultation, or leading a group for GPs, seeing someone for supervision or a patient in analysis. As Balint Group leaders, can we say something similar: in whatever group I am leading, my behaviour and aims might differ, but in essence I am *always* a Balint Group leader? In which case, what *is* that essence? What *is* a Balint Group leader? Balint Groups have many close relatives but defy easy definition. Perhaps it is only by continuing debate, discussion and working together, that any of us can begin to feel confidence in approaching such a complex question.

[3] Andrew Elder was an Inner London GP (1972-2008). Honorary Academic Staff Tavistock and Portman NHS Foundation Trust. Balint Group leader. Past President Balint Society (UK) and Co-ordinator of International Balint Federation (IBF) Leadership Taskforce for its first six years. Awarded Honorary Doctorate (2017) for work in primary care and mental health.

In his Appendix 1 on Leadership in *The Doctor, His Patient and the Illness*, Michael Balint is keen to point out that a leader 'will teach more by example than by everything else combined. After all (he says) the (leadership) technique we advocate is based on exactly the same sort of listening that we expect the doctors to learn and then to practise with their patients'. He encourages us to pay close attention to the parallel between the way a leader listens to the group and the way the participating doctors are encouraged to listen to their patients.

We have had over fifty years of research into the doctor-patient relationship when the doctor is a GP. But what do we know about the pharmacology of the drug doctor when the doctor is a psychiatrist? There is much scope for new research.

John Salinsky, Editorial Committee Member[4]

What happened to training-cum-research?

The Balints often described their groups for GPs as 'training-cum-research'. The aim was partly to show the GPs how to listen better to their patients and thus to hear some of the unexpected contributions from the Unconscious. That was the training. The research involved both leaders and members in learning to understand more about the doctor-patient relationship. Several of the early groups studied a particular subject that bothered the doctors, such as *Night-calls* (Clyne 1961) and *Repeat Prescriptions* (Balint et al 1984).

These 'research groups' ran for several years and each eventually published their accounts of the work as a monograph which was well worth reading. Most, if not all, of the group members contributed to the writing. But now we seem to have no more research aims. The last research group to be led by Enid Balint published its results in 1993; and the most recent Balint research book, (*What are you Feeling, Doctor?*), appeared 22 years ago in 2000. Its theme was 'Doctors' Defences'. This group used to meet every two months for a whole weekend day. Meeting days were hosted in turn by the doctors and included a convivial lunch and a refreshing walk. The leaders were Michael Courtenay and Erica Jones, both retired GPs, thoroughly marinated in the Balint process. Everyone had a good time, learned a lot and contributed to a book which is still available. Sadly, there seems to be no sign of any new research of this kind, and this is of great relevance to the theme of leadership. So, if you are a member or a leader of a group, I recommend that you discuss the project with your colleagues and find a theme. Training-cum-research!

[4] John Salinsky is currently leader (with co-leader) of local Balint groups for the last 15 years. GP Principal (1972-2018). Past Programme Director, Whittington GP Training (including Balint groups). Past president of The Balint Society. Past editor of The Journal of the Balint Society. Past treasurer and secretary of the International Balint Federation. Honorary founder member of the American Balint Society.

Acknowledgements

The Editors would like to thank Amber Segal, who was the editorial assistant and language editor of the current issue, Joanne Etches, who supported aspects of Journal communication, and Irina Culic, who read the entire issue in its close to final form.

References

Clyne, M. (1961). *Night Calls*. London: Tavistock Publications.

Balint, M., Balint, E., Hunt, J., Joyce, D., Marinker, M., and Woodcock, J. (1984). *Treatment or Diagnosis. A Study of repeat prescriptions in general practice.* London and New York: Tavistock Publications.

Balint, E., Courtenay, M., Elder, E., Hull, S. and Julian, P. (1993). *The Doctor, the Patient and the Group. Balint revisited.* London and New York: Routledge.

Salinsky, J., and Sackin, P. (2000). *What Are You Feeling, Doctor? Identifying and avoiding defensive patterns in the consultation.* Abingdon: Radcliffe Medical Press.

Salinsky, J. (2022). A History of Balint Group Leader Training in the UK. *Journal of the Balint Society, 49: 11-27.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A History of Balint Group Leader Training in the UK

John Salinsky[1]

[1] Balint Groups Leader, former President of The Balint Society UK: jvsalinsky@aol.com

Anyone trying to write the history of a small organization is likely to be faced by a serious lack of evidence. This is because the decision to reconstruct and preserve the history usually starts too late. Historians need documents, such as minutes of meetings, reports, articles in journals, chapters in books; previous attempts at history and, if possible, transcribed interviews with prominent elders. After 50 years, many or all of the founder members will have died, and their secrets with them; those who are still alive will be elderly, and most will have forgotten the dates and other details.

To make it even more difficult, everyone's memories are, to various degrees, confused and unreliable. Unless their recollections can be confirmed by the memoirs of others, they have to be viewed as interesting, but of uncertain validity: like the fantasies we generate in our Balint groups.

One of my advantages in writing about this biography is that I have been a member of the Society since 1976 and I have been a *witness*, if not often the agent of change, in our Society for over 40 years. I could a tale unfold, and I have the inclination, I can assure you. Often, I can tell you exactly what happened *because I was there*. But can you rely on my memories alone? The answer is: sorry, but no. You should ideally have corroborative detail from at least one other fairly reliable source.

You too may have been present at the same events and be able to confirm my mist-enshrouded impressions – or you may have come away with very different memories. As Chico Marx once put it (Wood, 2012): 'Who you gonna believe, me or your own eyes?' To which we can add 'your own ears'.

---

[1] John Salinsky is currently leader (with co-leader) of local Balint groups for the last 15 years. GP Principal (1972-2018). Past Programme Director, Whittington GP Training (including Balint groups). Past president of The Balint Society. Past editor of The Journal of the Balint Society. Past treasurer and secretary of the International Balint Federation. Honorary founder member of the American Balint Society.

The remedy, I think, is for everyone who reads this, and thinks I have got something wrong, to write to me and I shall publish a list of corrections and their implications. In this way I hope I shall be forgiven my inaccuracies – and the record will be set straight.

My history is also a kind of ethnographic investigation of the Balint community and its attempts to rear leaders who can be trusted to preserve the ideas and principles that they (or perhaps I should say we) have received from our respected elders, some of whom were direct disciples of the founding Father and Mother.

My history will be in two parts. The first, 1957 to 1976, covers the period from the publication of *The Doctor, his Patient and the Illness* (Balint, M., 1957) up to my own admission to membership of The Balint Society (UK). My information here will have been found in printed material and in rare interviews with members whose intact memories at the time went back further.

In part two, 1976 to 2011, I become a witness to, and participant in, the Society's affairs and will be giving evidence myself; although its reliability, where unconfirmed, should not be taken for granted. You must make up your own minds, ladies and gentlemen, and I can only hope that your brains will not be overtaxed. Let us start at the beginning.

*

In the beginning there was Michael Balint who was asked to join Enid in the Tavistock Clinic's Family Discussion Bureau, to which couples came (separately) for help with their marriage problems. Michael was a practicing psychoanalyst and Enid was soon to become one. Michael moved on to inviting local GPs to come and discuss 'the psychological element in general practice' in 1950 (Gosling, 1996.1).

Enid soon joined him and between them they devised, and she refined, a unique style of group leadership which owed little or nothing to group therapy or to the early work of Wilfred Bion on the behaviour of groups (Bion, 1961), although subsequent Tavistock groups, led by analysts, were to also make use of Bion's ideas (Gosling et al., 1967). Other psychoanalysts at the Tavistock Clinic became interested and, as more GPs applied to join Balint groups, the number of groups was expanded. This, of course required more leaders.

But early experience warned the Balints that leading a GP group required additional skills such as encouraging all the group members to have their say and the complete avoidance of psychoanalytic terminology. Didactic teaching was forbidden (although Michael sometimes gave mini-lectures himself). Most of the new analyst leaders were allowed to start their own groups; but some had to be discouraged because they were too wedded to their own discipline.

In view of the fact that most of these potential leaders were already leading groups, the Balints started a monthly supervision seminar which was held at Michael and Enid's home and accompanied by coffee and cake. Before each meeting, one of the members would circulate a typed transcript of an audio-recording of one of their group's sessions which the workshop could then analyse in detail, under the guidance of Michael and Enid (Gosling, 1996.2). This frequency of meetings seems to have declined, after a while, to once a term.

The new leaders naturally varied in their personal approach to leading a Balint group and also in their leadership skills. 'Even after psycho-analytic training, and some considerable experience in psychiatry as well as being observers in training seminars, the new leaders achieve significantly poorer results than the experienced ones' (Balint, M. et al. 1966). Andrew Elder (personal communication), remembers one unfortunate analyst being dismissed by Enid from her Leaders Workshop on the grounds that 'he'll never be able to lead a Balint group'.

By this time, some of the GP group members also wanted to lead groups of their own. Some were already leading groups, apparently regardless of the rule. Some discussion about this must have taken place because Michael made it very clear that he did not think anyone who was not also a qualified analyst would be capable of leading a group.

In 1969, Philip Hopkins, who had been a member of Michael and Enid's group from near the beginning, organized his group-member colleagues and started The Balint Society (Hopkins, 1970). Michael accepted the office of Honorary President but, sadly, he died soon afterwards in January 1970.

To the end of his life, Michael had retained his view that only psychoanalysts could be leaders. His reasoning was that, because of their training, only they could understand the material from the unconscious often uttered by both doctor and patient. These remarks would often seem strange and inconsequential: which is how they could be recognised by those who were practiced at looking out for them. Other special qualities of an analyst's mind and ear can be found in Enid's writing, for example in *The doctor, the patient and the group*, Chapter 4, not attributed to any author by name, but unmistakably, Enid's style (Balint, E., 1993). See also *While I'm here, Doctor*, Chapter 11 (Balint, E., 1987).

Michael did permit experienced GPs to lead groups for the Family Planning Association (later to become the Society for Psychosexual Medicine). This exception he probably allowed because, according to Michael Courtenay: 'that was limited in scope and we probably wouldn't be dangerous' (Salinsky, 2004).

After Michael's death, things changed. In 1972, Enid started a new group which she co-led with Cyril Gill, one of the most experienced GP group members (Balint, E., 1974). She believed that a GP who had been in an analyst-led group for a few years would have absorbed some of the way that analysts are trained to tune into the unconscious minds of their patients and themselves, and would therefore

be a safe pair of hands. However, they would still require a Balint-trained analyst leader as a senior partner! By 1974, other Balint trained GPs were also leading groups, with or without an analyst or an analytically aware co-leader.

Meanwhile, the Balint Society's Council had set up a Steering Committee to discuss 'the problem of training methods'. Presumably they also had discussions with the analysts leading groups at the Tavistock, though this is not mentioned in the Journal. These meetings led to the setting up of two training programmes, one for psychoanalysts and the other for GPs and other professionals. Each was to have a panel to appoint leaders; and psychoanalyst leaders would also have to be approved by the Society (Pasmore, 1975).

GP Leaders would be able to attend a regular GP Balint Leaders Workshop presided over initially by Enid herself. (See below).

*

In his Epilogue speech to the 1978 (4th) International Balint Conference, held in London, Tom Main said: 'The training begun by Michael Balint was conducted only by psychoanalysts but today psychoanalysts interested in this training are fewer. What could the British Balint Society do? It was decided to make do with general practitioners, even though that would mean second level, even second rate leaders, but all would follow Balint's method'.

He went on to say that the experiment was proving successful under the condition that the GP leaders were meeting regularly to discuss their work with Enid Balint. (Main, 1979). By this time, some GPs were already co-leading with analysts and others, notably in the GP Training schemes, were leading by themselves, as analyst partners were in short supply. At Northwick Park VTS there were three groups from 1978, each led by a single GP. I was one of them!

Why were more group leaders needed?

More GPs who had read, or partly read, Michael Balint's book wanted to find a Balint group to join. The book had enabled them to see a way of getting more satisfaction from their work by gaining a better understanding of their patients as human beings like themselves.

In addition, the training of GPs was changing. Three-year training programmes were starting up, providing four six-month hospital posts, followed by a year as a trainee attached to a practice. Individual mentoring in the GP year was provided by an accredited GP trainer. Each scheme was, and still is, supervised by a GP 'Course Organiser' – later rebadged with the grander title of 'Training Programme Director'. Course Organisers also ran a weekly teaching afternoon. It so happened that, especially in London, a number of Course Organisers were also members of the Balint Society. Naturally they wanted to incorporate a weekly Balint Group in this half-day 'release' and, if they were going to lead, they would need training.

I am admitted to the Society and emerge as a witness

As a young GP, I became a member of the group led by Michael Courtenay and Mary Hare. And, in 1976, having survived and benefited from two years of weekly meetings, we group members were told that we were now eligible to become members of the Society. Of course, I joined straight away.

So 1976 marks the year in which I first appear as a witness to Balint Society history. Too many witnesses of the early days have already died. I am now aged 80, myself, so you should take advantage of my testimony while I am still with you. But remember not to believe everything I tell you without checking other accounts for corroboration.

My own leader training

I was a member of Mike Courtenay and Mary Hare's weekly Balint group for nearly four years (1974-78). In those days it was possible to do a morning surgery and three or four home visits, travel from Wembley to University College Hospital, sit in the group from 2.00 to 3.30 p.m., go home for a cup of tea and then start my evening surgery at 4.30 p.m. Perhaps being a member of this group was the most important element in my training. I learned by osmosis from the leaders and my fellow group members.

Then, in 1978, I had a phone call from Oliver Samuel who was Course Organiser of the Northwick Park VTS, one of the new three-year training schemes for GPs. He wanted me to come and lead one of three Balint groups. Feeling I knew nothing about how to be a leader, I consulted Michael Courtenay who invited me to join, as an observer, a group for GP trainees he was leading with Enid at St Thomas's Hospital. At the same time, I accepted Oliver's invitation, and started leading a small group of GP trainees every week. A little later, I became a Course Organiser myself.

I attended the St Thomas's group for a year and used to give Enid a lift home afterwards. We discussed some of the cases but I can only remember a few things she said. One was that she always found herself talking more when she was leading a trainee group. In the car, after a particularly difficult session involving drug dependence, she said: 'I could do with a valium myself!'

Later, in the early 1980s, I was in a research group led by Enid which led to a book called *While I'm Here, Doctor* (eds. Elder and Samuel, 1987). As always, she was inspiring, protective and never used technical terms. Her contributions seemed to open our ears and eyes to what was really going on between doctor and patient: but how did she do it? Often she seemed to be reframing the elements of the doctor-

patient relationship by telling us what we had done and how helpful we had been even when we thought we had done nothing much. We didn't have to be an analyst; just a GP who could listen to the person as well as the symptoms; to be kind and attentive and to stick around as long as needed.

Another sort of ongoing training and supervision was, and still is, provided by the Group Leaders' Workshop: of which more later.

My Balint leader education was supplemented by regular visits to American Balint Society events and American family doctor training schemes. I attended the ABS group leader training 'Intensive' twice a year as a faculty member for about five years in the 1990s and occasionally after that. My last outing of this kind was in 2019.

Have GP leaders and non-analytically trained psychologists been a success? On the whole, yes. We all know some leaders whose methods are idiosyncratic. Possibly they think the same of us. There is room for quite a variety of leadership styles. We are all different personalities. No one wants to be led by a robot. But some standards must be upheld. We need guidelines if not rigid rules. I shall return to this matter also.

The Balint Society Group Leaders Workshop

Another source of leader education was The Group Leaders' Workshop. This enabled Balint group leaders, both novices and seasoned elders, to meet and present material from their group sessions for discussion. It was part of the deal by which GPs were allowed to become leaders. In the early days, to present your group to the workshop, you had to circulate a complete transcript of a recording of a recent session. This provided indisputable evidence of what was said at the group, although not necessarily the tone and emotional content. The transcriptions were done by an experienced audio-typist and cost (initially) around £30 which

was refunded by the Balint Society. Accounts vary as to how often the Workshop met. My impression is that it started off monthly but came down to three or four times a year.

Here are two descriptions of the early history of the Workshop from Andrew Elder and Oliver Samuel.

Andrew Elder (Elder, 2021)

By the 1980s many of the GPs who had been in groups now held positions as postgraduate educators and introduced Balint groups into their half-day release training schemes. By then, the Balint Society was running a regular 'Balint Group Leaders' Workshop' held in the evening at the Tavistock Clinic. This became the successor to the original GP and Allied Professionals Workshop which had met for many years at the Tavistock and earlier had started its life as a working meeting of colleagues in the Balints' residence at Park Square West. A small number of GP Balint leaders had always been invited to the earlier Tavistock workshop. I look back on the scrutiny given to verbatim transcripts at that workshop as one of the most searching and stimulating experiences of my professional life. Thus, a small group of GP leaders emerged who had worked with Enid Balint, Michael Courtenay, Tom Main, Antonia Shooter, Sandy Bourne, Mannie Lewis and others. Like others, I became a Vocational Training Scheme Course Organiser at St Mary's between 1979 and 1992 and throughout that period ran a weekly Balint group for trainees who were attending the three-year programme. For a time, I led it with Joan Schachter who was then a psychiatrist at the nearby Paddington Centre for Psychotherapy.

Oliver Samuel (personal communication, 2021)

The Workshop used to meet at the RCGP and we all sat round a long table. There were about 15 to 20 people attending. On the three occasions I went it seemed to be led jointly by Enid and Tom Main. A full transcript of the session to be discussed was circulated ahead of time and was the total focus of the discussion. In particular the interventions of the group leader were pored over and questioned. As always, Enid was engaged but mostly non-committal while Tom and the others were pretty challenging: 'Why exactly did you say that?' – 'what did you have in mind?' etc. Enid was more questioning and inclined to speculate about what was going on. On one occasion I offered a session of the group that Nadine Brummer and I had run at Northwick Park and we both came away feeling that we missed a lot but that the session had felt more successful than the workshop seemed to think – we needed a stiff drink to recover! More workshop sessions were held later at the Tavistock – led by Sandy Bourne. Rather more sympathetic in style but still focussed on transcripts.

*

By the time I had started going to the Workshop (around 1980), there were few analyst leaders and the more senior GP leaders took it in turns to chair the sessions for periods of two or three years. For the first few years we continued to use a transcript of a member's group session. What criteria were used, informally, to evaluate the leader's performance? I seem to remember the faults better than the good points. The chief targets of criticism were:

a) The leader talks too much. This was easily spotted when his mini-lecture went on for half a page or more.

b) The leader colludes with the group in avoiding a painful subject. This will turn out to have been what the whole case was about.

c) Everyone ignores the doctor-patient relationship.

But a brief 'touch on the tiller', by a leader who deftly steered the group back to its proper course, was very favourably received.

I don't remember when, but the time came when transcripts were abandoned. Possibly they had become too expensive or there were no audio-typists available. Lacking hard evidence of error and acquiring a gentler approach, the Workshop became more like a Balint group itself and has remained so ever since. The leaders' account of their group is now listened to with warmth and empathy. Helpful insights are offered. The group leaders leave feeling heard, supported and encouraged. The current chair, David Watt, embodies this approach and happily shows every sign of continuing for years to come.

Groups for leader education and training

1994 saw the publication in the Journal of the Balint Society of a paper setting out the '*Essential' and 'Desirable' characteristics of a Balint group.* This was the work of Paul Sackin, assisted by Andrew Elder (Sackin, 1994). This document was approved by the Council and it defined, for the first time, what it was that distinguished Balint groups from all other medical or psychological case discussion groups. It has stood ever since as the reference check-list for all new and evolving groups to measure their legitimacy. It was also taken up by the American Balint Society. In the same year, 1994, Paul Sackin ran a study day for group leaders in Ripon, Yorkshire, on the day preceding the annual meeting of the Association of Course Organisers (Salinsky, 1994). He was assisted by Heather Suckling and me. This was an early example of the model of rotating leaderships with a period of discussion following each group session. It was repeated the following year.

The next opportunity for formal learning about leadership came when the Society's residential courses started to include one or two groups for novice leaders to practice their skills and learn from their colleagues. The first of these embedded leader-training groups was attached to the Oxford weekend in September 2006 (Watt, 2007). There were two groups of eight: one chaired by Andrew Elder and the other by me. We started on the Friday morning, while the week-end for other delegates began, as usual, on the Friday evening. No wonder we were all exhausted by the end of the day! The Oxford prototype was followed by a series of residential courses which have all incorporated groups for aspiring or newly fledged leaders. These leaders' groups were first included by Caroline Palmer at Whalley Abbey (2007) and by Jane Dammers at Longhirst Hotel, Tyneside (Dammers, 2009). Since then, every residential weekend has included at least one group for leaders. Other meetings specifically for leader training are also held, but the weekend groups form the core of the Society's leader education and training.

The format of the leadership groups is very well described in the Journal by Caroline Palmer (2007). The basic idea is that group members volunteer in pairs to lead a 45 minute group session. If the group is large, two people in each session will sit outside the group as observers. In the second session, also of 45 minutes, there is a general discussion about the leadership. The presenter and the leaders are allowed to speak first, followed by the observers and then everyone else can join in. This plan is almost identical to the one that has been used by the American Balint Society since their first 'Intensive' leader education meeting in Wild Dunes, on the South Carolina coast in October 1993. Also present at this event were Peter Graham, David Watt, Katrin Fjeldsted and me. The American Training Intensives are now held twice a year in different locations. They provide 10 group sessions including one recorded on video for later discussion. Our leaders' group meeting is an

economy version with usually only four sessions but it receives good reports from participants.

In the North-East of England, Jane Dammers and others also developed weekday leadership workshops events in addition to weekends. The discussion period was extended in many groups from 45 to 70 minutes (Dammers, Personal communication).

What did we learn to begin with? What should a leader say?

I was one of the early solo GP leaders in charge of a group before the training structure was introduced. How did we manage? Our first instinct was to keep quiet. Some of our psychoanalyst colleagues would give long explanations and offer free associations. Lacking knowledge of both subject and vocabulary we thought it better not to try. This worked well.

Tom Main (quoted by Michael Courtenay), said that a leader needed only to say: 'What about the doctor-patient relationship? But to say it in as many different ways as possible'. We also learned to make sure that both doctor and patient were given equal attention by the group. If the group was fixated on the doctor we could say, 'How do we think this patient is feeling?' or *vice versa*. We could go further and represent the patient: 'I think if I were her I would be feeling very upset…' If there were too many questions (this was before 'pushback'), we could pre-empt the reply by turning the question back on the questioner: 'Can you tell us what *you* think? 'A more difficult intervention was to recognise that a painful aspect of the story was being avoided and to suggest that it might be visited. I suspect that we learned most of this from our own experience as group members. As course organisers we already knew about group behaviours and how to protect people who were being 'interrogated'. Most of the time, we just kept quiet. Some of us were able to co-lead with an analyst partner. Some, but not all, of these co-leaders were able to show us,

by example, how to listen more carefully and occasionally pick up messages from the unconscious.

After I finished being editor of the Journal in 2011, I ceased to be on the Balint Society Council and was no longer a witness of events and innovations in group leader education. I am aware of the development of a more formal scheme, with an Accreditation Pathway along which potential leaders now have supervisors to help them. At the end of the path there is a committee to assess the reports of their progress and decide whether they can be accredited. How this all came about must be the subject of another paper which I hope will follow this one.

Thank you for reading this account. And please accept my apologies if I have got anything wrong. If you disagree, I do expect you to have some evidence for your alternative narrative. Who will our readers choose to believe? You or me or their own eyes?

Author Note

I wish to thank Andrew Elder and Oliver Samuel for permitting me to use their contributions to this paper.

References

Balint, E. (1987). Research, changes and developments in Balint groups. In Elder, A and Samuel, O. eds. *While I'm here, doctor.* London: Tavistock Publications, 95-102.

Balint, E. (1993). The work of a psychoanalyst in Balint groups. In Balint, E., Elder A., Hull, A. and Julian, P. *The doctor, the patient and the group. Balint revisited*. London: Routledge, 35-45.

Balint, E. (1974). Michael Balint: The development of his ideas on the use of the drug 'Doctor'. (Michael Balint Memorial Lecture, 1973). *J. Balint Soc.*, 3: 5-11.

Balint, M. (2000). *The doctor, his patient and the Illness*. London: Churchill Livingston. (First edition published 1957).

Balint, M., Balint, E., Gosling, R., Hildebrand, P. (1966). *A study of doctors. Mind and Medicine Monographs*. London: Tavistock Publications.

Bion, W.R. (1961). *Experiments in groups and other papers.* London: Tavistock publications.

Courtenay, M. (2004). Lessons of the Masters. *J. Balint Soc.*, 32: 10-11.

Dammers, J. (2009). Northumberland Balint weekend and leaders' workshop. *J. Balint Soc.*: 77-8.

Elder, A. (2021). The Balint Society group leaders' workshop. In Waddell, M. and Kraemer, S. eds. *The Tavistock Century: 20/20 vision*. London: Phoenix, 73-85.

Gosling, R. (1996.1). The general practitioner training scheme. In Stewart, H., *Michael Balint: object relations, pure and applied.* London and New York: Routledge.

Gosling, R. (1996.2). Applied psychoanalysis. In Stewart, H., *Michael Balint: object relations, pure and applied.* London and New York: Routledge.

Gosling, R., Miller, D.H., Woodhouse, D. and **Turquet, P.M.** (1967). *The use of small groups in training.* London and New York: Karnac.

Hopkins, P. (1970). Constitution. *J. Balint Soc.,* 1: 5-8.

Main, T. (1979). Epilogue. In Hopkins, P., ed. *The human face of medicine.* (Proceedings of the 4th International Balint Conference (1978). London: Pitman medical, 265-270.

Palmer, C. (2007). Report on group leaders' intensive weekend workshop at Whalley Abbey, Lancashire, and June 2007. *J. Balint Soc.*, 35: 57-8.

Sackin, P. (1994). What is a Balint group? 'Essential' and 'desirable' characteristics of a Balint group. *J. Balint Soc.,* 22: 36-37.

Salinsky, J.V. (1994). A Balint day for course organisers. *J. Balint Soc.,* 22: 39.

Salinsky, J.V. (2004). An interview with Michael Courtenay *J. Balint Soc.,* 32: 6-9.

Watt, D. (2007). Secretary's report 2006-2007. *J. Balint Soc.,* 35: 54.

Wood, M. (2012). *Film: A very short introduction.* Oxford University Press, 12-15.

Fitzgerald, G. (2022). The Courage of Our Stupidity or Developing the Discipline of Being a Balint Group Leader. *Journal of the Balint Society, 49: 28-37.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

'The Courage of Our Stupidity' or Developing the Discipline of Being a Balint Group Leader

Gearóid Fitzgerald [1]

[1] Former President of The Balint Society UK: gearoidf@gmail.com

This day is a result of a lot of thinking and planning by the Training and Education Committee with the Council's support. I think we wanted to get leaders together to continue working on what Andrew Elder recently called 'the Balint Project'. I took that to mean the ongoing work in noticing how we are working as Balint leaders, with whom we are working, what they are bringing and how we think about that theoretically so we can take the project onwards. My other idea is that for theory to move forward one has to know the previous work upon which a lot of our present-day work rests. This thinking is not usually elaborated explicitly. One reason might be the books which describe it aren't always easily available, although they are from second hand online bookshops.

I have been invited to Bristol a number of times over the last years and there I got into the habit of talking about some of Michael Balint's core concepts from *The Doctor, His Patient and the Illness*, which is the first book about the Balint project. Concepts like the 'apostolic function', 'the doctor as drug', collusion of anonymity are all I think absolutely relevant today and if you are not familiar, I am happy to expand these in the discussion at the end. The other books I use as reference are *Six Minutes for the Patient*, edited by Enid Balint and Jack Norell; *While I'm here Doctor*, edited by Andrew Elder and Oliver Samuels; *The Doctor, the Patient and the Group*, with contributions by Enid Balint, Michael Courtenay, Paul Julian, Andrew Elder et al.; and *What are You Feeling, Doctor?*, by John Salinsky and Paul Sackin (2000).

Balint groups came about as a result of a chemical reaction between General Practice and psychoanalysis. The result was a body of theory and observations that may have some resonance with interactions in many fields. Today there is a large number of psychiatrists in the society and their culture and work will also begin to react with Balint. To elaborate that new chemical interaction, I think it is essential

[1] Talk given at the Annual Study Day for Balint leaders, February 5th 2021 on zoom.
[2] Dr Gearóid Fitzgerald is a Balint leader for over 20 years and former President of The Balint Society UK. Psychoanalyst in private practice. Formerly Consultant Psychiatrist in Psychotherapy and Training Programme Director for Psychotherapy Yorkshire and Humber region.

to know the essence of the theory. In particular internalised theory effects, the stance of the leader is important to the quality of data we then get from our groups. By that I mean you need to be in a proper Balint group to get observations that one can use to develop Balint theory. In my mind Balint is not like anything else, it is not a technique, it is a way of listening informed by the experience of being in Balint groups led by experienced leaders who know their heritage. I think we will all have experienced that. The first cohorts of leaders knew implicitly from their long experience and contact with the Balints and those trained with them that something needs to be passed on and made more explicit. I think that my personal main aim as the President is that we have these dialogues as leaders together using this rather remarkable heritage.

This leads me to want to talk about the second book from the Balint project, *Six Minutes for the Patient*, edited by Enid Balint and Jack Norrell. Each chapter was written by a member of the study group in their own way. It is in part a valiant attempt to prove some things that I describe in what follows, but my intertest is more in the description of the evolution of the ideas. For me Enid Balint always quietly seems to make key points. In the epilogue she mentions how Michael Balint was looking for what could be brought in and adapted from psychoanalysis (the long interview) here, and psychotherapeutic skills in *The Doctor, his Patient and the Illness.*

In *Six Minutes for the Patient*, the influence of the popularity of short term focussed psychotherapies seems to be around. Enid Balint describes how she thought it was about noting something that was already present in the work of GPs and drawing that out rather than importing something. I think this is terribly important. The aim of the book was to measure the therapeutic potential of doctor-patient interactions in its everyday setting. This is why it is 'six minutes': that was roughly how long a consultation in General Practice might last.

They chose to ask the GPs in their group to bring ordinary cases where they felt something therapeutic had occurred. Then they looked at these cases in detail and followed them up over time using a variety of forms they had developed. They described the previous work and its limitations quite honestly. They noted that psychotherapeutic techniques were of limited value in day-to-day work. They noted how they had chosen special patients for long interviews and really had functioned like detectives using the family history and their own listening to come up with what were essentially psychodynamic formulations. They called this the 'Great detective'. It meant a two-tier split system though, as some special patients got the long interview and essentially a form of psychotherapy. Others were relegated to something else, ordinary practice one might say.

I think here there is a resonance for psychiatry. All trainee psychiatrists will have done a long case and a good question is why, and is this of any use in their day-to-day work? This is exactly the territory this book is in. What makes a consultation have psychotherapeutic value? This question is being explored. And it is not applying the techniques and methods of psychoanalysis in those other zones of interaction. But maybe in General Practice it is about looking to see what happens when something 'clicks' in a consultation.

I have little doubt that the attention and telling their story will have been very helpful for many patients in these long interviews and the long case in psychiatry. I was a big fan of the nuanced personal history as a psychiatrist particularly focussed on transitions like going to school etc. However, I think in this book and in what comes after it something different is beginning to happen. In describing these consultations something emerged which they called 'the Flash'. This describes a moment of connection between GP and patient. In reading the examples it struck me that in each the GP had to have the courage of finding a way to say what had come into their mind unbidden and it was usually something that was a little outside what might be considered professional and polite. (I will read

one of the interactions from the book near the end). Then the GP had to find a way of translating that observation and choosing to say it. In noticing these flashes, they observed the GP and patient were somehow closer, and the patient felt the GP had got them, had really got them in a benevolent non-pushy way. The GP managed to be struck by something in their unconscious and put themselves in the patients mind for a while and then pull back and think about it. The effectiveness of the flash relied upon the intensity of that momentary flare between the two and wasn't a long process but seemed to move things onto a new level. Sometimes temporarily. It wasn't an interpretation but more a conveying by the GP of their understanding of how the patient really was in a micro moment. I was struck by the fact that these weren't great summing it up statements but just about what the patient who was sitting in front of them was conveying at that moment. It suggested that knowing about one's self might be secondary to feeling someone had got you at a particular moment and helped you then. It was catching hold of how the patient was in that moment, not some great formulation.

I would like to read an extract from *Six Minutes for the Patient* (p. 24):

> To summarise I think the main characteristics of our technique are
>
> 1. In the intensity of the contact
> 2. In the freedom it gives to the patient to use the doctor in his own way
> 3. In the freedom it gives to the doctor to make his own observations
> 4. In the freedom it gives to the doctor to be used i.e. to give himself, without anxiety that his patients will abuse his time.
> 5. In the discipline it imposes on the doctor during the brief interviews to observe both the patient and his own thoughts and feelings.
>
> In our work the doctor is freed from the primary task of trying to discover why the patient talks, thinks, feels and behaves in the way he does. The patient in due course may provide the answers to why; the doctor's task is primarily to observe a very small sample of how the patient talks, thinks and behaves, and why this causes him pain; what he is like and what he seeks in an obscure and confused way to share with his doctor; what really makes him want the doctor's attention. May I add that this aspect of our work has nothing to do with solving problems or averting crises. And it is very hard and disciplined work indeed.

> This method can perhaps be taught best by the way the seminar leaders behave by creating an atmosphere where such freedom and discipline exists; where it is not the leader who knows the answers but where his observations are as free and his attention as complete and his thinking as disciplined as that required by the doctors in their interviews with their patients. This is again a very difficult task indeed.

The project group were left with the worry of how or do you move forward with that. There is then an intriguing set of observations about when patients pick it up, when they leave it and move away and when they come back. They note the importance of the patients' right to hide, and a respect for their defences. The doctor is not trying to break through something as I think had been the more vigorous sense of the initial book.

Balint's GP roots are partly in psychoanalysis and the other is in the body/mind combination and its varied expressions. The body figures less in psychiatric and psychotherapeutic settings I think, or maybe we ignore it more. I find this 'flash' (and the 'great detective' model) fascinating ideas as they are linked with something I spent my whole career as a consultant psychiatrist in psychotherapy wondering about: I used a term borrowed from another independent psychoanalyst, Nina Coltart. She spoke of 'psychological mindedness' which is much more about a capacity to begin to use one's imagination in an indirect creative way to describe one's experience and sense of self. I think the majority of patients, ourselves included, have a lifelong ongoing struggle to develop a way of metabolising and describing to ourselves the interactions between our unconscious and the external world but particularly with our body and what it carries for us. These flashes are not insights, at least not only. I think they are a change in an unconscious capacity that may be temporary or permanent, but in that moment is there between the two people. Once it happens it is always somewhere in the unconscious. So, the question for me is: can patients and indeed, more relevantly, doctors develop that psychological mindedness? I think they can, but it is in the way this book hints at. Occasionally there is a moment when the doctor

and patient can suddenly be surprised by a new reality and the patient may feel understood. This moment may in some cases bring about a curiosity in the patient about themselves and how they have come to be as they are, and they may want to explore that further. In others it may bring a relief that one is understood and one's defences respected until they choose to come out again. I think this is the profoundly developmental work of good General Practice and good psychiatry in any of its subspecialties. A moment of potential change is brought about by careful listening. This tuned in listening is described as selective attention and selective inattention. Listening to one's unconscious promptings or imaginative upsurges, or not, and to discard if appropriate the way one's training can draw one away from just noting one's observations. This is the freedom referred to in the summary of the flash and the discipline that has to be used and developed in the doctor. Some of this ignoring may be due to the doctor's apostolic function but also to the primacy we give to illness diagnoses versus a more global holistic assessment of the patient. What is noteworthy in the book is the way physical illnesses and the person's state of mind are seen as linked and both given proper separate attention at times and when they overlap that is also given proper attention. Here there is a use of holistic assessment way before it had become fashionable.

It seems to involve learning not to hurry after answers to questions that are not the patients worry but part of what we have to do in our job.

I will cite the example of the case here in *Six Minutes for the Patient* (p. 33):

> The doctors in this research group were already experienced in long interviews on selected patients in their practices, whom they tried to help with personal problems. Our aim in the present research was to examine the ordinary 10-minute GP interview and see what we were able to do in such short contacts. There are many possible types of interaction between GP and patient. One might distinguish the following three categories with an example of each.

1. Traditional medical interview

A fifty six year old single woman not well known to the doctor, complained of feeling tired and unwell. He got her to enlarge on this, and learnt that she had felt sluggish and cold lately. He took a full history and examined her, bearing in mind such possibilities as myxoedema (hypothyroidism) and anaemia, which occurred to him early in the interview. He found nothing on examination, but sent her for appropriate tests.

2. Detective type of personal interview

The tests were all normal, but she still felt ill, so he asked her to come for a longer interview. He asked various questions about her life, and learnt that a recent change in the office had upset her. She was not easy to talk with, but he got a past history of dominating mother, who rather isolated her, but made her feel she should take a pride in her job, but that she would achieve little. She was now lonely and frustrated, and her symptoms dated from the office change which exposed her to a new and larger group of people who seemed unfriendly. He summarized this picture for her, as far as it went and she agreed it was relevant to her symptoms and was grateful, so she said, for his interest. But at the same time she made the doctor feel that further questioning on these lines would meet resistance. He could never change her of her life situation. So he prescribed anti-depressants and asked her to return in a fortnight.

3. Flash type of interview

She returned even more depressed and the doctor said 'Oh dear, we must try again apologetically, at which she burst into tears. The doctor's immediate reaction was that she looked ridiculous crying in the hat she was wearing. This thought shocked him, since he liked to think of himself as sympathetic to his patients, but he realized at once that she might be making other people unsympathetic to her in a similar way. She started apologizing for her tears, and was surprised when the doctor apologized in turn for not letting her feel she could cry with him before. She felt at once the new relationship that this interchange had established and understood what the doctor meant when he suggested that she might have been keeping people at arms' length by a rather stern manner. He referred to the hat, which was a formidable affair and she took this point with interest and good humour. Finally, she was able to agree that her initial complaint of feeling the cold might be because there was nobody to warm her up, but her stern manner was hiding this need from other people.

The first interview was 'illness orientated' with the doctor very reasonably looking for myxoedema, anaemia, or other physical illness.

The second interview was 'patient orientated, in a detective way. The doctor organized the interview to try to make a diagnosis of the patient herself rather than of an illness. He was aware of her as a cold dominating person, but was not involved very much with her himself.

The third interview was also 'patient orientated' but involved the doctor patient relationship as well as the patient. The doctor had a flash of understanding and was able to share it with the patient. Where this could happen they both lowered the barriers, the doctor admitting his failure, and the patient letting herself cry. The interview was much warmer than the earlier ones and established a new relationship between doctor and patient, which should be useful in time, but also helping her to react differently with other people.

So, using this case as an example, the authors talk about the traditional medical interview, the great detective (long interview) and the flash interview. What is a 'flash'? As Enid Balint says, one recognises it easily but it's very hard to define.

Here, something simple, everyday and ordinary struck the doctors unconscious – the hat. The patient uses her doctor to convey something that is obscurely felt by her. Here, this evokes something in the doctor that seems a bit edgy and maybe ought not to be thought or said. It leads to a description of how the patient comes across to him in a flash. Then he chooses to notice what he has said and done and his feelings. But there is a moment of mutual awareness that is genuinely felt, genuinely comes about. So, it is not a fabricated intervention, it just happens. Part of Balint training is noticing our feelings and actions and then reflecting on what they say about how this patient is at that moment. It also involves a knowledge of the patient and a being open to them at a deeper level that draws the doctor in and is emotionally hard work and can't be conjured up at will or regularly. It means the doctor has to allow for personal discomfort and the discomfort of thinking one should be in control of what's happening and tune into the patient's distress.

My own observation is that some patients evacuate their distress and don't want it back at that moment or maybe ever, so I wondered if some of these cases used the doctor like that and that some subsequent reluctance to open up again was because they were relieved of some burden. Is this a use for doctors? And other professionals, or not?

I thought I would leave us with the rest of the time to discuss as colleagues what this presentation evokes or might mean in the context of the different places and professions we work in. I definitely don't see it as a question-and-answer session; more as a chance to talk about these theoretical issues in our practice as Balint group leaders.

References

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient, and the Group: Balint Revisited.* Abingdon: Routledge.

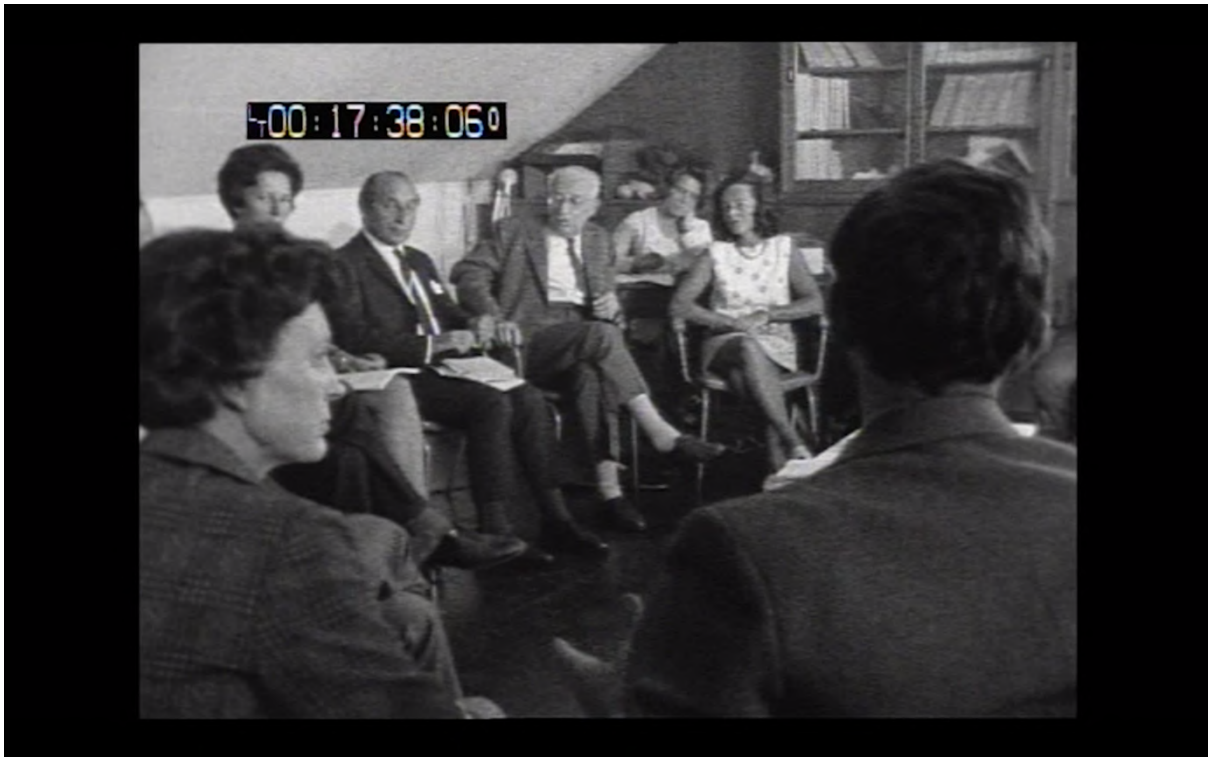
Balint, E., Norell, J. eds. (1973). *Six Minutes for the Patient – interactions in General Practice*. Facsimile by Routledge, 2014.

Balint, M. (1968). *The doctor, the patient and his illness*. London: Pitman Medical.

Coltart, N.E. (1988). The assessment of psychological-mindedness in the diagnostic interview. *Br J Psychiatry* 153: 819-20.

Salinsky, J., Sackin, P. (2000). *What are You Feeling Doctor? Identifying and Avoiding Defensive Patterns in the Consultation*. Abingdon: Radcliffe Medical Press.

.



Still image from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970. The short film shows the atmosphere of Balint groups led by Michael Balint himself, in the 1970s, and it contains selections from three case discussions.

Davies, T. (2022). Musings on the Evolution of a Balint Group Leader: From Crisis to Consciousness. *Journal of the Balint Society, 49: 39-46.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Musings on the Evolution of a Balint Group Leader: From Crisis to Consciousness

Theresa Davies[1]

[1] Specialist Registrar in General Adult Psychiatry, Portsmouth, UK: Theresamdavies@hotmail.com

"Psychotherapy is, above all, not theoretical knowledge but a personal skill" (Balint, 1964).

Most people do not intend to end up in rehab for alcoholism. It was certainly not in *my* life plan. Having been raised by an alcoholic mother, I felt myself rather above all that. However, during the second year of foundation training, I found my usual confident, friendly and out-going self being gradually eroded and replaced by an anxious and alcoholic replacement.

I was working in a busy Intensive Care Unit in a district general hospital. Having trained and worked as a psychiatric nurse prior to medical school, I found it incredibly difficult not to bond closely with my patients and their, often distraught, relatives. I simply could not see them as "the appendectomy in Bed 2". To me they were part of a family, a community. This was both a blessing and a curse. As one young woman said to me one day, as I approached the bedside of her dying husband, "I only cry when I see you". My holistic approach was good for families but bad for me. Being a perfectionist suffering with perpetual imposter syndrome (I was after all "not clever enough to be a doctor" according to my A-level teachers), I always took the sickest patients each shift and strove to cure the incurable on a daily basis. Gradually as the weeks went by, my nightly alcohol intake increased in order to drown the sorrow of the deaths and life-altering disabilities I was so frequently encountering.

After a particularly harrowing death of a young mother, with the screams of her four small children still echoing in my ears, I gave up trying to control my

[1] Dr Theresa Davies is a Specialist Registrar in General Adult Psychiatry in her final year of training based in Portsmouth. Prior to entering medical school age 30, she was a Mental Health Nurse. Theresa has a passion for teaching and supporting junior colleagues. She has been running a group based on Balint principles for SHO doctors single-handedly in the Emergency Department for the last five years.

alcohol intake and plunged headlong into alcoholism. Thankfully, I had the insight to know I was in trouble. I went off sick and approached first the British Dentist and Doctors Group then the Practitioner Health Programme who promptly sent me to a rehab in Wiltshire. Once there, the true extent of my depression became apparent and I spent the next 14 weeks in rehab very unwell.

I firmly believe that had there been a Balint style group based in the ITU where I could have deconstructed my experience and gained the support of my peers, I would not have become as ill as I did. My ITU clinical supervisor was a compassionate and thoughtful man but I could not confide my distress to him as my peers all seemed to be coping so well. At the time I wanted to pursue critical care as a career and I thought it would go against me if I let him see my distress.

Psychiatry called me back to it and as a new registrar, I found myself back in the same hospital in a liaison psychiatry post. As the team was based in the emergency department, I had ready access to the junior doctors. I was determined to prevent anyone else suffering as I had for want of a space to reflect on their work experience. After three years of fortnightly Balint groups during my core psychiatry training, I felt that I had the necessary skill to start and facilitate a group of my own. So, I used my special interest time to set up a Balint group for the foundation trainees and senior house officers working in the department.

As I write this just over two years later, I smile as I think how naive and unexperienced I was.

The group was, and still is, held on a Wednesday afternoon during the trainees teaching programme. It happens sporadically and infrequently. There is a great deal to learn in emergency medicine and I am given slots as and when there is a gap. It lacks the regularity of my core training group but I am grateful to the consultants for every hour they give me with their junior doctors.

Each group lasts an hour and is attended by 10-12 doctors. My fellow participants are at various stages of training and specialty. Many are on a General

Practice training scheme, some are future ED consultants, surgeons or anaesthetists and many are too junior to have chosen a career path yet. The group also includes members of the armed forces as it is based in a tri-service hospital. The doctors rotate on a 6 monthly basis and there have been 4 cohorts through the group so far. In each group, roughly a third will have experienced Balint training before having completed a psychiatry job. The majority, however, have never done any sort of group like this before. It makes for an interesting, lively and anxiety-provoking mix.

I begin each set of groups by explaining via a handout the basic tenants of Balint work. I also ask them to complete a short questionnaire with the aim of attempting to justify the group to their seniors by demonstrating an improvement in their wellbeing or empathy with patients. This questionnaire has not been brilliantly helpful and in many participants it has actually demonstrated worsening wellbeing by the end of the rotation. As the groups are so sporadic, I suspect (and hope) that this is due to the stressful nature of the job rather than the uselessness of the group. The comments section at the bottom has been insightful, however. Almost all participants want to continue attending a Balint group in their next job and most have found it valuable. Phrases such as “really helpful” and “very useful” come up frequently. And many trainees express surprise that despite being “someone who is not normally keen to share emotions or personal experiences” they have enjoyed the group and found it supportive.

In the first session, I set the ground rules of confidentiality, punctuality (this is not very successful as trainees finish off odd jobs before teaching) and choice. I am very clear that there is no register of attendance. I ask them to try one group. However, if they then feel their hour would be better spent relaxing in Costa with medium cappuccino, I will neither be offended nor inform their bosses. So far no one has taken me up on this!

These days, I always rearrange the room, pushing the tables back and arranging the chairs in the traditional circle. In the beginning I tried having groups sat around the table as that is how the room is laid out, but it was not successful and I quickly learnt that the table is not just a physical barrier but also a barrier to contemplation. I have always permitted eating and drinking though I know this is not always allowed. This is their one time to eat – and eating is important to promote wellbeing, too. I have experimented with having the presenter sit out of the group and with them remaining in. I am still unsure about the merits of each, but I find that by not permitting them to speak, the group is forced to speculate on the case rather than ask the presenter to fill in the gaps. So, this is my current preference.

My favourite group with each new cohort is always the first one. I observe with an inner smile the expressions of terror when I say we will be discussing "feelings", the dawning realisation that if nobody speaks I intend to sit with them for an hour in silence, the inability to tell their story without commenting on the patients white cell count or ECG result, the relief when someone finally speaks and realises their colleagues empathise and relate to their case. The lack of judgement. The settling into a safe and containing space, maybe for the first time in their medical careers.

I am privileged to have been present when trainees have shared very difficult situations, where things went wrong or they made an error. Problems in the doctor-patient relationship when they judged a situation wrongly or where they experienced a negative outcome. Recurring themes are patients with mental health issues, substance abuse problems, self-harm, sexuality and gender differences and how these may obscure the human being behind the complaint and seduce the doctor into missing important diagnostic information. I am repeatedly humbled by the bravery of my peers in sharing their challenges with the group. It

is a delight to watch as new ways of seeing arise and the human being behind the label of "patient" emerges.

The group has challenged me too in many ways. When I started this endeavour I had no leadership training beyond being part of a group myself. I made many mistakes. I am a natural talker. I have a tendency to interrupt, to fill silences, to be intolerant of uncertainty, to find boundaries difficult to maintain. I had to learn to be still and listen more actively.

The group was also a trigger for my imposter syndrome, my low self-esteem and my poor self-worth. I did not choose psychiatry as a career. I chose emergency medicine, prehospital care, critical care medicine. Psychiatry chose me. It grabbed me firmly and tightly and I could not shake it loose. I constantly worried that my peers were doing the "real" work of doctoring while I was "just" a psychiatrist. Sometimes, this was triggered by a person in the group who would sit, leant back in the chair, arms crossed, looking bored, refusing eye contact. I am a master at mind reading (!) and I would just *know* they were thinking how pointless this process, and by default the whole of psychiatry, is. This is still a work in progress and I suffer this still after every group.

I also worried that I was not knowledgeable enough and that I was missing the deep psychoanalytic insights that were being raised in the group. Throughout this process, I have been sporadically supervised by more than one supervisor. More than once I have wished one of them were leading the group instead of me and felt guilty that my peers were missing out. When I began the group I believed I was just about qualified to be a leader. My supervision sessions frequently call this into question. I gain new insights with every conversation and frequently wish I had had my supervisor in the group with me when the issue arose. I grow in psychological mindedness as (I hope) the trainees grow alongside me.

One of the biggest challenges of this group is that I am asking my members to look deep within themselves, to confront "personal conflicts and difficulties, of

(their) unsolved and often unconscious problems" (Balint, 1968). To become sensitive to their own automatic patterns, to have an emotional response to their patients. To examine difficult transference and counter-transference issues. Tears are not uncommon. Realisations occur suddenly and painfully. Then, they go back to work. Straight into a busy emergency department working at full tilt. The work for me is to find the balance between allowing insights to arise, emotion to flow but stability and resilience to remain.

I am now attempting to become an accredited Balint leader which has been rather curtailed recently by the covid crisis. I have attended one leadership day in London and plan to attend several more when they restart. I joined a Balint group which plans to meet several times a year headed by a psychoanalyst. I have asked to join the supervision group which will meet online. I had the pleasure of presenting my group at the Tavistock to members of the society and I look forward to the conference even though I will be attending from my kitchen table.

I am not a brilliant Balint group leader. I am, quite possibly, not even a very good one. I know from the feedback I receive from junior psychiatry doctors that I am considered respectful, empathetic and kind. That I am able to provide a safe space for them when needed. That I am trustworthy and supportive. Despite my worries about my worth, I choose to believe that this is a good place to start. That these qualities stand me in good stead as I continue practicing holding space for my ED doctors as we explore together the doctor-patient relationship and attempt to find the common humanity within us all.

I will never know the impact of my work on these doctors. I choose to believe that the group helps them to grow in knowledge of themselves and their patients. I hope that their patients experience a more therapeutic and empathetic response from the participants. I hope that they become more curious and tolerant in their interactions. And, as well as this, if I can spare one person from experiencing some

measure of the agony I experienced eleven years ago as a result of my work, then I will be satisfied.

That will be enough.

I will have been enough.

References

Balint, M. (1968). *The doctor, the patient and his illness*. London: Pitman Medical.

Fitzgerald, G. and Hunter, M.D. (2003). Organizing and evaluating a Balint group for trainees in psychiatry. *Psychiatric Bulletin*, 27(11): 434-436.

Gabbard, G.O. ed. (1999). *Countertransference issues in psychiatric treatment*. London: American Psychiatric Press Inc.

Johnson, A.H., Nease, D.E., Milberg, L.C. and Addison, R.B. (2004). Essential characteristics of effective Balint group leadership. *Family Medicine*, 36(4): 253-259.

Fitzgerald, G. (2022). The Use of the Group Leader's Countertransference in a Balint Group. *Journal of the Balint Society, 49: 47-60.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

The Use of the Group Leader's Countertransference in a Balint Group

Gearóid Fitzgerald [1]

[1] Former President of The Balint Society UK: gearoidf@gmail.com

I would like to thank the Severnside Institute and Judy Malone for asking me to talk today. It is a real pleasure: I am giving this talk in the hope that we may have a discussion about two overlapping but distinct theoretical strands.

For me there is a paradox in Balint groups. We focus on an emotion or impression of one in the presenting clinician as one of the major items of importance in the consultation. Yet, in a Balint group, we rarely talk about the feelings evoked in the group leader as of any use to the process of understanding that clinician-patient relationship, nor do we talk a lot about the overall emotional atmosphere of a group. I view Balint groups as an application of psychoanalysis, but Balint Groups have a particular body of theory that leans on but is different to doing psychoanalysis, and is definitely not like an analytic group.

This interest has developed in time after a number of Balint Group Leadership workshops in London and weekends in Sligo. There was one person in particular, a Group Analyst from South Wales, who brought it clearly into focus for me: a number of people were commenting on what might be seen as a 'parallel process' in groups (i.e. where somehow the group process or the presenter parallel what happened in the actual consultation with the patient without realising it). They felt one might intervene by describing a group process to the group along the lines of: 'I think the group is doing x or feeling x'; and linking this with the consultation. It is an absolutely acceptable stance and I imagine it can be used creatively. My heritage, however, like that of Michael Balint, is psychoanalysis and its theoretical constructs. It is from those that Balint groups originated. I began wondering how one can theorise this in Balint terms. And how one can conceptualise the fact that the Balint Group Leader is not immune from feelings or from acting out in various ways on those feelings.

---

[1] Dr Gearóid Fitzgerald is former President of The Balint Society UK and a Balint leader for over 20 years. Psychoanalyst in private practice. Formerly Consultant Psychiatrist in Psychotherapy and Training Programme Director for Psychotherapy Yorkshire and Humber region.

*

An example from a group always helps me think about these issues.

This is from a fortnightly group of SpRs[2] with 8 members on this occasion and a mixture of psychiatric specialities. The doctor who said he would present is an experienced adult SpR. He tends to mumble and speak quickly. He said what had happened with this patient troubled him and had made him angry. Two months before, he had been called to see a middle-aged male patient who had been found on a bridge and brought in by the police for the second time. He described how the crisis consultant had filled out the section form and said to staff: 'If doctor x doesn't make the recommendation then that's fine'. But he went home and never spoke with the SpR. The man didn't say a lot except the he was going to kill himself. He was somewhat aggressive and bullying. They got very little information. He had been seen the night before and the SpR had not sectioned him. Then he had been a lot more bullying and threatening behaviour. He had signed the form to section the patient, as he felt he couldn't take the risk not to. He had felt angry and had followed up what had happened with the patient. He found out he had a court case the day after and was facing a prison sentence. He moved from another city and had no friends. The doctor said he had been appalled that the patient was still there and had been to PICU without a diagnosis being made. The ward consultant whom he had expected to discharge the next day was treating him as depressed.

Some desultory questions followed, and then the group launched wholesale into a shared conversation about being put under pressure by the consultant, being put in an impossible position. The group spent some 10 plus minutes talking about the system, its inadequacies and its impact on them. I had a whopping countertransference of fury and a sense of them being cowards and blaming the system. One thing about countertransference in my opinion is that it is rarely about feelings one is comfortable entertaining. I let them talk because I knew if I came in

[2] Special Registrar.

I would convey something very critical in my tone. I eventually said that I wondered if the doctor liked the patient. He said he had disliked him, he didn't know why but he thought he was horrible. Some people spoke about him being a psychopath. But there was no effort (unusual in this group) to speculate about the patient's feelings. They went back to the pressure they felt under and how impossible it was to take a risk. The presenter chipped in with talk about defensive medicine and his career and they all spoke a bit about this. They were in agreement: 'This was how it should be'.

I had struggled throughout the group not to become one of those sad old consultants who says things like: 'In my days…'. I did find it hard not to be swept away into a hectoring stance towards the presenter and one group member who was particularly vocal about the patient and the consultant. I eventually said that I had wondered how the other SpR of the night before had felt able to do something different in the face of all these realities they had been describing.

The conversation continued a bit as before then one doctor said he wondered how the other SpR had managed it and they paused. A number of appeasing solutions to their agreed viewpoint were offered. One then remarked it is hard to take risks, but maybe the other had felt more able because of seniority. The presenter said with some surprise that usually he could but this time that had felt impossible for some reason. Just not possible. He then remarked he had disliked the patient so much and he seemed to sum up what was wrong with psychiatry; why was he seeing someone with no mental illness.

I said it did seem like he was describing having to risk-manage this patient only. I tried to lead the conversation away from a general one. He nodded and said he felt ashamed actually at what he had done and then baffled as to why the consultant kept the patient on the ward. And angry. So angry. This was very unusual for him he said. The member previously mentioned reverted to 'the system' and how cruel it was to her and the others. I could see they were about to

go off again and I said maybe could we think about that this doctor had said at the beginning: he would be finishing his training and maybe with this patient he was also thinking what would he do as a consultant when the buck stopped with him. Silence and irritation, I thought. Then the presenter said: 'I worry about having to take these decisions as a consultant as I feel there is no support from the Trust but I also suppose I was ashamed of myself here and frustrated with myself at not being able to do what I knew was right and was my opinion'. Then there was some sadness and talk about how the patient had intimidated the doctor or tried to control him. He agreed that that was how he had felt but couldn't get at it then; instead, he had just felt really angry and wanted to lash out at this man in a way to really punish him. Then it ended.

My reflection on the process of this group would be: the hidden feeling for both the doctor and patient may well have been one of shame and humiliation at the position they find themselves in and their powerlessness therein. Both are hard wounds to one's sense of self to bear and very painful feelings. My impression was that the doctor felt more and more ashamed of himself, but that was the painful feeling he had to be left with, to do with as he could. Anger and outrage projected outwards are defences against those more painful feelings. Now my job was to bear and play with the feelings I had to try and metabolise them to get to a position where something split off could be kept in my mind and eventually I could say something where a more open possibility might arise in the group.

There are many things in this group which I could focus on. This group usually works well and creatively together. Yet, on this occasion, the group went away from that usual pattern. How do I understand why I was under the sway of very strong feelings for the majority of the group and struggled to be benevolently thoughtful? It took me very long to remember this was a group that worked well not a group of cowardly self-serving creatures.

Enid Balint once made the point I think that Balint groups are essentially countertransference groups. But how do we make sense of that for ourselves as leaders?

*

I would like to draw on a few basic orienting quotes from Balint.

Balint groups and seminars are guided by simple and elegant concepts: 'this is to examine the relationship between the doctor and the patient, to look at the feelings generated in the doctor as possibly being part of the patient's world and then use this to help the patient. If these feelings do not seem to belong to the patient but to the doctor it helps to know that too, to be a participant in a relationship and its observer is fraught with difficulties and potential bias. The aim is to study this (bias) carefully. As a consequence, the doctors can take the feelings that arise from their work seriously and pay attention to much that would otherwise be disregarded' (Balint, 1964).

The Balints were the first to introduce the idea of the participant observer into the area of clinical medicine: 'whenever doctors use their feeling as a tool as a personal internal barometer, they open themselves to the kinds of error to which any instrument is prone. What troubles the patient may be obscured as the doctor picks up other sounds, they may arise from inside the doctor patient interaction or they may be extraneous.' There are various psychoanalytic constructs that underline this idea theoretically, the main being the transference and countertransference.

If one listens carefully to the feelings that are presented in the telling of the dilemma, one might get a sense of what is going on in the doctor-patient relationship, hidden out of view. I think this is very clearly picked up in the emotional tone or atmosphere of the consultation which can be communicated to the group and become the group atmosphere. It then influences the subsequent discussions and feelings. The countertransference of the group leader might be

described as feeling the subtle unconscious ways we are pushed to re-enact and react to formulate scenarios with our groups that come from the patient's past, or the presenter's conflicts, or group member conflicts, or our own conflicts and biases.

Technically you could see Balint groups as countertransference groups. I find for myself that my countertransference feelings orientate my interventions much more than the verbal material. It may determine the selective facts I pick up to intervene on or the tone or the way in which I intervene.

*

I would like to look theoretically at both the notion of countertransference and the notion of what we might be doing as Balint Group Leaders in a Balint Group. Here, I want to acknowledge a debt of gratitude to Jane Dammers, who, as President of the Balint Society UK, was very gracious in encouraging my view that, as leaders , we had to have a dialogue with theory and see to its evolution in order to conduct alive Balint groups.

If I think about countertransference first, up until 1950 Freud and Klein had both held the position that feeling strongly in consultations, or feeling at all, was a deficit in the analyst. The analyst should go back and explore what it was about. And so the idea of neutrality was idealised and paramount. In the 1950s, in Britain, Paula Heimann wrote that actually analysts in consultations did have feelings and they could be of use. I think both are very important to think about theoretically. Sometimes the analyst or the Balint Group Leader can have a personal countertransference, a reaction against a transference in response to the group, that is the analyst's personal conflict zone or one of the analyst's personal conflict zones. That is one type of countertransference. It is literally transference to the emotional goings on in either the patient or the group or a particular group member. That is one that needs a particular form of thinking about as the analyst or group leader will contaminate the group if it is left un-metabolised or acted out. In this group I

have to wait to figure what it is about one particular group member that I so dislike that I act out by overcompensating and offer every benefit of doubt to them.

*

What has taken over in people's thinking is that countertransference is always of use in thinking about the patient. All these have become a bit clichéd. One error is that everything has to do with the patient; this neglects the fact that in any countertransference there are conscious and unconscious elements. One has to do quite a bit of work to get at what might be the underlying conflict or feeling rather than just taking the surface feeling as what is going on. There is a story that I am not sure is true about Klein, but I certainly have been told it in the British Psychoanalytical Institute. Somebody went along to her and said 'I felt sick and the patient was making me sick' and Klein said 'No, no, my dear, that's indigestion'.

I think she was making a very valid point that actually one shouldn't confuse what is yours with what is the patient's, and if you start to feel something in the process of professional activity then one has to feel foremost, and then think and work at what it is: what it might mean and how much is one's own and how much belongs to the scenario that you are involved in, be it a Balint Group or individual work with a patient. Irma Brenman-Pick wrote a paper, 'Working through the countertransference', and then a second paper 'Further working through the countertransference', because she was concerned by the fact that everybody was taking a linear view of what she was saying that if you feel what the patient has put into you, that is working through. I don't think that that's what she meant, there is something way subtler here. What is implicit in the British Psychoanalytic tradition at the moment is that the feelings in the analyst, therapist or Group Leader may indeed be very important to the split off parts of the patient and subsequent projective processes that are happening in the room. It is the job of countertransferential work to get at what might be happening in that. The other possibility of course is that one can act it out without knowing it. It is my stance

that there are always unconscious processes going on. There are some situations where one is trying to catch them and let them come to the fore, and then let them be elaborated and worked through. That will then lead to a greater understanding of either yourself in minor key, but more importantly to greater understanding for the group/person with whom you are meant to be working with. Therefore, this work is done in the service of the patient. I think it is about letting oneself entertain the feelings and associated thoughts and ideas, but keeping them in the position of potentials, which is very similar to Balint idea of the participant observer stance. To be in it and not taken over by it is the key.

I have noticed two things in thinking about Balint Groups. One is that we are told a story in a Balint Group about a certain doctor with a certain patient in a room, sometimes with a family involved, sometimes with a team involved, and they are part of the story. A second thing to notice is the atmosphere that is created. I have noticed in groups that frequently it is the atmosphere that is never commented on, never thought about as having merit to the doctor/patient relationship. Certainly, the thing that is almost never commented on, no matter how obvious it is, is the attitude the doctor demonstrates to the patient non-verbally. By this I don't mean how they sit and how they look and make eye contact. I presume that's part of it, but GPs are pretty tortured by these things in terms of their video supervisions and so on. What I am talking about is something more subtle in the way they use words and the tone of voice and the emotional tone. They conjure up something about the atmosphere and the situation.

This, I believe, has an impact on the group and because we are in the presence of these very sophisticated youngsters who want to convey that they are not that sophisticated. The idea of saying what you actually feel or what you actually think is not common at all now in medical education and it is seen as a bad thing: all speech has to be very bland or correct in a way. My consultants keep saying, for instance, 'a 43-year-old lady/gentleman…', so a large part of the group

is frequently getting through formulaic phases, like challenging or frequent attender, or a rationale stance with patients, even if they are obviously troubled. But what happens when the group is happily caught up in an agreement on what is happening with the doctor and the patient, while the Group Leader has a very different impression of the consultation? This is the case in my example. The group leader is sitting with feelings that they consider part of the consultation, but which have been – if you want to be technical – split off and projected into them. It is a very difficult situation because you might not have any material in the group to comment on, but at the same time somehow you have a bit of a conviction that something is being omitted. One can be left, or saddled with an odd set of feelings.

For me the first step in thinking about my countertransference is a developmental one. I have been a Consultant for 23 years now and am coming up to retirement. I have got to be careful that what I think isn't necessarily what's happening because I am not at the same developmental level as these junior doctors are and introducing something too far ahead may not be in any way helpful to where the group is. Some Leaders are very silent and let the group go where it goes. I think that is admirable and something I've never managed myself. Other people feel it is quite important to reintroduce into the mixture, in some tactful way, the possibility that something might be missing from the group and I think it is important. But the question is how one does that.

Countertransference is not a neutral thing: a lot of the time it is manageable and you metabolise it with some effort, automatically and sympathetically. But there are other countertransferences that demolish sympathy for the presenter or for the group and one is invited into a very different emotional territory. I see it much more in the 'paranoid-schizoid position', but one has to struggle with very strong judgemental harsh attacking feelings. This may not happen with everybody – it may be part of how I deal with it – but then one has to be very thoughtful about what one might say and how one might say it. Frequently it comes out in my tone.

Then one is left with a group of young people who have been told what to do or grandstanded at by a senior Consultant and it stops all creative discussion. They are much more likely to comply and go down that route, but not really learn anything because actually where they were going is not where I was going. At the same time, the place sometimes where they are going is not a place where they should really spend too long in, but you might need to let them spend some time in it to move on to somewhere else.

I am thinking here of Esti Rimmer's paper on the containing function of a Balint Group Leader. If one has sufficient trust in the process, then one might think: 'Well, this is going to come out at some stage', and one just waits. I think the problem with trainee groups is that they are not coming to you for long enough. The Foundation Years come for four months, the Core Trainees for a year. The Specialist Registrars come for three years, so this does give you a chance to sit back and see what evolves.

The first step in any dealing with the countertransference is to try and see what sort of narcissistic investment one has in what one is feeling and, in particular, how much one adopts a subtle high moral ground or a subtle 'Let me demonstrate to you where I am at' stance. Whenever I detect that in myself, if I detect it in time, I shut myself up and try and wait. Frequently, that effort of waiting is worth it and usually something comes out; or my co-leader will come up with something more thoughtful and more benevolent. There are times when one isn't able to last. There are other times when one can get hold of something and the question is how does one tactfully introduce it as a possibility, rather than introducing it as an instruction from a senior person. How does one introduce the idea of opening up the space for wondering when one might be very far from that space oneself?

I have found that the easier set of feelings to deal with are the denied or disavowed negative feelings that young doctors bring to groups. I have found that if one can, in a kind of neutral way, realise that there is the possibility of negative

feelings and that they are not terribly bad, one can introduce them. The group members tend to run with that and there tends to be an ambivalent discussion. I think the outcome of a good intervention is to get both sides of a possibility explored and not sorted. I don't feel I am forcing something, I do genuinely feel like there is something that they are hinting at, that they want to discuss, but that some part of them cannot allow it to come in. Sometimes if one needs time, if there is a particularly brave member, they might bring it up. One can support them a little bit and support that possibility.

There is another set of feelings about tenderness and sexuality. They can be split off, and one has to keep aware of difference. The difference in race, culture and sexuality. Sexuality is a particularly big one because it is one that people tend to underestimate quite a bit. I am not saying racism is over-estimated, I am just saying it's the one people don't tend to think about in partnership with the doctor/patient relationship and linked with sexuality in a more ordinary way. A fact to consider is that you have young doctors with young bodies and young minds and young healthy attitudes to things usually (or not), who are in a room with people who are either physically ill, or mentally ill, and who haven't had the same trajectory as them. One has to keep in mind the possibility of the patient being envious or jealous of them and of that envious feeling influencing the consultation.

I think doing groups with trainees/medical students requires a slightly different application of the Balint Leader stance. I find I talk more and describe what might be happening in the consultation or in the realm of feelings much more. The aim is to free up something, particularly in the realm of feelings that can't be spoken about, but are implicit in the way the consultation is being described or in the material of the consultation. That intervention may allow them to begin to play a bit more and free-associate or say more honestly what's on their mind.

He describes the listening required of the clinician and the similar task of the leader. Both are stated with the admirable simplicity and brevity born of long thoughtful experience. He pinpoints accurately that it is this listening to the language of the unconscious and saying enough to open up something potentially new that is important. It is not interpreting or translating, on the part of the analyst/Balint leader, into clever interventions or phrases that is essential, but more an openness to not teach or suggest, to wonder about something that strikes them in the emotional atmosphere of the case and the doctor patient relationship, and the way the story is told and received by the group.

He is kind and, I think, respectful of the fact that analysts are trained to especially listen for and to the unconscious but also clear that it isn't a preserve of psychoanalysts. In Balint groups, it is something one can develop and refine with the help of properly trained leaders and contacts with interested psychoanalysts.

Today there are a number psychoanalysts involved with the Society and trained as Balint leaders, so we are once more in a position where a new fruitful dialogue about listening might take place. This time I think it might be with psychiatrists in the main and their clinical work though hopefully more GPs will re-find Balint.

This paper would be helpful to the many people who lead Balint groups who have not had much contact with trained leaders as it gives them a clue as to why it's important to maintain the links with psychoanalysis and the language of the unconscious.

References

Balint, M. (1964). *The Doctor, His Patient and the Illness.* London: Pitman.

Brenman-Pick, I. (1985). Working through in the countertransference. *The International Journal of Psychoanalysis,* 66(2): 157–166.

Heinmann, P. (1950). On countertransference. *The International Journal of Psychoanalysis,* 31: 81-84.

Salinsky, J. (2022). Invitations to a Balint Group: Let me count the ways. *Journal of the Balint Society, 49: 61-70.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Invitations to a Balint Group: Let me count the ways…

John Salinsky[1]

[1] Balint Groups Leader, former President of The Balint Society UK: jvsalinsky@aol.com

(Variations on the reminder to attend the next meeting of the Wembley Balint Group)[1]

The Wembley chapter of the distinguished physician, mental philosopher and scholar, the late Dr Michael B, who hath instructed us to assemble in small groups by means of which our patients and clients will prosper in the emotional and spiritual spheres (indirectly) and ourselves (directly) through the limited tho' considerable transformation which was promised us if only we will sit in a closed circle, bespeak our narratives and hearken diligently to the wisdom of our comrades allowing meanwhile the process of free association to cross-fertilise our cerebral apparatus (and especially the *Amygdala*, widely agreed to be the seat of the Emotions, or if it be not actually *There*, 'tis is doubtless somewhere Nearby (I cannot be bothered with too many neuro-anatomical niceties) politely and respectfully request your presence in the Chalkhill Foot Locker at 8 o'clock on Wednesday 27 February 2019 where you will be most welcome.

Dear All
Wembley Balint group will be convening, conjoining, communicating, cogitating, confessing, comforting, counselling, connecting, conniving, confederating, contemplating, collaborating, conspiring, continuing, co-facilitating, conglomerating and coagulating
once more on
Wednesday 13 March at 8 p.m in the Olde Shoe Boxe at the Welfordde Centre
Contrive to Come if you Can!

[1] John Salinsky is currently leader (with co-leader) of local Balint groups for the last 15 years. GP Principal (1972-2018). Past Programme Director, Whittington GP Training (including Balint groups). Past president of The Balint Society. Past editor of The Journal of the Balint Society. Past treasurer and secretary of the International Balint Federation. Honorary founder member of the American Balint Society.

Dear All

The Wembley Balint group will resume, rezoom, revive, reappear, regenerate, reconfigure, reshape, reposition, renew, resist, relax, relate, respond, reveal, restore, realise, resolve, review and return on Wednesday 18 November at 8 p.m.

Rejoice!

ReJohn

***

July 1st, it being, as I believed, a Wednesday, I had engaged, as usual, a coach and two horses to take me to Wembley, there to attend the Balint Society of Physicians and Philosophers at the Foot-doctors Antechamber. But my wife did remind me, in time, that the place remains unsafe on account of the plague still raging, The coachman arriving at my door, I did tell him that I should not be needing him. To my annoyance, the surly fellow protested and would only be appeased on receipt of a five groat peece. He having gone at last, I addressed myself to the little glass plate kindly installed by my friend, Sir T Berners-Lee, of The Royal Society who hath devized an ingenious method that he calls the *Inter Nett* whereby an imprint of my image and the sound of my voice will be carried, (by what means I know not but it is exceeding clever) through the *aether* where it may be seen and heard by my friends, attending similar 'screens' so that we all may hear and see these *apparitions* of each other.

I did need only the secret code of admission, provided by My Lady Joan, our ingenious hostess. It was writ on a paper delivered this afternoon. I being unable to find it, however, and in much distress, my wife called in our servant girl who, like many of the youth of this town, was able to produce it on my 'screen' by a few taps on the machine's letter board whose inner workings are, I confess, beyond my wit to decipher. My wife, did then kindly point out that, it being only Monday, there remained yet two daies until the Meeting. So, resolved to possess my soul in patience, and instead conjur up on my screen the latest play being streemed from Drury Lane...

***

(With apologies to Fred Astaire)

You just got an invitation through e mails:

'Your presence requested, Wednesday evening,

It's Balint! Wear your top-hat, white tie and tails.'

Nothing now could take the wind out of your sails;

Because you're invited - to step out We'n'sday evening

And listen to your colleagues' tales.

'It's a-bout this patient-who

Is driving me

Out-of my mind.

Everything I've- tried has failed -

No sol-ution can-I find.'

So we listen carefully

Weigh up every word

Analyse the feelings

They will leave us stirr'd

And so:

We're steppin' out, my dear,

To breathe an atmosphere

That simply reeks of Freud!

And when the evening's over

We'll feel so much better

Maybe even overjoyed.

So come along on Wednesday

Never mind the Autumn gales

And don't forget to wear your top-hat,

white tie and tails.

***

Molly eavesdrops on the Balint group

Yes because I never did a thing like that before so it was quite a shock I was just playing about on the computer and didn't I find I was watching one of those zoom things is it some kind of secret cult I dont know they were all sitting in little boxes with their names on having a hilarious time men and women well live and let live I say but it was a shock when I saw my doctor from the surgery was there and he was talking about some weird woman patient sounded a bit like me and then I thought blimey it is me I thought I shouldnt really be here but you cant help being

interested that doctor whats her name the woman I Iike her better because how can a man really understand what we have to go through but she never has any appointments left I call them appointments but its just a phone call these days unless they call you in and that I dont want because it might be serious so now another man is saying he wants to know more about me and they start on about what was my childhood like I could tell him a thing or two but they never ask and anyway it wasnt that I phoned about I expect theyll get it all wrong oh bugger its all gone but one of them said theyll be there again on wensday27th january so maybe ill look in again its a change from bloody netflix yes I will yes.

***

Ladies and Gents.

This is your captain speaking:

Wembley Balint takes to the airwaves again this Wednesday. Boarding will be at 8 p.m. Your individual seats have been assigned and well-spaced out to ensure comfort and safety. We shall be flying over the Relationship Islands with excellent views from our virtual windows. We will pass through thick clouds where visibility will be restricted and everyone will feel confused (including the pilot) but there will also be rays of bright sunshine illuminating the foothills of Realisation. Please bring a Case on board with you. This should be placed under the seat in front of you so that it can be easily accessed during the flight.

On behalf of Balint Airwaves, may I wish you a pleasant flight with intervals of creative Turbulence.

***

If you're blue

and you don't know

where to

go to,

why don't you go –

where the little group sits?

Down at Mike Balintz

Boom, boom, boom, we can go zoom, zoom

To that little virtual room

Where the gang all sits.

You can be a thoughtful Balint grouper

Tryin' hard to look like Gary Cooper (super duper)

So come let's talk and listen well

To the tales health workers tell

Of the sad yet well-to-do

Strolling down Park Avenue

and the mad and anxious too

Down at the Balintz

Mike and Enid showed the way

Now lets all Zoom in and play

Groupin'. at Balintz!

8 p.m.Wednesday, you know where

We shall meet up then and there

Puttin' on Balintz!

(Lyrics by John adapted from *Puttin' on the Ritz,* Music by Irving Berlin)

***

We can't Balint face-to-face

But we have a *virtual* space

Virtual Balint? Don't disparage

Leave your motor in the garage

You don't have to drive to Wembley

(That might make your knees go trembley)

Stay at home and join the team

Sitting in boxes on the screen.

And if you have a case that's sticky

Bring it on! We are not picky.

Our discussions disentangle

relationships that used to rankle

And

When all is done and said -

You can simply go to bed!

***

Soon shall arrive with earth's rotation black of night when we on winter wednesdays have been wont to wander wembleywards in way of wisdom. Then would fingers freeze and faltering footfalls fail. Balint's beneficence we besought betimes! Yet rash to risk our softish selves and blundering bodys on slipperie surfaces at stupydde speed!

But now with lockdowne loomynge, in own lodgings linger we, from covid cringing. Staring at screens facsimiled faces find we of friends far flung! In virtual view with vibrant voices, gladly gathers our gregarious group. Patients peculiar with perplexing payns and personal trayts praeposterous we present and, in melodious murmuration, our meditations merge. Solutions seldom surface yet, when closure comes, gratitude, for good gains, we oft-times feel!

***

Just a group at twilight

when the light is low,

And the doctors gather

in the waiting-room we know.

Though we all be weary

and the day's been long;

we can share our stories

From the surg'ry's busy throng

Deep in our hearts,

these patients seem to dwell;

Our friends understand us,

they've been there as well.

So the talk continues

with some insights (and some fun!)

Time passes quickly,

Soon the group is done.

Just a group at twilight

now the sun has set.

Still we've learned a few things

that we shall not forget -

that we - shall - not - for-or-get!

(See YouTube: Love's Old Sweet song (Just a Song at Twilight) J L Molloy)

Still images from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970. A doctor present with notes, uncharacteristically.

Dunleavy, D.L.F. (2022). Experience of the Group Leader, 1976. *Journal of the Balint Society, 49: 72-80.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Experience of the Group Leader (1976)

D.L.F. Dunleavy [1]

[1] Senior Lecturer in Psychological Medicine, The Royal Victoria Infirmary, Newcastle

I like to think of myself as something of an expert when it comes to running groups. At the outset I was confronted by three difficulties in describing my experience with our seminar in Nottingham. The first problem is that it is still developing, and it would be premature to talk about a number of things at this time. The second problem is that I relinquished leadership three weeks ago on taking up my new post in Newcastle. The third difficulty, however, looms much larger, and those of you who have been members of a seminar will understand my problem. We have developed a very close group-identity and at an emotional level it is almost like betraying a trust when one comes to talk about ourselves to outsiders. There is a part of me which does not wish to share our experience with others, and a feeling of guilt was hovering in the background while I prepared this paper. I have, I hope, successfully resolved some of this conflict, and would now like to describe my personal experiences in three ways. First of all I would like to say how I personally came to have an interest in this type of work; secondly, what I felt I had to offer; and thirdly, to share some of the seminar experiences.

My involvement

I had been intrigued for some time by Erikson's writings on developmental and accidental life crises. He talks of the time when one becomes engaged, when one marries, the first day one's children go to school, etc., as normal developmental life crises. Accidental life crises would be the death of a loved one, one's divorce, possibly a car accident, or a period of severe sickness. At these times of crisis the individual is likely to fray at the edges a little. He is much more vulnerable to other stresses impinging upon him, and the probability of decompensation increases with the number of things he has to cope with at this time.

---

[1] First published 1976. Vol. 5, *Journal of the Balint Society.*
At the time of publication, D.L.F. Dunleavy was a former Lecturer in Psychiatry at the Nottingham University Medical School and a Senior Lecturer in Psychological Medicine at The Royal Victoria Infirmary, Newcastle.

However, although there is a potential for destructiveness at these times, there is also a potential for growth. This idea became linked in my mind with Caplan's work on crisis consultation. His idea, basically, is that minimal intervention at these times can be of major benefit to the individual. I always remember one of his encapsulated statements which I feel I should have framed on the wall of my office. He claims that 'excellence is the enemy of the good'. I understand him to mean by this that we should be prepared to do a little even where we realise much more is called for. If we could do this little amount of work at times of crisis our efforts would be rewarded to a much greater extent.

As a psychiatrist, I am also aware that we deal with only a small percentage of the psychological disturbance which exists at any one time in the population. In fact, it has been shown that referral to psychiatric agencies is very idiosyncratic, and it is very hard to tease out why one person ends up seeing a psychiatrist, and another does not, although both may have the same symptomatology. We are also much more removed from people, while the general practitioner is on the spot. Unfortunately he is all too often literally on the spot! If he could be trained to be more psychologically aware of current life stresses and how they act on the individual, his intervention at these times of crisis would hopefully be more effective. The Balint type of seminar seemed to me to be the best medium for developing this expertise.

What did I have to offer?

I had been involved in therapeutic groups in Edinburgh over a four-year period. For two and a half years of this time I had been supervised in a group by Dr J.D. Sutherland, who has been a great influence on my orientation. He has been concerned for some time that psychiatrists may not be involved where they are most needed. He feels that we should act as consultants to the people who are performing caretaker functions in society. In other words, we should be talking

about their case work with general practitioners, social workers, and other community workers. There is no doubt that there is a great demand for this form of consultation from people who work in the community, and also from their clients. The latter often speak through the bulletin of the National Association of Mental Health, 'Mind', and what they have to say makes alarming reading. Psychiatrists, because of their field of work, should have an expertise in this form of consultation, but unfortunately it is true to say that many of them do not.

As an academic, I am also interested in small-group teaching and, fortunately, much of the undergraduate teaching in Nottingham occurs on the small group-seminar principle. Dr Skinner has described how he was interested in starting a seminar in Nottingham (p. 18), and I felt that I might be able to act as a resource person for this group. It was fortunate for me that I happened to be in the right place at the right time, as the intended seminar combined my interest in teaching and doctor/patient interactions.

Personal experience of the group

I will discuss this under two broad headings: firstly general problems that remained with me throughout the seminar's duration and secondly, specific problems that arose at different stages in the development of the group.

General problems

a) Isolation

The first thing I would like to comment on, in my personal experience of the group, was the experience of isolation. I did not have a co-leader, and in retrospect this was clearly a mistake. There were many occasions when I did not know what was going on, and on other occasions so much was happening that it was impossible for one individual to absorb it all. It is very necessary to have some sort of sounding-board where one can discuss one's ideas, or possibly have one's own

feelings reflected back. Most writers on group work talk of the absolute necessity for ongoing supervision and consultation. This is one of the problems, of course, of any type of work in the psychotherapeutic field outside London. There are few people with whom one can discuss one's involvement, and I grasped avidly at any opportunity for discussion when I met friends who were involved in psychotherapy.

b) Anxiety

I had realised from my experience in therapeutic groups that the leader often feels anxious about his abilities. This of course may be a very realistic appraisal of one's own talents, but one also becomes very much involved in group processes. When the group is in a despondent stage one becomes 'infected' with feelings of hopelessness. One doubts one's own ability and questions whether one has the skill to deal with particular situations which are being presented. One feels that here are people who are giving up their valuable time and are eager to learn, and one has nothing to impart to them. Fortunately my natural buoyancy reasserted itself at these times, but there were occasions when I went to the group with reluctance, or went home biting my nails. It is not very pleasant having your identity threatened, and here again, discussion would have been helpful.

Specific problems to the Group

a) Name

This caused a great deal of frustration in the initial stages of the seminar, and illustrates once again some of the bureaucratic nonsense to which Dr Skinner has already alluded. We were billed on the noticeboard in the Postgraduate Centre as 'Psychiatric Tutorial'. This annoyed me considerably as I did not feel that my function in the seminar was in any way connected with teaching psychiatry. Neither did I feel that I was going to teach psychotherapy directly. I was interested only in looking at the doctor/patient relationship as it was expressed in ordinary,

everyday general practice, and I had been at great pains to spell this out in the prospectus which was distributed before we established the seminar.

After some exchanges, we thought we had arrived at another, more appropriate title, i.e. 'The General Practitioner Group'; however, we were eventually billed, to my chagrin, as 'The Psychiatric Group'. At this stage we gave up. At least if nobody else seemed to appreciate our purpose we, in the seminar, felt that we shared a common ideal.

b) Tape Recorder Incident

Research work has shown that recall of group meetings is very fallible, and quite significant incidents are often forgotten and possibly repressed by the leaders. Having a poor memory I decided to tape-record the seminar to facilitate my own thoughts about the group afterwards. Unfortunately, I did not take a tape-recorder to the first meeting, but brought one along to the second meeting and left it on a side table, and discussed recording the seminar with the members who were already in the room. As luck would have it, there were two latecomers, one of whom had had previous experience of seminars.

Without any disrespect to other members of the seminar, she was the most experienced member in psychodynamics. When this individual noticed the tape-recorder, paranoia became rampant, and there was a heated, irrational discussion. I eventually capitulated and said that I would not record the seminar. This was my first serious mistake - she had made a successful bid for leadership of the seminar, and was colluded with in this by the rest of the participants. I was shown up by this event as having clay feet, and this, allied to my youthful appearance had, I feel delayed the development of the seminar for a considerable period of time.

c) Attempt to Become a Therapeutic Group

Michael Balint has described in his writings the drive which was shown on many occasions in his seminars to turn them into therapy sessions. Although I had an intellectual appreciation of this, I did not anticipate that this impulse could be so

strong. On several occasions in the first trimester members expressed a wish to discuss some of their personal difficulties, and was met with great hostility by the other members of the group when I forcibly intervened and stated that this was not one of the aims of the group. I had to reiterate on a number of occasions that we were going to discuss cases in the group, and this was our only function.

Dr Skinner, in one of our private conversations, spoke about the function of a referee. If he is to function effectively he must stamp his personality on the game in the first few minutes. This principle applies also in a group situation. The leader and the participants must establish the norms of the group in its early phase. In dealing with the tape-recorder incident I failed to be sufficiently positive, but in stating the manner in which the group was to function I was quite adamant. Often we seem to become so preoccupied with internal reality that we do not deal sufficiently firmly with external reality when it intrudes, and there are some situations where one has to put one's foot down.

d) Visit of Dr M J Courtney

Most groups have a natural evolution. The initial phase is one of questioning and establishment of group norms. However, this is followed by a period of unquestioning belief in the omnipotence of the group's experience and existence. This is a period of unbounded optimism, when all problems are going to be solved by the magic of ‘groupness’. Inevitably reality reasserts itself after a varying period of time, and there is a decline in group morale, with loss of confidence us the group itself and in the leader. There is a great deal of questioning as to whether the group is of any use, and the group itself is pervaded by a lack of direction and hopelessness. This period characterised the third term of our group, and it was interesting that at this time when the group had lost confidence in me as a leader, an invitation was extended to Dr Courtney to come to visit us. His visit happened to coincide with the last meeting of the first year of our group.

The meeting itself was memorable for the activity of the group. They were more animated than I had seen them for many months, and were on their best behaviour in order to show our visitor how much they had gained from the group experience. He gave his 'apostolic benediction' to us, saying that he had felt very much at home, and that we seemed to be following Michael Balint's principles to the letter. There was a post-group rendezvous at the home of one of the members, and the evening could only be described as manic. Great optimism for the future of the group was expressed, and we all went off on summer holidays with the feeling that confidence in the group itself had been restored.

e) The Case Material

I was unprepared for the sort of material that members brought to the group; I had expected we would discuss ordinary, everyday exchanges in the surgery. However, with monotonous regularity, case after case with severe personality disturbance was produced. Readers will be aware of the YAVIS type of patient, i.e., the young, attractive, verbal, intelligent, and successful patient. If you have to select a patient for psychotherapy the nearer you approach that ideal the more successful will be the outcome. All the cases I heard about seemed to be non-YAVIS and conformed more to the stereotype of the patient that a skilled psychotherapist would have difficulty in managing.

I am a great believer in the principle of preserving oneself, as it is only in this way that one can be of benefit to other people. Attempting to take on too many insuperable problems would tax the already strained timetables of general practitioners, even if it did not strain them emotionally.

f) Group Identity

The group has, as expected, developed its own form of communication and culture over a period of time. Initially we seemed such a heterogeneous group and it was difficult to see how we would ever get to know each other. We have now shared many experiences, and it is noticeable when we get together that one stimulus word

or phrase will unleash a variety of emotions and recollections. In a relatively short period of time we became very cohesive and the group bond is now so firm that the original seven members of the group are here tonight!

Summary

In conclusion I would like to say that I have found this a personally maturing and very rewarding experience. It has emphasised for me the difference between community and hospital practice. I have been frequently amazed at the difficult type of patient that the general practitioner has had to continue seeing, as he cannot pass the buck! I feel that this type of seminar helps enormously in understanding and tolerating the emotional demands which are made in the doctor/patient relationship. I hope we have achieved that in Nottingham, but only time will tell.

Courtenay, M.J.F. (2022). The Role of the Balint-Group Leader: A Critical Re-appraisal, 1985. *Journal of the Balint Society, 49: 81-89.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

The Role of the Balint Group Leader: A Critical Re-appraisal (1986)

M. J. F. Courtenay[1]

[1] GP, London

My re-appraisal consists solely in relation to general practitioner Balint-group leaders, as I still believe that the primary model of the Balint-group leader is of a psychoanalyst who understands the general practice setting. Our problem as general practitioner Balint-group leaders is that we, broadly speaking, are not psychoanalysts and are too deeply identified in the general practice setting, in which we do our daily work. Although we are not psychoanalysts, we must have absorbed, perhaps by a process of psychological osmosis, something of the analyst's understanding of unconscious processes. Without a training analysis and the supervision of cases in that discipline, it is difficult to validate the general practitioner leader's qualifications to be a Balint-group leader. I certainly could not validate my own credentials. I have been encouraged by Enid and my dear late friend and colleague Mary Hare, to accept that I have some understanding of unconscious processes as revealed in group-work, although I often remain sceptical myself.

The Society is honouring me in asking me to give this talk, and I have been touched by some personal apologies from members who cannot be here tonight. It is perhaps these mundane events that make me reflect on an interesting parallel. Many of you are apparently approaching this evening with the unrealistic and idealised expectations that the Old Guard (of which I am not in historical terms a member, though they often seem to forget it) approached Michael and Enid in that first seminal seminar.

We somehow expected the Balints to tell us the answers to those questions we raised about our work, even though we knew they were not general

---

[1] Paper read to the Society on 26 November 1986.
First published 1986, Vol. 14, *Journal of the Balint Society.*

[2] At the time of publication M.J.F. Courtenay was a General Practitioner in London.

practitioners. In your sober moments you know perfectly well that given your long experience of working in Balint-groups with many leaders that I am not in a position to tell you anything you do not know already, and that my best hope is to shine a light on our work from a slightly different angle so that you will be able to say 'Of course I know that!' And of course you do.

It is in the preparation of this talk that I have perceived in one of the great Balint exhortations, 'Have the courage of your own stupidity', a deeper level of truth. I am courageous, sitting here in front of you, not because I know more than you, understand better than you, or lead a group more competently than you, but because I understand the word stupidity more deeply. I know I am stupid, but the Balints have allowed me to come to terms with it — I understand more about myself as a doctor (and as a person come to that), and have learned to live with it better. In Enid's words it concerns the naturalness of man himself, particularly the aspects which seem most irrational and unacceptable.

You are now, I hope, fully prepared for that sense of anticlimax which is bound to descend on you as the evening advances. Jack Norell posed the question to the Leaders' Workshop 'What is the essential role of the group-leader?' My reply would be 'the encouragement of a “safe” atmosphere for the doctors to explore their own personalities interacting with their patients, so that they may become more flexible and develop new skills in dealing with patients as people in distress! That's a tall order, and it obviously needs putting into Anglo-Saxon. Perhaps, in simpler terms one might see the leader's role as freeing the imagination of the members of the group, with the hope of reducing any rigidity in them, while at the same time protecting them from personal overexposure. The leader must not be too authoritarian, but always responsible for what goes on in the group. He may be wise to eschew

psychological obita dicta, but on the other hand a short burst of 'teaching' may be entirely appropriate. This does not mean that he has to expound any theory, but boldly say what has to be said if he feels the group is going down the wrong path; calling every patient 'manipulative' for instance.

The introduction of such jargon, especially if pejorative, can easily become a canker. The problem is that, especially with a new group, there is a great pressure on the leader to 'succeed', whatever that might mean. Principally it may mean that the group should not fall apart or leave. This tends to promote too much activity on the leader's part, 'trying too hard' in fact, and we all know what that does for our tennis shots! If one looks on the continued life and growth of a group in the same way as one might approach a patient seeking self-understanding and personal growth, it becomes obvious that the leader must aim at an active passivity, tuning his third ear to all that goes on in the group, whether it be the kind of case presented, the reaction of the members to the case material, the presenting doctor, and each other. For instance, is there a resonance between the patient's problems presented and the doctor's own? Do certain members always behave in a particular way, and what does that mean?

A problem which may persist for the leader is the temptation to treat the presented patient, rather than lead the group. This is a bunker which seems difficult to get out of. I have observed it often in the Leaders' Workshop, and even by experienced analyst Balint-group leaders commenting on demonstration groups at International Congresses. The problem is that the leader must make a diagnosis of the presented patient quickly and privately, and then use this in terms of the group-work only. That doesn't mean the leader will understand the case perfectly, and may often miss aspects which group members discern, but that is how it should be. However, it does allow

the leader to formulate what he would like the group to learn from the presentation of the case.

But apart from listening to all that goes on, the leader must also listen to what is not said. Such negative findings can be as, or more important, as what is actually said.

With regard to the interaction of the group, there must be a constant watch on any vicious tendencies which may arise, and need to be countered, and the difficult line between constructive confrontation and open aggression must be drawn and held.

Even group interpretations may occasionally be useful, though their use should probably be sparing if avoidance of a therapeutic group is to be achieved. Other questions are thrown up: What should govern the nature and frequency of the leader's remarks; by what criteria may a leader judge his/her effectiveness at the end of a meeting (or in previous meetings)? But these expose the problem, such judgements can only be retrospective and applied to a particular group session or series of sessions. Making plans in a vacuum is a meaningless exercise.

But this is all old hat, and rather than listening to me developing this in detail, I should like to try a participatory exercise, to see if it is a useful analytical exercise (using analysis in the vernacular sense). I have asked the members of the Leaders' Workshop to bring a case, and I am now going to invite them to come into the centre in two interlocking circles: the inner one representing group members, and the outer one, leaders. I am going to hand them each a little folded card, inside which is written an 'instruction', if they will bear with me using that word. The presenting doctor will be presenting a genuine case, but all the other members of the group will be behaving in a manner distorted by my instructions. Each of the leaders will have received

instructions which request him/her to concentrate on one particular dimension of the leadership role. I shall attempt to act as master of ceremonies, and we can arrest the process to discuss anything that arises, or wait until some time has elapsed in the group-work and discuss the various points which have arisen. So, let's try it.

The members of Leaders' Workshop present were invited to sit in the inner ring of a fishbowl arrangement. They were then handed small cards, alternately to a doctor who would be a groupee (presenting group-member), and a leader, so that in effect the group was made up of nine groupees and eight (part-time) leaders with the author as master of ceremonies.

What was written on the cards appears in the Appendix. The first case discussion (at a time when nobody in the inner circle knew what was written on the cards other than the one held in the doctor's hand (and all totally unknown to the outer circle), proceeded remarkably similar to a real Balint-group discussion. The author cut it short after half an hour, and invited each doctor to read what had been on the card.

A further set of cards was then handed round the inner circle, the previous groupees becoming leaders and vice versa. This time the discussion was stilted and unreal, the reason for this being disputed. Was it that the groupees did not believe the case to be an actual one, or was it that everyone knew what sort of role instructions were printed on the cards? The author contended that the exercise demonstrated that one couldn't lead a group by numbers.

In fact, in the first case the master of ceremonies did not speak. In the second case he made one attempt at a group interpretation (that being his role listed on the card). There was an extremely lively discussion, in which all points of view were advanced, but there was only general agreement that it

did attempt to tease out various facets of groupee behavior and leadership activity. It was thought that this aspect might usefully be explored in greater detail at another meeting.

It was thought that the 'game' would have been improved if there had been only two people playing leader roles, as it was clear that the groupees could not focus on any specific leadership because of the fragmentation of the leader role into nine separate individuals.

Appendix

Groupee Cards

I) You are a groupee (not a leader).

If you have a case — Yes, you have! Claim priority. If you haven't thought of a case before tonight, pick the nearest 'pregnant nun' and present it as if you are a crazy doctor (in a controlled sort of way).

2) You are a groupee (not a leader).

Please present a case if you want (allowing for the usual bargaining).

During the discussion of the case comment on any traditional aspects (medically speaking) that you can identify, to the exclusion of the emotional.

3) You are a groupee (not a leader).

If you have a case, please present it (allowing for the usual bargaining).

If you are not selected, please support the presenting doctor in any way you like during the discussion of the case.

4) You are a groupee (not a leader).

If you want to produce a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please be somewhat aggressive towards the presenting doctor during the discussion.

5) You are a groupee (not a leader).

If you have a case, present it (allowing for the usual bargaining).

Whether or not you present, please challenge the leader's 'hidden agenda' during discussion.

6) You are a groupee (not a leader).

Even if you have a case, please do not offer it, and do not join in the discussion of the case.

What a dreadful task I have set you! Bear with me if possible! And remember how you felt for later.

7) You are a groupee (not a leader).

If you wish to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, please contrive to have a conversation with the person next to you, regardless of the group work.

8) You are a groupee (not a leader).

If you want to present a case, do so (allowing for the usual bargaining).

If you have not a case, or are not selected, try and get the leader to tell the group the 'answer' to the presenting doctor's problem during the discussion.

9) You are a groupee (not a leader).

Even if you have a case, please do NOT present it. During the discussion please play the role of a 'superior' doctor who knows exactly what to do about the case presented, and tell the group what!

For the second case card No. I read:

1) You are a groupee (not a leader).

If you have a case — Yes, you have! Claim priority. If you have not thought of a case before tonight pick the most goddam awful case you are dealing with at present, and present it in distress.

Salinsky, J. (2022). Do We Still Need an Analyst for a Leader, 1989. *Journal of the Balint Society, 49: 90-95.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Do We Still Need an Analyst for a Leader? (1989)

John Salinsky[1]

[1] GP, Wembley

In the beginning the leader was always an analyst. How could it be otherwise? Michael and Enid Balint and their colleagues at the Tavistock Clinic were offering their psychoanalytic skills and insights as their contribution to a joint exploration of the psychological content of general practice. The work was to consist of 'research and training' and while the research partnership might be an equal one, the training was seen as a training in psychotherapy which a family doctor could not possibly acquire from a group led by another family doctor.

The Tavistock groups continue to be promoted and led by analysts. But since 1974 the Balint Society has also sponsored groups led by general practitioners (who were themselves trained in Tavistock groups). Furthermore, because of their enthusiasm for medical education, many of the early Tavistock graduates found themselves in charge of the new general practice vocational training courses. Not surprisingly, they wanted to give their vocational trainees a taste of the Balint-group experience by incorporating groups in their half-day release courses. These trainee-groups are led by Balint-trained general practitioners, either singly or together with a co-leader from another discipline which values psychoanalytic ideas, e.g.: a social worker, counsellor or clinical psychologist. Some trainee-groups stand up better than others to a comparison with the Tavistock Gold Standard, but the fact that their leaders are trying to promote the Balints' ideas must be seen as encouraging. Balint-training, or at least, Balint-influenced training is being made available to many young doctors who may never have heard of the Tavistock and are too far away from Hampstead to take advantage of it anyway.

There are very few analysts outside North West London and an even smaller number who show any interest in exploring the world of general practice with a Balint-group. So when our vocational trainees finish their training and look for a principals' group they are unlikely — unless they can go to the Tavistock —to find an analyst to lead it. Instead, we are now seeing the emergence of a third generation

[1] First published 1989, Vol. 17, *Journal of the Balint Society*.

of Balint-group leaders: general practitioners who have had several years' group experience as trainees but may never have been in a group led by an analyst. Does this dilution of the analytic influence matter? What exactly does a psychoanalyst's presence do for a group and can we manage without it?

To answer these questions I think we need to consider both the style and the content of group leadership. The style or attitude of the group leader is described by Michael Balint in Appendix 1 of *The Doctor, his Patient and the Illness*, where he says 'if he (the leader) finds the right attitude he will teach more by his example than by everything else combined'. After all, the technique we advocate is based on exactly the same kind of listening that we expect the doctors to learn and then to practise with their patients. By allowing everybody to be themselves, to have their say in their own way and in their own time, by watching for proper cues — that is, speaking only when something is really expected from him and making his point in a form which instead of prescribing the right way, opens up possibilities for the doctors to discover by themselves some right way of dealing with the patient's problems!

This passage seems to me to say it all, as far as the group-leader's style is concerned. It must make anyone who has ever tried to lead a Balint-group say, 'yes, that's the way I should be doing it — if only I could be that sort of leader more of the time'. Keeping quiet and being a good listener can be difficult: especially if the leader is eager to teach. It may even be easier for a general practitioner leader, who is not burdened with much theoretical baggage, to concentrate on being a listener and 'facilitator' (horrid word, but it serves my purpose) than it is for an analyst who has things to explain. Certainly my impression of our 3rd generation general practitioner leaders is they recognise the importance of this part of the job and they do it well.

But what of the content? When the leader does open her mouth does she have to make clever interpretations? By no means. Some of the most effective

interventions are very simple ones in which the leader shows the group her own ability to respond emotionally to the patient's feelings, e.g. 'it makes me feel very sad to think of him sitting all alone in his bedroom with no one to talk to!' This sort of thing gives the group permission to have feelings too, and can be very liberating. It requires no knowledge of the Oedipus complex or Primary Narcissism.

So what do we need an analyst for? Even analyst leaders do not sprinkle their discourse with technical terms (at least the good ones do not). But are they using their psychoanalytical education in some less obtrusive way? Back to Appendix 1 of *The Doctor, his Patient and the Illness*.

In the paragraph headed The Use of Group Methods, Michael Balint writes, 'Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously in the patient's mind when doctor and patient are together!' He then refers to certain 'events' going on in the minds of both doctor and patient which are subjective rather than objective, 'often hardly conscious or even wholly beyond conscious control'. In other words there is a lot going on just beneath the surface of the ordinary doctor-patient discourse which it is all too easy to miss if your antennae are not tuned in to the language of the Unconscious.

My own acquaintance with psychoanalysis has made me realise that this language is rather like poetry. It expresses its meaning subtly and indirectly through images, metaphors and allusions. A patient may unconsciously say something very important about herself by attributing her own feelings to another person or even to a natural phenomenon; just as a poet may use the Pathetic Fallacy to show human feelings reflected in the state of the weather. Psychoanalysts are familiar with this language and can recognise it when they hear it; the rest of us may not do nearly as well. I do not mean that I expect analyst leaders to offer detailed translations (interpretations) to the group: these are seldom needed, may be inaccurate and generally do more harm than good by turning the leader into a

lecturer. But a little help with the language, enough to pick up a few phrases here and there; enough to get by, as the travel writers say, can be enormously helpful. Let me illustrate with two examples from my own practice:

1) A young girl told me that she was afraid to leave her flat unaccompanied in case she met a dog. The barking of dogs terrified her: 'they seem so angry' she said. A little later she told me that she was often afraid her own angry feelings would get out of control and she would smash something.

2) An old man dying of cancer persisted in believing that he was going to get better until, one day, he stumbled and fell, hitting his head sharply on the edge of a table. Although there was no fracture, he felt that he had been severely damaged by the blow and would never recover. It occurred to me that the nearness of death had 'struck' him in that moment like a smack on the head (or in the head). I did not 'interpret' that thought back to him, but I was able to agree with and share with him the importance of the knock on the head as the cause of his decline.

Without some exposure to psychoanalytic ways of thinking it would have been impossible to tune in to these patients' feelings in quite the same way, and something valuable would have been lost. We seem to need the input from psychoanalysis to give us that extra dimension of understanding. Without the missing ingredient Balint-work can still be very nourishing but it does not taste quite the same.

So what is to be done? The shortage of analyst leaders is likely to continue. Not all analysts make good Balint-group leaders in any case; not many are interested in general practice and those who are, want to be paid! This seems to offend general practitioners, although I can see that it is entirely reasonable from the point of view of an analyst with a living to earn. But why should a Balint-group not be a learning experience for a young analyst or psychotherapist as much as for a general practitioner? Perhaps general practitioners should invite analysts and psychotherapists in training to join in, not as leaders, but as members with a special

contribution to offer: the art of listening to the Unconscious. And if a group cannot find an analyst, perhaps they could invite a poet or a novelist to join them instead...

Fitzgerald, G. (2022). A Short Response to John Salinsky 'Do We Still Need an Analyst for a Leader?', 1989. *Journal of the Balint Society, 49: 96-97.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Short Response to John Salinsky 'Do We Still Need an Analyst for a Leader?' (1989)

Gearóid Fitzgerald[1]

[1] Former President of The Balint Society UK: gearoidf@gmail.com

Even though written in 1989, this paper is relevant to Balint groups and, as John puts it, 'Balint influenced training' today.

He describes the listening required of the clinician and the similar task of the leader. Both are stated with the admirable simplicity and brevity born of long thoughtful experience. He pinpoints accurately that it is this listening to the language of the unconscious and saying enough to open up something potentially new that is important. It is not interpreting or translating, on the part of the analyst/Balint leader, into clever interventions or phrases that is essential, but more an openness to not teach or suggest, to wonder about something that strikes them in the emotional atmosphere of the case and the doctor patient relationship, and the way the story is told and received by the group.

He is kind and, I think, respectful of the fact that analysts are trained to especially listen for and to the unconscious but also clear that it isn't a preserve of psychoanalysts. In Balint groups, it is something one can develop and refine with the help of properly trained leaders and contacts with interested psychoanalysts.

Today there are a number of psychoanalysts involved with the society and trained as Balint leaders, so we are once more in a position where a new fruitful dialogue about listening might take place. This time I think it might be with psychiatrists in the main and their clinical work though hopefully more GPs will re-find Balint.

This paper would be helpful to the many people who lead Balint groups who have not had much contact with trained leaders as it gives them a clue as to why it's important to maintain the links with psychoanalysis and the language of the unconscious.

---

[1] Dr Gearóid Fitzgerald is a Balint leader for over 20 years and former President of The Balint Society UK. Psychoanalyst in private practice. Formerly Consultant Psychiatrist in Psychotherapy and Training Programme Director for Psychotherapy Yorkshire and Humber region.

Sternlieb, J.L. (2022). Letter from America: A Short Response to John Salinsky 'Do We Still Need an Analyst for a Leader?', 1989. *Journal of the Balint Society, 49: 99-102*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Letter from America. A Short Response to John Salinsky 'Do We Still Need an Analyst for a Leader?' (1989)

Jeffrey L. Sternlieb[1]

[1] PhD, Past President, American Balint Society: jsternlieb@comcast.net

As if on cue, while preparing to fly to Brussels for the IBF Congress (2022), and while I ponder this invitation to write a commentary on a John Salinsky article from 1989 ('Do We Still Need an Analyst for a Leader?'), I have a dream. Not just any dream; a vivid and disturbing dream full of disorientation, my lost cell phone, not knowing the day of the week or time of the day and thinking I'm late for a supervisor's meeting of group leaders while still trying to figure out the location of the venue and where we are supposed to meet, all the while knowing I do not have enough time for lunch. And I wake up realizing I am lost in a stream of consciousness while feeling stranded in a sea of associations.

In his 1989 essay, John Salinsky looks back at 33 +/- years of Balint groups, and then he looks forward to wonder about the future of these groups as their increasing numbers outpace the number of analysts available and interested and trained as leaders.

How appropriate that Dr. Salinsky's starts his article with 'In the beginning…'? and how could it continue in any way other than '… the leader was always an analyst.'? It is an origin story, almost Biblical, and of course, there is an original document which he references, and over which later generations would debate. The crossroads Salinsky inhabits, and which instigate his article's title question, involves a shift to include both the continuing education of GPs in practice, and educating vocational trainees in the Balint method. This seemingly appropriate new application of Balint's method necessitates, in Salinsky's words, the incorporation of '…co-leader(s) from another discipline which values

[1] Jeffrey L. Sternlieb, PhD, is a past President of the American Balint Society. He earned his doctorate in developmental psychology with a focus on Piaget's epistemology. His experience includes college teaching, his own clinical practice, and a faculty position at a three-year family medicine residency. He continues to lead Balint groups (including one with clergy) and trains and supervises future Balint leaders.

psychoanalytic ideas, e.g.: a social worker, counsellor or clinical psychologist.' Is this an appropriate expansion of Balint's original intent and process, what might the 'originalists' think about its appropriateness, and who will lead these groups?

The look and nature of Balint's program morphed into a psychoanalytically informed group process rather than a content filled opportunity to teach, becoming less didactic and more inductive, less direct and more indirect, and relying less on Balint's initial 'wisdom' and more on the specific wisdom hidden just below the surface of each unknowing participant physician's awareness.

In what ways might these 'co-leaders from another discipline' embody psychoanalytic principles that would demonstrate fidelity to Balint's model? How might the risks of a dilution of impact in the absence of an analyst be identified?

'To answer these questions, I think we need to consider both the style and the content of group leadership.' In his consideration of style and content, Dr. Salinsky quotes from Appendix 1 of Balint's consequential opus. Early in my Balint leadership journey, I read *The Doctor, His Patient and The Illness*. However, I did not recall reading Appendix 1. I felt relieved when I returned to my 'Balint bible.' Throughout Appendix 1, I found my notes in the margins, my underlining and other indications of time spend in this section. Yet, my relief was short lived as I wondered why I have not returned to this treasure trove of guidance, valuable as much for a budding leader as for a more experienced supervisor

To demonstrate these points, Salinsky uses examples from his own practice to make the case for a psychoanalytic way of thinking as a path to understanding. He further speculates on several ways to accomplish this goal. Unfortunately, he provides no evidence for the value of Balint with trainee groups that may not have the benefit of an analyst leader.

What if this paper were read some time in the future? Could we still consider his questions, and would they be understood differently? Fast forward another 33 +/- years of Balint groups. As I read Salinsky's paper today, I hear his

questions with a familiar mindset of listening for the question underneath the question, wondering what impact would follow, thinking about content and process of a group, and concerned that variations in form might compromise the function. Most of all, I appreciate the examples that he offers to bring the issues to light in their most vivid and practical manner.

The doctor-patient issues today in America are both macro and micro. There are not only challenges in training of Balint leaders, but also basic challenges when a doctor desires to accomplish anything more than to collect a brief traditional medical history. Stress and burnout for health care professionals have been complicated by a pandemic, and doctors have reached a level of distress equivalent to the need for psychological emergency room care. Ironically, this pandemic which has kept us more apart from each other has also led to an adaptation through technology that allows more of us to be together. We accept and struggle to work with the oxymoronic notion of remote yet intimate relationships. What does it mean for and require from any of us to conduct a Balint group on a video screen?

One of the most intriguing points of reference is Salinsky's association to the language of poetry, as a form of human expression 'with a special contribution to offer: the art of listening to the Unconscious.' I think about Rilke (*Letters to a Young Poet*), the lyrics of Bob Dylan or Paul Simon, and even the poems or adages of Rumi, all of which stir the imagination. It also occurs to me to include the visual art of Edvard Munch, Van Gogh or others, or dramatic works from the Greeks to present-day dramatists as additional avenues into the patient's experience of illness.

And what about that dream I experienced? In fact, the schedule of the IBF Congress seemed unreasonably tight, I did, in fact, temporarily lose my cell phone, left in a taxicab, but which was miraculously retrieved, and supervision – ever holding the frame and trusting the process – continued to inform the leaders' experiences and provided the space to name and contain the emotional impact that might otherwise be lost and buried.

Author Note:

The author would like to thank Paul Scott, M.D.

Courtenay, M.J.F. (2022). Lessons of the Masters, 2004. *Journal of the Balint Society, 49: 103-107.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Lessons of the Masters (2004)

M. J. F. Courtenay[1]

[1] GP, London

This is the title of a recent book by George Steiner based on his Charles Eliot Norton Lectures of 2001-2002. My introduction to his thinking was reading his *Grammars of Creation* a few years ago, which led me, among other things, to read Proust. He suggests that, pivotal in the unfolding of Western culture, stand Socrates and Jesus, who were charismatic masters who left no written teachings and who founded no schools. In the efforts of their disciples and the passion narratives inspired by their deaths, Steiner sees the beginnings of the inward vocabulary, the encoded recognitions of much of our moral, philosophical, and theological idiom. He goes on to consider a diverse array of traditions and disciplines, recurring throughout to three underlying themes: the master's power to exploit his student's dependence and vulnerability; the complementary threat of subversion and betrayal of the mentor by his pupil; and the reciprocal exchange of trust and love, of learning and instruction between teacher and disciple.

I found his theme fascinating and prompted me to read a number of books to which he had referred, but finally led me to wonder how Michael Balint might fit into his thesis. It seems to me that Michael might be someone special, the exception that proves the rule, a Master who strived to liberate his disciples from dependency. Not that he escaped rebellion, even if it falls short of betrayal. I recall listening to a paper read at the second Balint congress in Budapest which suggested Michael was not the initiator of what we now call Balint-work, but ascribed that role to a named other. I was astonished that the author of the paper should choose a Balint conference to air this view, rather than by the nature of the assertion that Michael was not the prime mover. The fact that I cannot remember either name of the author of the paper or the name postulated as the true genius can, of course, be construed as evidence that I have repressed both as a consequence of dependence on my part of 'the master'. Again, at the memorial meeting for Enid Balint arranged

[1] First published 2004, Vol. 34, *Journal of the Balint Society*.

by the British Psychoanalytical Society I heard Bob Gosling suggest that Enid's calm demeanour had been a key element in modulating Michael's wildness. David Malan, who had attempted a rigorous scientific approach to evaluating brief psychotherapy published in *A Study of Brief Psychotherapy*, once remarked that when Michael Balint came through the door, science went out of the window. Did these critical views suggest that, although Michael was convinced that his whole work was based on psychoanalytic principles, other analysts were aware that he was in some sense a maverick, basing his approach somewhere between scientific medicine and psychoanalysis? He certainly did not think that being a practising psychoanalyst was in itself sufficient to qualify for being a Balint group leader, even though he considered undergoing analysis essential. This is illustrated by the case of an analyst who was in the position of associate co-leader to Enid in a GP trainee (registrar) group, whom she had invited to learn the necessary skills, but proved to be unable to apply psychoanalytic expertise in a way appropriate to a leading a Balint group. What, then, was the latent factor necessary? Having a thorough understanding of the nature of the work of a GP (or specialist if that is the focus of the group work) was certainly a vital requirement — I always had an uncomfortable feeling that Michael could conduct a surgery in my practice better than I could. But it is not only that. In my own case I was astonished that Tom Main considered that I could lead a Balint group which was then seeking a leader. I was even more astonished when Sandy Bourne, at a group leader conference held in Bern, Switzerland, made the remark that I had reached the country inhabited by analytic leaders by an alternative route. If these encouraging noises mean anything then it must mean that both analysts and non-analysts must make a journey into a `Balint space' of special expertise. Not that I am smug, let me assure you. One member of my last (research) group expressed disappointment in not having had an analyst leader of the group. While remembering that Michael always forbade the overt use of analytic terms, especially transference, he never changed his view

that all group leaders should be analysts, though he did sanction the members of the groups who were doing research on psycho-sexual matters to lead groups set up under the auspices of the Family Planning Association. Whether this meant he thought that restricting the area of pathology made this a safe procedure or that whether he was really changing his mind we shall never know. My first GP group was co-led with Mary Hare, so I had a feeling of safety in her analytic insights, while she relied on my firsthand experience of general practice. This was a happy and, judging by the current position of several of the group members, a mutually enriching one. Mary's long battle with depressive tendencies was won after we attended a conference in Japan, at which we presented a paper, when she confided that she now realised, at last, the worth of her own professional work. What is clear to me now is that though I fell under the spell of Michael, there was nothing he enjoyed more than being stood up to, so to speak. I well remember Rosa Taylor saying, during a group meeting, that he was like Henry Ford who didn't mind what colour the car was as long as it was black. He laughed his head off!

The greatest personal rewards for me have been events that have mirrored things the Balints spoke of: how something learned by a ‘student’ has changed his/her professional aims, or how a colleague feels their work was understood even beyond their own understanding. But this satisfaction is not achieved by feeling the recipient is in thrall to the 'master' but rather that one has opened the door of the cage and let the bird fly free. So I believe that Balint-work makes us all free, even though this echoes the dreadful, cynical, words that surmounted the gate of Auschwitz. Perhaps that very echo means that Jewish genius transcends even a holocaust and may lead us to understand what is the essence of the process which we have shared in Balint-work training. This somehow combines the insights of psychoanalysis and traditional medicine, and sets a completely new standard for teaching and learning. Can this help the International Balint Federation in its quest to define the necessary qualities of future Balint leaders?

Reference

Steiner G. *Lessons of the Masters* London: Harvard University Press, 2003.

Still image from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970. The group with Michael Balint as leader.

Parker, V. (2022). My Experience of Facilitating a Balint Group for GPs and its Interface with Supervision, 2009. *Journal of the Balint Society, 49: 109-122.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

My Experience of Facilitating a Balint Group for GPs and Its Interface with Supervision (2009)

Valerie Parker[1]

[1] Primary care counsellor

Ever since I began working as a Primary Care Counsellor I have been fascinated by how the relationships between GPs and their patients effect medical consultations. I was therefore very interested when a GP asked for my help in exploring his inexplicable anxiety about his work. During our discussion we realised that much of his concern focused not on worries about individual patients, but on his struggles with time-keeping. We began to wonder how this impacted on his relationships, with his patients, and how his ability to assert himself varied according to the feelings evoked by individual patients. We also reflected on how firmer boundary-keeping might change these relationships.

Following our discussion, I was invited to run a workshop on boundaries and timekeeping for all the staff at the surgery. The issues that emerged were fascinating. We began to think about the power some patients have to elongate appointments or receive special attention, while other patients seem to be almost apologetic about having any time. We also reflected on how individual patients deal with their annoyance and frustration at being kept waiting and how this might affect their relationship with the doctor and the surgery. One of the GPs at the workshop was enthusiastic to develop the ideas further, and he asked me if I would be interested in setting up and facilitating a `Balint'-type group with local GPs.

This was a great opportunity for me to develop my interest in the dynamics of the doctor/patient relationship and to experience leading a group, but I was apprehensive about what the doctors would be expecting. What is a Balint Group? Was this to be a supervision group, or merely a discussion group? How assertive should I be as a leader? I began to research information on Balint Groups, joined the Balint Society, and decided to enroll on a counselling Supervision Course with 'Counsellors in Primary Care', which I hoped would help me with the supervisory aspects of the work and its context in Primary Care. One of my concerns involved

[1] First published 2009, Vol. 37, *Journal of the Balint Society*.

the problem of language and culture. I was aware that although GPs might be attending such a group to increase their reflective and psychological awareness, there is an inevitable cultural divide between the medical paradigm of diagnosis and cure and the more reflective psychological search for meaning in illness. I was conscious that while the doctors were hoping to open up their awareness and ways of thinking, it was important to be sensitive to their differing attitudes; developing and encouraging mutual respect would create an opportunity for growth and learning for us all.

Although I have always enjoyed working with GPs, I have also been conscious of some deeply embedded transference responses which could affect my confidence as a leader. The underlying danger is that my sense of awe, combined with a tendency to undermine my own ability and expertise when I feel under pressure, may either make me anxiously over-controlling and dominant, or too self-effacing and unable to assert a sense of leadership. When I explored these feelings I realised that the underlying dynamics in my relationship with my younger sister, who is a GP, probably affects my attitude to all doctors. I have always had a sense that her profession is more highly regarded in my family; in addition my sister and I have a tendency to be both over identified and competitive in our relationship with one another. It has been helpful to reflect on this and begin to clarify the effect that some of these unconscious projections may have on my relationship with the doctors.

In order to better understand the origin and context of Balint Groups, I read Michael Balint's seminal book *The Doctor, His Patient and the Illness* (1957) in which he describes his work with groups of doctors at the Tavistock Clinic in the early 1950s. These groups were established by Balint to investigate the relationships between patients and their doctors and to help the doctors develop more effective skills in understanding and relating to their patients. `Balint Groups', as they became known, usually comprised 10-12 'family doctors' and one or two facilitators

and met weekly for a period of several years. The doctors were encouraged to present cases which they considered problematic or uncomfortable or provoked an unusual amount of frustration. They would discuss their reactions and insights, and reflect on what they felt was happening unconsciously in these relationships, with the aim that this might help them to understand their patients better. In the words of Balint: 'Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously, in the patient's mind when the doctor and patient are together.'

I realised that in many ways a Balint Group is similar to a supervision group for counsellors — it provides the GPs with support, an opportunity to share problems and concerns, and helps them to think about their work in a new way. So how might such a group compare to a supervision group, and how would this affect my role as its facilitator? Hawkins and Shohet (2006) cite three main functions of supervision —developmental, resourcing and qualitative. Their definition of the developmental aspect of supervision relates very closely to the aims of a Balint Group. To help a supervisee:

- understand the client (patient) better
- become more aware of their own reactions and responses to the client
- understand the dynamics of how they and their client were interacting
- look at how they intervened and the consequences of their interventions
- explore other ways of working with this and other similar client situations.

Hawkins and Shohet describe Resourcing as the process of supporting supervisees through the emotional stresses of their work. This would not be an overt aim of a Balint Group, although understanding the unconscious effects of their interactions with patients, and feeling supported by their colleagues may help doctors cope better with the stresses of their profession. The Qualitative function of supervision refers to the supervisor's responsibility for the work of their

supervisees. This does not apply to Balint Groups in which the doctors remain individually accountable for their work.

Another important comparison with supervision involves the behaviour and involvement of the group leader. It is generally agreed that there is a very strong didactic element to counselling supervision (Kadushin 1976, Proctor 2000). Onso (1985) even considers teaching to be 'the primary function' of supervision. In the context of a doctors' group however, I believe teaching is inappropriate; it is important to stand back and allow any learning to evolve naturally through discussion and observation. This is strongly endorsed by Enid Balint et al (1993): 'The psychoanalyst is there as a facilitator — an opener of doors — not as an instructor.'

The concept of the leader as a support rather than a proactive manager or director is respectful, and reinforces the importance of allowing the GPs to maintain a sense of their own expertise. Gosling (1996) emphasises the importance of respecting the unfolding process: `Using the Balint Method every effort was made to reinforce the GPs' authority in what they did or didn't do so that they would adopt new ways learned in the group only to the extent that they themselves found them useful in the light of experience.'

I have found it helpful to think of the group as a co-operative learning experience, much like Proctor's (2000) Co-operative Group Supervision model, in which the leader's most important function is predominantly to facilitate the group process. This involves containing the group and its members through the challenges and stresses of becoming a lively, functioning and collaborative entity. Tuckman's (1965) definitions of the stages of group development, *Forming, Storming, Norming and Performing*, have been a helpful guide to the unfolding process.

Forming

The primary task in the early stages of any group is to establish a solid framework or a *Group Working Agreement* (Proctor, 2000). From the very beginning it is fundamentally important that the leader or supervisor can manage the group confidently and firmly through this process. This includes establishing boundaries for time management, confidentiality and presenting behaviour and, in doing so, clarifying a firm sense of holding and containment. Bearing in mind my underlying concerns, I was aware that the task of establishing a clear position as leader, balancing assertiveness with openness and respect, was going to be challenging.

Before the real work of the group began, the GP who helped to set up the group called a preliminary meeting to discuss our ideas and to set out a proposal. I felt that it was important from the outset that I took administrative control, allowing Dr A to hand over responsibility and become a member alongside his colleagues. Ten GPs attended this meeting, all of whom decided to come to our first group. We established that I would be responsible for all communications, for the time keeping during the meetings, and for booking the venue. We planned to meet once a month for 90 minutes. I anticipated that this relative infrequency would make it difficult to establish a sense of unity and coherence in the group. During the early months several doctors decided to discontinue, and it took several months to establish a regular group. This concerned me, feeding into my own lack of confidence about my ability as leader. It was important to appreciate the insecurities present for every member of a group, and to realise the value of being proactive in managing boundaries and helping to establish a sense of safety for everyone.

The task of containment also includes managing external disturbances to the boundaries and I have realised that at these difficult moments it is helpful to make links with what is happening in the group as a way of refocusing attention. I recently had the experience of co-leading a short-term group at a Balint Society

conference, and in our first session we were interrupted by several very annoying and uncomfortable intrusions. At one point a porter urgently came in requesting keys. Several members of the group were very angry, and it was clear that it would take some time to settle. I noticed how this disruption mirrored both the cases that we had been discussing that morning, in which someone had stood in the way of the relationship between a doctor and his patient. By making a link between these experiences, I was able to help the group refocus and return to their task with greater ease.

Storming

During the early stages of group life it is usual for the members to be preoccupied with trying to find a balance between individuality and belonging (Proctor 2000). This is a challenging time; all the members will be testing the boundaries and trying to establish their own place in the group. Proctor suggests that participants will be primarily concerned with issues involving *'difference, competency and hierarchy'* — who speaks the most; who is the most insightful, and how to gain respect. The insecurity and anxiety present at this stage of the group was particularly demonstrated by Dr B. At the end of our second session, he took me to one side and said that he was worried about whether we would expect him to present a case at our next meeting. He explained that he was off work on long term sick leave but that only two members of the group knew this. I said that I thought his personal experience would be valuable to the group and I hoped that he would feel able to talk about this next time. The next day I received an email from him expressing his apprehension about presenting to the group when he is currently not seeing patients and asking for my clarification about how he could approach such a discussion.

My reply was as follows:

> Firstly, I really appreciate that you are braving coming to the group, and I think that when and if you feel ready to share some of your experience, it will be very enriching for everyone, and will only serve to deepen the relevance of the group. I hope that you are able to talk to us at the next meeting and I would suggest that you don't prepare anything. We have not formalised what we present and this will develop and emerge as the group matures. However, beginning to look at the emotional impact and stress of your work on your life and reflecting on how your patterns of relating have affected your work would be extremely relevant. Starting to open up in this way will encourage everyone to look deeper at the inter-personal dynamics of their work and could be really helpful. It is important that we keep appropriate boundaries so that it does not become a 'therapy group', but as facilitator I can keep an eye on this.
> I think it was right that we did not speak on the phone, as contact about the group outside it should be kept to a minimum to ensure safety and confidentiality. If you agree and feel comfortable, then perhaps we should share our communication with the others, so that there is no danger of 'splitting' the relationships within the group.
> I hope this helps. V

This exchange brought up some very important points. Firstly, it allowed me to establish my role as a guide to the appropriateness of the material — encouraging the GPs to open up to their personal experience, but ensuring that this is relevant and contained. It was also an opportunity for me to clarify boundaries about safety, confidentiality and openness within the group.

I was fully expecting that Dr B would now have the courage to open up to the group at our next meeting. What I did not anticipate was that I would fall ill and would be unable to attend. This presented another challenge about contracting. We had made no provision for my absence. In the event I rang Dr A, who decided to cancel the session, but two doctors missed his communication and did in fact turn up. This prompted me to reaffirm our arrangements and to circulate a list of personal telephone numbers. I have realised that throughout the life of a group boundaries need to be continually reaffirmed and reinforced. It seems to be a question of negotiating a delicate balance between containing frustration, anxiety and discomfort and interpreting and challenging, while maintaining an awareness of what is happening in the group and how this might be reflecting the dynamics of the patient/doctor relationship.

The following month I turned up to the meeting anticipating that Dr B would now speak, and was disconcerted when he did not volunteer to do so.

Reflecting afterwards I was unsure how to proceed — should I leave it, ignoring our correspondence, and wait for him to find his own time, or should I confront him? I decided to telephone him the following day and he agreed to open up to the group at our next meeting. I wondered afterwards whether this intervention could be considered a boundary violation, and whether I should have let the situation unfold naturally. On the other hand it modelled an approach of facing emotional challenges, and it was important to ensure that Dr B became a full member of the group, which could not happen until he had participated fully. Ignoring the situation may have reinforced this split. As Proctor (2000) writes:

> Collective energy is released when supervisees, with the help of a facilitative supervisor, can sufficiently acknowledge and respect their own, and other group members' needs for identity. By experiencing themselves as included and including; sufficiently influential and acknowledged; clear where they stand; acceptant of differences and of strengths and shortcomings, members can work freely, purposefully and creatively — at least from time to time.

Norming

As we all began to grow in confidence, I was able to be less proactive and develop a clearer perspective on the group as a whole. I began to notice the phenomenon of 'Parallel Process' —when the group dynamics seem to be unconsciously reflecting the material being discussed. It is often difficult to observe because I can also become a participant. I am learning to notice that when things feel confusing, or when I feel under pressure and unable to think, it might indicate such unconscious processes.

Dr B's presentation gave us all the first really clear example of Parallel Process. His case concerned a patient whose enormous need became overwhelming and so difficult to contain that it began to impact on Dr B's health. The patient was a woman in her thirties with a rare and terminal brain disease. She suffered from multiple nervous problems and debilitating and untreatable pain. The case became especially worrying and complex when the patient discovered that she was 20

weeks pregnant. This caused huge dilemmas for the patient and the doctor. The patient desperately wanted a chance to have her own baby but Dr B felt caught in a terrible moral predicament. Medically, remaining pregnant was totally inadvisable for both the mother and the baby, but this woman was clinging to hope and it was painful to disappoint her so fundamentally. The patient decided to have a termination, which was medically complex and emotionally traumatic for her. Dr B increasingly struggled to draw clear professional boundaries, visiting her on his day off, giving out his personal phone number and even leaving a family gathering to take the patient to hospital.

As Dr B presented his case to the group, I noticed that the doctors began to reflect these difficulties in their emotional responses. When he complained about feeling unsupported and `dismissed' by his colleagues, the emotional atmosphere became increasingly stressed. It was as though the group were determined to show that they were not 'dismissive' — that they too would put themselves out as he had done. When I warned the group that we were approaching the time we had set for the next presentation, there was great resistance and a sense of urgency to help Dr B 'find answers' before we could move on. Dr C was particularly insistent, suggesting that we should forego the next presentation. The group seemed to readily agree. I felt uncomfortable and under pressure, realising that the doctors were reflecting Dr B's inability to draw effective boundaries; that they were being unconsciously seduced by Dr B's vulnerability, just as he had been by his patient. We were also modelling allowing ourselves to change our plans, which did not seem safe. Against the wishes of the group, I said that I felt strongly that we should give Dr D the space that we had allocated for her. Dr C was clearly angry with me, which felt uncomfortable, but I knew that maintaining group discipline at this moment was essential.

Although not explicitly expressed, the group was reflecting the powerful response that can be evoked by very needy and damaged patients, and I realised

afterwards how important it was to model an ability to contain this. This had been a big challenge for the group and to my role within it, but I think it was an important test of the group's resilience. Such situations are typical of this 'Storming' stage and are part of the growth and development of a strong, healthy and functioning group.

At our session the following month Dr D commented on my intervention, saying that she had been grateful to have been able to present her case. She also realised that the firm boundary keeping had been a helpful model. This was very affirming.

Performing

The group met five times before the summer break. Eventually four GPs left the original group — three clearly felt that it wasn't for them and the fourth could no longer make the time. We agreed that six members was too few, and invited one new GP to join us. Two members missed the final sessions before the summer due to sabbaticals, and so it was not until we resumed meetings in September that I began to feel that we were becoming a coherent group.

Despite two members being absent, there was clearly a different quality to the September meeting. I noticed that I felt more relaxed and confident, and it seemed much less urgent to impose a strict structure to the evening. For the first hour, the doctors reported back on their recent progress with patients whom we had discussed earlier in the year. Before the summer break, Dr E and Dr F had been encouraged by the group to resist some entrenched situations where patients had become over-reliant on them. Dr E was persuaded to try to break a cycle of dependency with an alcoholic patient, by using his imminent sabbatical as an opportunity to confront her and end the patient's reliance on very frequent consultations. Dr F decided that she would more assertively resist being sucked into a negative spiral of being persuaded by a patient to keep changing her

medication. In the September meeting both doctors reported back very positively and expressed surprise at the ease with which their patients accepted their stance when previously they had been so resistant. It was as though the pressure had disappeared. In the discussion that followed the GPs began to realise that the change in their own resolve, reinforced by the support from the group, had provoked a change in the patient's response. Dr D commented: 'It seems as though what we bring massively dictates how the patient responds.' There followed a discussion about whether the GPs bring their own needs into their consultations — perhaps a need to be relied on, to be empathic or particularly caring. They talked about handing out the tissues as 'doing the solemn "I care" thing' and were astonished to realise how much their attitude might affect the patient's behaviour.
I found myself able to sit back and observe their process of enquiry, reflection and understanding. It did not seem necessary to intervene or comment, and it was moving to observe the creativity that was beginning to emerge. Afterwards I wondered whether my own shift in perspective and deepening confidence in the group had influenced the unconscious group dynamics. Had my own development affected the group process, enabling me to subtly let go of my need to be recognised, so that I could allow things to proceed with their own momentum? I am mindful of Winnicott's wise words in *Playing and Reality* (1971):

> If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers.

As we approach the end of a year of work together, I am aware that this has been an enlightening journey for us all. It takes great courage for GPs to be prepared to open up to one another and reflect so deeply on their work and relationships. I have grown in confidence as a group facilitator during the year, and am learning the value of trusting the group process.

In these times of target setting and accountability, doctors are expected to cope, keep going and know the answers. Traditionally, cases are discussed briefly in the corridor or over coffee, and there is a culture of self-sufficiency and autonomous practice that does not encourage enquiry or exposure of vulnerability. As a result doctors develop ways of 'cutting off' (Burton and Launer 2003) by splitting their needs onto their patients and ignoring themselves, resulting in cases of burn-out and stress. Currently there is growing concern about the lack of provision and opportunity for reflective practice and support for GPs in Britain (Launer 2007). As a result Balint Groups seem to be undergoing a revival. It is a great privilege to be part of this process.

References

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression*. Tavistock: London

Balint, M. (1957). *The Doctor, his Patient and the Illness.* Edinburgh: Churchill Livingstone.

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient, and the Group: Balint Revisited.* London: Routledge.

Burton, J. and Launer, J. (eds.) (2003). *Supervision and Support in Primary Care.* Abingdon: Radcliffe Medical Press.

Elder, A., Gosling, R., Stewart, H. (1996). *Michael Balint: Object Relations Pure and Applied.* London: Routledge

Hawkins, P. and Shohet, R. (2006). *Supervision in the Helping Professions.* Maidenhead: Open University Press.

Kadushin, A. (1992). *Supervision in Social Work.* New York: Columbia University Press.

Launer, J. (2007). Moving on from Balint: Embracing clinical supervision. *British Journal of General Practice*, 57: 182-183.

Onso, A. (1985). *The Quiet Profession.* Macmillan.

Proctor, B. (2000). *Group Supervision: A Guide to Creative Practice.* London: Sage.

Tuckman, B.W. (1965). 'Developmental Sequences in Small Groups.' *Psychological Bulletin* 63(6): 384-399.

Winnicott, D.W. (1971). *Playing and Reality.* London: Tavistock.

Marshall, E. (2022). A Short Response to Valerie Parker 'My Experience of Facilitating a Balint Group for GPs and its Interface with Supervision', 2009. *Journal of the Balint Society, 49: 123-126.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Short Response to Valerie Parker 'My Experience of Facilitating a Balint Group for GPs and its Interface with Supervision' (2009)

Eamonn Marshall[1]

[1] Psychotherapist, South London: eamonn.marshall@gmail.com

So much has changed in the primary care landscape in the UK since Val Parker wrote this candid and intimate account of her work with GPs, not least, and not only, the COVID pandemic of 2020 and its aftermath.

In terms of primary care mental health provision, a highly centralised IAPT (Improving Access to Psychological Therapy) model has now superseded a world in which individual counsellors were based in surgeries where relationships between doctors and their patients could be negotiated face to face. Opportunities were then possible to develop trusting personal relationships with GPs that often led to creative interventions like the one that Val opens her paper with. In discussing their patients' mental health issues face to face, doctors might also broach something of their own vulnerabilities, often obliquely, but sometimes directly, which in some way acknowledged the inevitable toll that their work takes in the daily exposure to the suffering of their patients.

Counsellors and psychotherapists may well take for granted their supervisory relationships, but the whole question of what constitutes support for medically trained professionals is still very much an ongoing question. In the wake of the Shipman Enquiry the General Medical Council instigated the requirement for doctors to maintain a career-long e-Portfolio of CPD activities together with annual appraisal and quinquennial revalidation, much of which evidently serves the purpose of monitoring 'performance' and spotting aberrant or dangerous practice. Whilst framed as a broadly supportive activity by the GMC, this regime

[1] Eamonn Marshall is a psychotherapist and clinical supervisor in South London. Working as a clinician, supervisor and manager in Newham PCT's Brief Therapy Service (2001-2008), he started to develop an interest in supporting the work of GPs using the Balint method. For the last eight years he has been co-leading a monthly Balint group in the London Borough of Lewisham, and since 2016 he has been co-leading Balint groups for Transition Year (first year clinical) medical students at St George's Medical School in London, as part of their Student Selected Component programme.

does little to actually address the obvious need to support doctors day to day, week to week.

Following the case of Dr Hadiza Bawa-Garba[2] and her controversial conviction for gross negligence manslaughter in 2015, there followed widespread mistrust amongst the medical community about the confidentiality of reflections recorded in e-Portfolio records. Whilst the rumour that the General Medical Council had used Bawa-Garba's reflections in building their case against her was factually untrue, trust was severely damaged amongst the vast majority of doctors wanting to record their candid and honest reflections. This was evidenced in the British Medical Association's review of the Williams Review[3] into medical gross negligence manslaughter, which found that 'in a survey of 1000 junior doctors, 81% had changed their reflective style following the Bawa-Garba case'.[4] In 2019, in recognition of the damage done, the GMC committed to relinquishing any rights to access reflective practice records in Fitness to Practice cases.[5] Full guidance for doctors and medical students is now published on the GMC website in a 14-page document titled 'The Reflective Practitioner' in which this position is restated.[6]

Medical education is changing. Medical students are all too aware that the pressures inherent in an under-resourced, post-Covid NHS pose a real threat to their own and their colleague's mental health (at least those choosing the Balint group option for their first year clinical Student Selected Component at St George's

[2] https://www.theguardian.com/uk-news/2015/dec/14/doctor-nurse-suspended-jail-negligence-death-jack-adcock (accessed 2 October 2022)
[3] Gross negligence manslaughter in healthcare. The report of a rapid policy review (2018). Department of Health and Social Care, http://qna.files.parliament.uk/ws-attachments/921290/original/180611%20Williams%20Report%20FINAL.pdf (accessed 2 October 2022)
[4] Hodson, N. (2019). Reflective practice and gross negligence manslaughter, BJGP 69(680): 135 DOI: https://doi.org/10.3399/bjgp19X701561 (accessed 2 October 22)
[5] General Medical Council (2018) Williams review into gross negligence manslaughter in healthcare — GMC written submission, https://www.gmc-uk.org/-/media/documents/Written*submission*Williams*Review*74084026.pdf (accessed 2 Oct 2022)
[6] https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/the-reflective-practitioner---guidance-for-doctors-and-medical-students (accessed 2 October 2022)

Medical School in London tell us). Trained in patient-centred medicine, today's doctors have nowhere to hide - collaboration is expected; the hierarchical structures that perpetuate in a fading patriarchal model are disdained. In a world in which our doctors are expected to meet ever increasing demand, and NOW! it is in the quiet reflections of a well-run Balint group that the humanity of both the doctor and the patient can be recalled, thought about, and nurtured. In that respect, nothing at all has changed since Val's article was first published.

Tyndale, A., Salinsky, J. (2022). Sitting in – or Sitting out? A Discussion about Group-leading, 2010. *Journal of the Balint Society, 49: 128-131.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Sitting in — or Sitting out?
A Discussion about Group-leading (2010)

Anne Tyndale and John Salinsky

You may have noticed that we now have two slightly different models of conducting a Balint group. In the 'traditional model', when the presenter has finished speaking, a general discussion follows straight away, with the presenter taking a full part.

In the newer variation, after the case presentation, the leader asks the group if anyone has any questions of a purely factual or clarifying nature to put to the presenter. Questions such as 'how does this patient make you feel?' are excluded at this stage. The leader then invites the presenter to move their chair back a few symbolic inches and remain silent for the first part of the discussion. After about 20 minutes, they are then invited to rejoin the group fully, for the rest of the session. This is called 'sitting out' or sometimes `pushback' (referring to the movement of the chair).

The point of sitting out, according to those who favour it, is that it blocks the overeager interrogation of the presenter, which is often a problem for the leader at the beginning of the discussion. Once the factual questions have been dealt with, the presenter is free to listen and reflect on what she hears without having to answer questions. The group, meanwhile, are thrown back on their own resources and have to work on the case themselves, by examining their own thoughts and feelings about the story they have heard.

Some group leaders are very enthusiastic about sitting out. Others think that it detracts from the flow of the traditional group process with its free association and the phenomenon of 'parallel process' in which the presenter and the group mirror the interaction between patient and doctor.

[1] First published 2010, Vol. 38, *Journal of the Balint Society*.

Where and when did sitting out begin?

It began in Germany, but we are not sure exactly when. According to Heide Otten of the German Balint Society it was often used on an occasional basis when it seemed to be appropriate. Perhaps if the questioning of the presenter was getting too prolonged and too intrusive. Balint doctors from other countries experienced it at International Congresses and it became popular in Scandinavia and Britain, Australia and the USA. Sitting out has been used as a matter of course in the very successful American Balint Society Intensive Leader Training courses for a number of years. It seems to be used much less in France and Belgium. The present position in the UK is that some groups and their leaders use sitting out while others stick to the traditional model.

The London Group Leaders Workshop Discussion

On 11 February 2010, the London Group leaders' Workshop devoted one of its meetings to a discussion of the relative merits of the two models.

Those present were Doris Blass, Tessa Dresser, Andrew Elder, John Salinsky, Oliver Samuel, Lenka Speight, Heather Suckling, Anne Tyndale and David Watt.

What follows is a summary of the main points made for and against the sitting out model:

Points against sitting out

- It makes the discussion less alive because the identification with the patients and the projections which the presenter may be carrying are put aside.
- There is awkwardness when the presenter comes back in and they sometimes feel a pressure to 'report back' on the discussion they have heard.
- The presenter may feel identified with a repulsive or rejected patient and therefore discarded from the group.

Points in favour of sitting out

- It makes the task easier for the leaders who no longer have the burden of trying to get the discussion into the group rather than continuing as a question and answer session with the presenter.
- Sitting out is sometimes useful if the group gets stuck.
- An example was given of a group which was nagging the presenter to say why she found the patient repulsive; she didn't know and when she withdrew, the freer discussion brought up ideas.

There was a feeling that Sitting Out had been adopted in most countries and might soon become worldwide practice. But that didn't mean that we all have to do it!

This led to a consideration of *The Aims of a Balint Group* which were thought to include:

- To facilitate free association as effectively as possible.
- To help all the members to think about the patient in relation to themselves as well as the presenter so that all can benefit.
- To facilitate 'the limited though considerable change in personality' which was the Balints' ideal result. This seemed to imply a move towards withdrawing one's own projections from the patients and being able to deal with the patients' projections onto the doctor. This would lead to a capacity to relate to a wider range of patients.
- To help the doctor and the patient to be seen as human.

Other issues about the format

There should be at most a low table in the middle of the group and not a high table.

Should group members be allowed to eat biscuits?

Should note-taking be discouraged or permitted? (It sounded as if the doctor in one group who regularly took notes was allowed to get on with it without much comment).

There was a general consensus that there should be no rules. This meant no rules about whether the presenter should stay in or withdraw for a while; and no rules about asking factual questions at the start.

Elder, A. (2022). Balint Group Leadership: Where Are We Now?, 2011. *Journal of the Balint Society, 49: 132-139.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Balint Group Leadership: Where Are We Now? (2011)

Andrew Elder[1]

[1] FRCGP DEd (Hon): andrewelder@blueyonder.co.uk

In *The Doctor, his Patient and the Illness*, Michael Balint wrote, when considering the effectiveness of Balint groups, 'perhaps the most important factor is the behaviour of the leader of the group.' Although there has been quite a lot of effort put into attempting to demonstrate effectiveness, it is striking how little has been written about leadership.

Clearly it remains necessary to pursue research into effectiveness. How else are we to persuade our funders, programme directors and faculty to support us? But no one ever joined a group because there was evidence of its effectiveness. It is our experience in a group that convinces us and changes the way we practice. And surely the quality of the group experience has quite a lot to do with the person leading the group and the approach the leader adopts.

In the last ten years or so, there have been very few papers published that concern themselves directly with leadership. I will briefly refer to three of them. In 2004, Alan Johnson, Don Nease and colleagues published a paper entitled 'Essential Characteristics of Effective Balint Group Leadership'. In the opening paragraphs the authors make their concern about this subject clear, 'this lack of research in Balint Leadership [...] has had unfortunate consequences [...] ineffective group leadership has sometimes dampened enthusiasm for Balint work.' As a result of their research, they come up with what they describe as essential characteristics: creates climate of safety, acceptance and trust; establishes and maintains group norms (boundaries etc.); promotes movement towards the group's task; understands group process; personality and style of leader (modelling behaviour). Few would quibble with that list. The difficulties, however, lie more in the complexity that lies behind each of these characteristics.

Much more recently, Andre Matalon and his colleagues in Israel have written that 'little has been published about the leadership of Balint groups for

[1] A short introduction to the First International Balint Group Leadership Conference held in Copenhagen (April 28th-30th 2011). First published 2011, Vol. 39, *Journal of the Balint Society*.

general practitioners [...] and little is known about guidelines and goals for leading such groups.' They then make a comparison between answers given by Israeli Balint leaders to questions about how they perceive their role with Michael Balint's own views about the role of the leader in these groups. I will give one example. The Israeli group leaders placed emphasis on 'giving support' and on 'reducing anxiety and tension'. Michael Balint, in his Appendix on training', has a heading 'crises in the group,' most of which he seems to think can be valuable. But he goes on to say 'if such crises occur too often, or leave bitter resentment behind, it is a sign that the pace of training has been too exacting…' But he continues, 'it is an equally ominous sign [...] if no crises occur; it means that [...] the group and its leader are in real danger of degenerating into a mutual admiration society in which everything is fine and the whole group consists of nice, clever, and sensible people.' This difference in emphasis would seem to reflect an important parameter to consider — the question of productive levels of anxiety and a necessary degree of conflict within the group.

And lastly, at Brasov in 2009, Dorte Kjeldmand and Karen Glaser read a paper called, 'Gender and other predicaments in Balint groups'. I recall their opening question. 'Where to begin if we are to consider the fundamental question of the Balint group leader's countertransference to the group?' With gentle irony, they outline that the role of the leader is usually suggested to follow a few, very tasteful and humble parameters [...] and illustrate this by the use of genteel English phrases such as applying a 'touch on the tiller to keep the group on course.' Pertinently, they ask 'what does the group leader bring by way of unconscious biases and countertransference towards the group members and where are these feelings accounted for?' A good question, surely?

Now, there might be many good reasons for there being so few papers concerned with leadership. Group leadership is a practical matter, highly individual and not at all easy to characterise or study. Certainly there are a growing

number of workshops and intensives devoted to leadership training internationally. In the UK there has been a marked increase in this activity during the last five years or so. But I would like to suggest another possible reason.

At the beginning of the Balint movement, leadership was the province of psychoanalysts, most of whom were also psychiatrists. Discussions of leadership technique, pitfalls and difficulties were the province of the psychoanalyst leaders and held (in the main) at separate conferences and workshops. Michael Balint himself emphasised this separation very clearly by putting his remarks about leadership in an Appendix of his 1957 book'. 'This chapter', he wrote, 'is intended for psychiatrists [...] not primarily for general practitioners [...] its tone is somewhat different from the rest of the book, technical terms being used more freely...' The Tavistock Clinic in London held a regular meeting called the GP and Allied Professionals Workshop, to which a few of us were occasionally invited but in the main this was a meeting attended only by psychoanalysts. A number of valuable papers were written about leadership by members of that workshop, but they are not part of our literature. In the UK, no psychoanalyst joined the Balint Society when it was founded. The International Balint Federation (IBF) is an affiliation of Balint Societies which were all founded out of the enthusiasm of GPs for a Balint approach to their work. Thus, from the outset, the study of leadership lay outside their main interest and expertise. Later, as GPs took on more of an interest in leading groups they did so largely from within the educational structures in which they already held positions of responsibility.

So, who is leading groups today? In 2009, IBF conducted a simple survey.

IBF Questionnaire Summary

Questionnaires were sent to all (22) member countries affiliated to IBF. Responses were received from 13 countries and Norway and AIPB (Association of International Psychodrama Balint).

Five countries have their own criteria for accrediting leaders. Four said they were in preparation.

Who leads groups?

Mainly GPs: 3

Mainly psychoanalysts: 1

Only doctors: 1 (50:50 psychiatrists/GPs)

Mixed professional leadership: (a clear preference for co-leadership between GPs and mental health professionals): 10

Does your society have a formal leadership training course or programme?

Yes (USA and Austria); Hungary (one day/month for a year); Denmark had a cohort trained (1998-2000) and a further is being planned.

Quite a few (9) countries offer varied programmes of weekends, conferences, intensives and workshops.

Different Professional Directions to Leadership

Neither Michael Balint nor Enid thought that being a practising psychoanalyst was in itself sufficient to qualify for being a Balint group leader. *In Lessons of the Masters* (2004), Michael Courtenay says that, 'both analysts and non-analysts must make a journey into a `Balint space' of special expertise. It is perhaps interesting to think about the nature of that special Balint space. Looking back at my experience of working with Enid Balint, I can say that she never sounded like a psychoanalyst when leading a group, even though she would have fiercely defended the special nature of the analyst's contribution. As a result of Michael Balint's earlier proscription have GP leaders lacked confidence in developing a conceptual framework with which to think about issues associated with leadership? Is this partly where we are now?

Questions

In his *History of the Theoretical Roots of the Balint Group Movement* (2009), Alan Johnson asks 'precisely, what was, or is, the theoretical foundation of the Balint

group method?' Although we might not want to try and give an answer to this question, it's not a bad question to have in mind. How do we navigate whilst leading? To what basic concepts do we refer when considering issues that arise in connection with leadership? What can we observe in a group without some sort of theoretical framework? On the other hand, if we hold to theory too closely, will we see anything other than confirmation of our theory?

What is our view of the group part of a Balint group? Do we take what might be regarded as an analytic view of groups, perhaps derived from Bion or others? Or, do we hold a more benign view in which groups are thought to be somehow self-running and intrinsically developmental? As leaders, do we press the starter, keep the show on the road but basically trust 'the group' to work away, or does our view of groups involve the unconscious, defences and psychic phenomena which require more active intervention? And whatever our views, how do we lead in practice, with what basic assumptions about process? In the UK, when recently we debated the relative merits of the presenting doctor sitting in or sitting out, it became clear that this couldn't be thought about without an understanding of how such a move might affect group process, and a view about the aims of the group.

How much do we consider the relationship between the aims of different Balint groups and different approaches to leadership? The aims of a group for students, or one for GP registrars, or one for cancer physicians, or an ongoing group for established GPs, will all differ. Parallel process is often referred to in workshops and discussions about leadership. This usually refers to the process whereby the relationship between patient and presenting doctor becomes enacted in the group process as the group set about trying to help the doctor with his case. How do we use this in practice as leaders? Should we also be bearing in mind a further 'parallel' relationship — that between the group process, including the stance of the leader, and the parallel changes in the consulting room? John Salinsky makes this point in his interesting review of the history of Balint work, *Hanging by a Thread* (2000). He

asks the question whether the reported shifts in emphasis of the doctors' consulting approach through the various Balint books from *Six Minutes,* through *While I'm Here, Doctor; The Doctor, the Patient and the Group* to the last such book, *What Are You Feeling, Foctor?* also require a corresponding change in leadership? After all, if the leader is primarily interested in encouraging the group to get behind the presenting complaint, then the doctors are being unconsciously encouraged to become 'detective inspectors.' If the leader is less concerned with history, more alive to the present work in the 'here and now' of the group — perhaps listening for the way a group might pick up small changes in the doctor-patient relationship — then those attitudes will be more likely to be acquired by the doctors in the group. In the last book written by a research Balint group, *What Are You Feeling, Doctor?* the emphasis is placed on doctors becoming more alert to their defensive reactions (red lights) when consulting. In the same way, perhaps, leaders need to develop an ability to notice their leadership 'red lights.' Perhaps when thinking about any aspect of Balint group process, it is helpful to think about the parallel process, in the consulting room. It is, after all, what goes on in the consulting room that is the point of the whole exercise.

This brings us back to the question of the behaviour of the leader and the modelling that this engenders in the group members. Certainly the early leaders, the 'masters', set great store by this, actively modelling in the group process an enquiring, rigorous, attentively listening attitude of mind which they thought doctors needed to develop in the course of their clinical work. They were a confident breed, not afraid to take risks. If doctors are to be encouraged to have the courage of their stupidity, leaders definitely do as well.

Where are we now?

References

Balint, M. (1957). *The Doctor, His Patient and the Illness.* Pitman: London.

Courtenay, M.J.F. (2004) Lessons of the masters *Journal of the Balint Society* 32: 10-11.

Elder, A. and Watt, D. (2010). Thoughts on sitting in or sitting out. *Journal of the Balint Society* 38: 30-31.

Hakim, R, Maoz, B., Yaphe, J., Rabin, S. and Matalon (2011). Balint Group Leaders in Israel: A mixed method study of the goals and roles of the group leader. *Journal of the Balint Societ*y 39.

Johnson, A.H., Nease D.E., Milberg, L.C. and Addison, R.B. (2004). Essential characteristics of effective Balint group leadership, *Family Medicine*: 36(4): 253-259.

Johnson, A.H. (2009). A history of the theoretical roots of the Balint group method *Journal of the Balint Society* 37: 13-24.

Kjeldmand, D. and Glaser, K. (2009). Gender and other predicaments in Balint groups. In *Proceedings of the 16th International Balint Congress*. Romanian Association of Balint Groups and the International Balint Federation, 37-40.

Salinsky, J.V. (2000). Hanging by a thread: the history of Balint in Britain 1972-99 *Journal of the Balint Society* 28: 6-10.

Salinsky, J.V. and Sackin, P. (2000). *What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation.* Radcliffe Medical Press: Oxford.

Tyndale, A. and Salinsky, J.V. (2010). Sitting in or sitting out*? Journal of the Balint Society* 38: 28-29.

Malone, J. (2022). A Short Response to Andrew Elder 'Balint Group Leadership: Where Are We Now?', 2011. *Journal of the Balint Society, 49: 140-141*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Short Response to Andrew Elder 'Balint Group Leadership: Where Are We Now?' (2011)

Judy Malone[1]

[1] Psychanalytical psychotherapist, Bristol, UK: judymalone27kd@gmail.com

In reading this interesting piece by Andrew Elder, I enjoyed his approach and the thoughtful overview and description of the varying aspects of Balint group leadership. I particularly appreciated Andrew's pertinent questions.

I believe the International Balint Federation have recently done a further survey looking at leaders and leadership training across the various international Balint societies and it will be interesting to note the results and compare with the 2009 survey – we know the societies are changing with changing membership and times and this will have to be reflected in various ways.

There are a range of leadership styles with differences in leadership due to the discipline, experience and personality of the leaders.

In my view, leaders need time in a range of Balint settings to take in the Balint model and a robust leadership training is essential. I would hope that leaders take on the important tasks and 'essential characteristics' as described in the article and particularly allow themselves to help the group – if and when it needs it – note the unconscious communication that becomes apparent from the clinician's presentation of the patient and the ensuing and evolving discussion.

To build on Andrew's points I would be wanting leaders to be attentive to what they observe and experience in the group and to allow themselves the space and time to think what might be a useful intervention for the particular group they are leading. I would want leaders to notice the feelings that get stirred up within themselves as they listen to and observe the group and to consider what these feelings might be indicating about the presented clinician patient relationship.

---

[1] Judy Malone is currently co-president of the Balint Society. She is a BPC registered psychanalytical psychotherapist based in Bristol. She originally trained as a GP and has been interested in Balint and supporting medical students, and a range of trainees and clinicians through Balint, teaching and supervision throughout her career.

Lee, L. (2022). A Short Response to Andrew Elder 'Balint Group Leadership: Where Are We Now?', 2011. *Journal of the Balint Society, 49: 142-144*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Short Response to Andrew Elder 'Balint Group Leadership: Where are we now?' (2011)

Liz Lee[1]

[1] Retired GP, Bristol: drlizlee@gmail.com

In his paper from 2011 Andrew Elder asked what makes for effective Balint Leadership. He notes the lack of research into this question and so is compelled to think and write about it from his own long experience of Balint work. Many of his thoughts still resonate today in spite of immense changes to the social and medical landscape.

And what of more recent research into effective leadership? Well the question seems to have been put in the 'too difficult' box and quietly dropped. Attention has turned instead to outcomes, for example the recent paper from China: 'A Randomised Controlled Trial into Balint and prevention of Burnout in Medical Residents (Huang, 2020). Rather presciently, Elder notes that no one ever joined a group because there was evidence of its effectiveness, 'It is our experience in a group that convinces us and changes the way we practice'.

So what changes have affected Balint work in the intervening years? Both general practice and psychiatry are very different. General practice is now dominated by large group practices often staffed by women working part time and providing lots of appointments by phone. Their autonomy is greatly reduced and their sense of ownership and belonging is weakened. Most significantly there has been a catastrophic loss of continuity of patient care. This is something that has recently been discussed at the Parliamentary Health Select Committee but there is no prospect of any imminent improvement. Psychiatric services are also in constant flux and stretched to breaking point. Many patients now receive their care from teams with caseloads rather than from individual professionals, again at the expense of continuity.

The changes are not all negative. On the plus side we have local, national and international Balint groups meeting regularly online. For the first time there

[1] Liz Lee is a retired GP and continues to co-lead four Balint groups: the Bristol GP Trainee group, two Bristol GP groups and a multidisciplinary Balint Society on-line group. She is also in the team delivering Balint groups to medical students in Bristol. She was a member of a Bristol GP group for fourteen years.

are no more Balint wastelands where no leaders dwell or groups ever meet. And there is continued enthusiasm for Balint work and excellent attendance at Leadership training days. We have even managed to get the Royal College of General Practice to support initiatives introducing Balint work back into practice.

Elder asks if we should consider different approaches to leadership according to the aims of different Balint groups. In essence, what do group members need from their Leaders? Perhaps this is the key question we should be asking now. We have the tools to be flexible in what we offer and a Health Care workforce that has surely never needed it more. Now is the time to explore new ways of meeting these needs.

Reference

Huang, L. et al. (2020). A Randomized Controlled Trial of Balint Groups to Prevent Burnout Among Residents in China. *Frontiers in Psychiatry* 10: 957.

Froggett, A. (2022). How to Fail at Running a Balint Group, 2013. *Journal of the Balint Society, 49: 145-149.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

How to Fail at Running a Balint Group (2013)

Anthony Froggett[1]

[1] Training Analyst, Institute of Group Analysis

Introduction

I like to think of myself as something of an expert when it comes to running groups that fail. Several years ago I was asked to set up a 'learning set' group for locum GPs for a year. This group stumbled along, typically with two or three members each time, before coming to a close. I've set up a private Balint Group that started with eight GPs and closed after a year because of low attendance. I also co-led a group with Ceri Dornan for junior doctors at a local teaching hospital. This group had nine people signed up for it on paper. Four people attended the first couple of sessions but the numbers quickly dwindled to the point where we were sat by ourselves eating the sandwiches that had been ordered for the group!

Talking to other Balint Group leaders, I don't think these experiences are uncommon. Many groups are enthusiastically conceived but few reach full maturity. Why is this the case? What are the factors that lead to a group not enduring? Thankfully I have also conducted groups that have managed to survive, including a private Balint Group that has met for the past ten years. So, what is the difference between groups that thrive and those that limp along or close after a short period?

In *The 'essential' and 'desirable' characteristics of a Balint group* (1994), Paul Sackin gives a helpful outline of the core elements that are necessary to run a successful Balint Group. He describes the task of the group and gives helpful tips about things such as the size of the group and not using case notes for presentations. He refers to 'the standard rules for small group working' such as confidentiality, but what are these rules? They are omitted perhaps because a list of all the things one had to think about in order to lead a successful group would be long, tedious and perhaps rather obvious. I doubt a complete list of 'rules' would be possible. In this short

---

[1] First published 2013, Vol. 41, *Journal of the Balint Society*.
At the time of publication, Antony Froggett was a training analyst and training supervisor with the Institute of Group Analysis. He was the Director of Training for the IGA training courses in group analysis in Manchester (2007-2012).

article, I have set myself the much easier task of listing some of the ways to get things wrong when running a Balint group.

Here is my list of ten ways to run a group in order to demoralise participants, encourage drop-outs, and to ensure the early closure of the group.

Ten ways to run a group that will fail:

1. Run the group as soon as possible without minimal planning. Allow yourself to get carried away by your own enthusiasms. Assume that each enquiry about the group is someone who is committed and willing to join. Start with low numbers if possible and assume that others will soon be joining the group.
2. Isolate yourself professionally from others if you can. If it is a private group — don't bother to network with colleagues – send out an email to a general email list. Better still, get someone else to do this on your behalf.
3. You may be asked to run a group to fail in an organisational setting. Although this may not always be explicitly stated — look for signs such as the group being optional, last minute organising, and clashes with other meetings. If you are asked to run a group in an organisational setting then assume that all practicalities have been sorted out beforehand. Turn up on the day and see what happens. Don't speak to tutors or managers; especially do not speak to secretaries, caretakers, or admin assistants. Assume everyone in the organisation knows what you are doing and are fully supportive of the group.
4. If you are setting up a private Balint Group try to avoid any discussion of money. Wait until the last minute to mention fees and then ask, in an embarrassed way, in order to communicate the lack of value you attach to the group. If possible don't ask for money at all and pay all expenses yourself. This will ensure that you are left resentful and do not want to continue running the group.

5. Choose an inappropriate venue if possible —medical settings are best, if these are not available choose another venue with strong emotional feelings attached to it (I know of a course that was successfully closed by running it in a hospice for several years). Venues that are obscure, or with poor parking, or that are very busy are a good option. Choose a room that might get double-booked or where you might be interrupted.
6. Don't have any 'selection' or induction process for the group. Let anyone who wants to join come along, regardless of their interests or suitability.
7. Don't ask for any commitment from participants — be as flexible as possible. Let people come for a trial period rather than making a commitment to attending. If people do not attend the group don't follow them up by email or telephone. If this is not your style, then alternatively you can anxiously contact each member about the group to check if they are going to attend the next session — in order to communicate that you don't think the group will survive without their unwavering commitment and attendance.
8. Choose a co-leader who is unknown to you, or (even better) someone whom you actively dislike or distrust. Don't take time to discuss and plan running the group together. Dynamics of competition and rivalry are very helpful in getting a group to fail.
9. Don't have any system for taking notes about the group. Do not record attendance, apologies and notices of future absences. Do not write down your thoughts about how the group went or ideas that you have had about the group.
10. Finally, avoid reflecting on how the group is going. Arrange your schedule so that you have to immediately dash off after running the group without speaking to your co-leader. Do not arrange any form of supervision or consultation to help you with thinking about the group.

Conclusion

I have listed above ten of the things I have done that have resulted in the failure of Balint and other groups that I have conducted. There are, of course, many other ways to fail at running a Balint group. You may even have done some of these yourself. Most of the ways of failing stem from not wanting to think about the ordinary difficulties of running a group. Paradoxically, by trying to avoid the feeling of failure we often inadvertently bring it about. By avoiding awkward conversations with colleagues we temporarily feel less anxious, but we are also no longer in a position to learn from our experiences. Running a successful Balint group requires many of the same attributes needed for being a participant in a Balint group — one must learn how to reach out to others in order to achieve something that is not possible by oneself, to be tolerant of one's own and others' mistakes, and to have the courage to learn from these. Instead of trying to avoid failure we should perhaps consider how we might embrace it; that is to celebrate our mistakes, stumblings and mishaps as we learn. In the words of Samuel Beckett 'Ever tried. Ever failed. No matter. Try again. Fail again. Fail better.'

Still image from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970. Transcribing and audio recording the group discussion.

Elder, A. (2022). Balint Group Leadership: Conceptual Foundations and a Framework for Leadership Development?, 2017. *Journal of the Balint Society, 49: 151-161.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Balint Group Leadership: Conceptual Foundations and a Framework for Leadership Development? (2017)

Andrew Elder[1]

[1] FRCGP DEd (Hon): andrewelder@blueyonder.co.uk

'A leader is an ordinary person in an extraordinary position' - Donald Winnicott

The Question

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

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

[1] Leadership conference in Warsaw, 2016.

First published 2017, Vol. 45, *Journal of the Balint Society*.

Underlying Principles: Psychoanalysis, Medicine and Mutuality

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

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

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

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

Parallel Process: The Consulting Room and the Group

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

be influencing the doctor and to distinguish the patient's influence from the doctor's own distorting tendencies and professional needs' (Gosling and Turquet 1967). In other words, who is speaking? Is it the patient or the doctor? Perhaps we need to be careful when we use those apparently distinct and deceptively circumscribed words 'doctor' and 'patient'. Both are more porous than we imagine. As discussion of a case proceeds, different aspects are taken up by (or will subdue) different members of the group according to their personal psychological disposition (often called valency). In a well-established group, a leader may become familiar with the group member's personal patterns of reaction, enabling her to 'read' unconscious aspects of the case in the reactions of the group. The leader tries to listen to how the group takes up the case and how the other participants work with the presenter. It is these processes that are the focus of the group work as the detailed interaction between doctor and patient is revealed in the parallel between the reactions of the participants in the group and the presenting doctor. All this, of course, the poor leaders have to try and observe as well as being part of the process. The leaders have to be prepared to be alone in their role and to withstand the many pressures to which they will feel subjected.

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

Work of the Group

Medicine is about serious matters. Tom Main, a close colleague of the Balints, reminds us in a comparison between medicine and war, that 'both are concerned

with issues of life and death, crippledom and loss, sadnesses and terrors about external dangers; and both are also complicated by anxieties from the inner world, unconscious fantasies of primitive sadism, punishment and so on' (Main 1978). Just as doctors have their necessary defences which enable them to function in a professional setting, so do individual group members and groups as collective entities. Some of these defences will be personal or derive from disturbing aspects of the case whilst others will be connected with the unconscious preoccupations of the group itself.

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

Parallel Process: The Group and the Consulting Room

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

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

presenting doctor is the only person in the group who has actual contact with the patient. For this reason, follow-up reports were always encouraged by the Balints and their colleagues.

Developments

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

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

Pushback

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

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

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

The last area I want to highlight *is a subtle shift in the aim of Balint work towards* a more explicit concern with morale. Low morale is of great concern but there is a

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

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

Conclusion

In all Balint work there is the need for a secure frame which enables the freedom and creativity of the participants to flourish. There are many ways in which we could think about the creativity of a Balint leader in attempting to embody that frame: use of clear language which resonates with the group members, free of euphemisms or jargon; supporting the creativity of members of the group - perhaps

thinking of leadership as something that passes from member to member; and allowing the group members time to discover their own ways of thinking about the difficulties presented. Disturbing ideas tend to shut down thinking. A Balint group is a place in which to explore and play with new ideas. The space for exploration in the group is, to a certain extent, a function of the negative capability in the leader's mind. Borrowing from Keats, perhaps we could say: when a Balint leader is *capable of being in uncertainties, mysteries, doubts, without too much irritable reaching after fact and reason.* And for this to occur, the leader must be sufficiently comfortable to lead in his or her own way, not in any correct way, but keeping in mind the *Basic Concepts of a Balint Group and the Leader's Role within that Framework.*

References

Balint, E., Courtenay, M., Elder, A., Hull, S. and Julian, P. (1993). *The Doctor, the Patient, and the Group: Balint Revisited.* Abingdon: Routledge.

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression.* Tavistock: London.

Balint, M. (1957). *The Doctor, His Patient and the Illness.* Pitman: London.

Courtenay, M. (1994). The 'Good' Leader (personal communication).

Courtenay, M. (2004). Lessons of the Masters, *Journal of the Balint Society* 32: 10-12.

Elder, A. and Samuel, O. (1987). *While I'm here, doctor.* Abingdon: Routledge.

Elder, A. (2007). The Role of the Balint Group Leader, *Journal of the Balint Society* 35: 15-18.

Gosling, R., Miller, D., Woodhouse, D. & Turquet, P. (1967). *The Use of Small Groups in Training*. London: Karnac Books.

Main, T. (1978). Some medical defences against involvement with patients. In *The Ailment and Other Psychoanalytic Essays*, eds Johns, J. & Rayner, E.: London: Free Association Books, 1989.

Seigel, S. (2022). A Short Response to Andrew Elder 'Balint Group Leadership: Conceptual Foundations and a Framework for Leadership Development?', 2017. *Journal of the Balint Society, 49: 162-165*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Short Response to Andrew Elder 'Balint Group Leadership: Conceptual Foundations and a Framework for Leadership Development?' (2017)

Shake Seigel[1]

[1] Independent medical practitioner, Staffordshire: shake.seigel@btinternet.com

In his paper from 2011 Andrew Elder asked what makes for effective Balint Leadership. He notes the lack of research into this question and so is compelled to think and write about it from his own long experience of Balint work. Many of his thoughts still resonate today in spite of immense changes to the social and medical landscape.

The paper presented by Andrew Elder on the 10th of February 2017 captures much of the current debate and discussion about Balint Leadership. In my opinion this paper is very topical and current. There are aspects of the paper that I think are particularly relevant to the current situation in the UK.

I will highlight some of the points to consider.

1. **Mutuality.** Here we are referring to the two-way influence between medical practitioners (mainly GPs) and analysts. Michael Balint initially designed groups with this in mind and this genetic inheritance lives on productively within Balint Groups. The value of medical practitioners understanding aspects of long-term psychodynamic factors, awareness of unconscious processes in their patients as well as themselves are some of the benefits. For analysts to get a deeper insight into the ups and downs and the feelings and thoughts of practitioners in the setting of the consulting room, working under many different constraints, remains something of immense value to them. Currently GPs and psychiatrists in training attend Balint groups. For some it is mandatory (the psychiatry trainees), and for others optional. This inevitably affects the group's functions as attendances vary widely and with varied motivations. In short, more psychiatrists are doing Balint groups than

[1] Shake Seigel is an independent medical practitioner, educator and mentor, based in Staffordshire. Currently Chair of Balint Society UK Training & Education Committee. Former positions include: Village GP, Training Programme Director and GP Trainer, Retired Associate Prof in PBL at Nottingham University, Graduate Entry Medical School (GEM).

GPs. Maintaining and restoring a balance is a current challenge. The benefits and value of mutuality are at stake.

2. **Group Processes and Theory.** At the outset group analysis was not incorporated into Balint group thinking and working. This has however changed much over the intervening 50 years, and many group leaders are now group analysts. Over this time there has been recognition and attention to parallel processes, what I like to call 'fractals' or repeating patterns within groups. Andrew Elder refers to the numerous parallels at work in the group in his article. The 'layers' he refers to are:
   i. The doctor and the patient,
   ii. The doctor and the group,
   iii. The leader and the group, and
   iv. The leader and the doctor presenting a case.

I believe this is now an established aspect of leadership awareness and continues to require attention. Leaders in training and established leaders need to hold these concepts in mind.

3. **The need for ongoing discussion, debate and reflection.** The world has undergone major convulsions in recent years. One of the most influential for Balint Groups has been the pandemic and groups going online. How to lead a group online is something that has become a 'must do' and requires sharing of best practice and discussion worldwide. This is not to say this is the only pressure. I refer also to the changing demographic of leaders being accredited within the UK: many more psychiatrists than GPs. This is important because of the initial point above, regarding the benefit of mutuality of experience. Medical students are also increasingly being introduced to Balint work. The net result is that different types of Balint groups are emerging depending on who the participants are and who leads them. More than ever, this requires active discussion and debate about what

> we think we are doing when we lead a Balint group. A recent 2022 conference hosted by the International Balint Federation (IBF) captured the challenge in its conference strap line of 'Core Values: Cohesion and Flexibility'.

I believe the current challenge to leadership training and practice is similar to the emergent phronesis (wisdom from doing) prevalent in General Practice. There are technical aspects and theories that influence how we lead groups and train leaders. However the way in which leaders lead a group, comes from experience of doing it in many different settings. I believe we need to continue deliberating on leadership as a society of professionals. We need to avoid mechanistic or 'formulaic rules' for leadership. For example 'pushback' can be viewed as 'a tool and not a rule'. We need to acknowledge the variety of types of Balint Groups. We need to acknowledge that leaders are human and individuals who make choices in the moment in groups and lead in unique and possibly idiosyncratic ways. However underpinning all the above, I believe that the major implication and challenge for us is to continue the discussion conceptualising what we mean when we talk about 'what a Balint Group is, and how to lead one?'.

Still image from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970.

Khan, M. (2022). The Elephant in the Room: The Balinteer in the Background. *Journal of the Balint Society, 49: 167-178.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

The Elephant in the Room: The Balinteer in the Background

Balint Society Essay Prize 2021 Joint Winner - Student

Maria Khan[1]

[1] Aga Khan University Medical College, Karachi, Pakistan: maria.khan@scholar.aku.edu

It has been a year, give or take, since I first came across the word 'Balint'. I was lucky enough to be offered a place in a Balint group happening near me, which was quite the surprise, considering that I live in a lower-middle income country in Asia. But work like Balint has a way to spread its roots, and quickly.

Ever since then, every month, on Sunday morning, I am transported into a world of transcendence. I've figured out that mesh of discomfort that comes from having unnamed feelings bundled up inside one's chest. I've gone from only being able to relate to others by sharing a similar experience to actually using thoughts and words to express myself. A lot of the time, this comes as a shock: was I really that... ignorant? Or maybe the word here is 'aloof'. I'm like the patient with a mild pain who has been ignoring it for years, only dropping in to see a doctor because they were in the area and had time to kill. If I was hearing this story, for example, from someone a year ago, I'd reciprocate by saying, 'I know! There was one patient I saw…', as though 'I know' took the place of all or any of the complex feelings brewing in me.

There is, however, something missing in the world of Balint, probably because not many 'of our kind' are here yet. See, there is never just a doctor-patient relationship, the dynamics of which must be explored from different aspects and angles; at least not in teaching institutions; at least not the way I see it. There is one more person, a wallflower if you will, the elephant in the room: the medical student.

We stand in doctors' clinics, we 'shadow' physicians, we 'do rounds with' surgeons. But we are very much physically present and, it wouldn't be a stretch to say, emotionally invested. Indeed, this is the age of 'firsts' for us. It's the first time we see blood and someone faints, the first time we see a very sick patient that makes us dizzy, the first time we watch a miraculous recovery and passion is revived, the

[1] Maria Khan is a medical student at Aga Khan University Medical College, Karachi, Pakistan.

first time we see death or its grief as we stand around a lecturing professor in the ward.

And it doesn't have to be the first experience of something that shakes us to our core. They say that in war zones, you feel all the feelings, but not always at the right time. Here at the hospital it could be the second patient, or the third, that one patient we will remember forever when we actually feel things for the first time. And it is these feelings that eventually settle in and unsettle us. It is the first time we process feeling that something great has possessed us and that this great event has really stirred in us a feeling.

But the first time we process our feelings is in no way the first time we actually acknowledge them. That comes down the line somewhere, at least if you are as taken by surprise as I was, or as emotionally naive. And that brings me to a word I have been using a lot now: feeling. Feeling what? Just like 'I know' and 'right!' it has become one of my go-to words to describe anything from a grumbling stomach to true love. What exactly the feeling is, part and parcel of which is what it does to us, is wholly ignored. You can go through your whole day by saying you feel things and not actually describing them and I was doing just that, until I found myself sitting in front of my laptop screen in a meeting with ten or so participants being nudged to finally do it: describe what I feel and how I feel.

The strongest feelings are not evoked only during the classic *quadrad* (as I call it) of birth, disease, recovery and death. Somehow, a lot of literature revolves around these delicate absolutes. The truth is that a lot of how we feel about a patient encounter has to do with how we feel, full stop. And that's where those special patients come in. There are stories we cannot separate ourselves from; even though we may have been scrubbed-in to that same procedure multiple times, somehow this child is different from all others. Why that is remains a mystery.

There are talks and workshops that we attend to deal with difficult patient encounters. Again, it would be a stretch to think that there are some difficult encounters and other easy ones. Any encounter, of any nature, be it a clinic visit or a pre-operative assessment, can become a challenge when things go wrong. I think it takes great observation to realize that. It can be the sudden change in expression, so mild it could only be a twitch, that escapes a watchful resident's gaze as they look down to take a note. It can be slightly unconventional wording that indicates to you that this patient might just prefer it if their spouse wasn't around. It might even be a new piece of information that the patient is given that makes their situation considerably more difficult, such as being informed of a hospital stay when they thought it would be a day-care procedure.

All of these situations have been described in the third person, because that is usually who I am. The third person in the room. I am the prequel who asks a whole bunch of 'unnecessary' boring questions while people wait for the real doctor. I am also the one who bugs patients a lot more in the ward, asking them the same thing a junior doctor might have already asked them half an hour ago. I am the clerk who fills out the investagram when clinics need to be sped up. And, many times, I am dead weight that patients do not have the headspace to care for, and doctors are too busy to engage with. But throughout this grunt work, I am alive and observing.

Rotating through different wards has one important implication from the Balint perspective. It means we see a snapshot of a patient's life and are likely to never see them again. If there is anything I have learnt from my Balint groups so far, it is that incomplete stories are the hardest to tell and often take a huge toll on you. We immerse ourselves in the patient's story (just one of many). We focus all our energy on 'this case': we read about it, we write about it, we give it undivided attention – and then, just like that, we move on to the next bed. So we'll never know

what happened to them, if they got better, if they had a relapse, or if their multiple sclerosis is resulting in more contractures.

We are just expected to move on, and these multiple one-offs are incomplete, like a diary entry that is started but never signed off. The Balint case becomes not an exploration of the patient's life and our perspective of it, but a fragment of a story that has so many missing chapters that it is difficult to make out the present. If a student, like myself, is presenting a case in a Balint group with no other students, one might have to explain the glaring reality that not being able to follow this story is one of the reasons it is so taxing. I learnt this when, in the first few groups, the presenter reflected that this case was emotionally taxing because the client never came back after a few visits. This was a common theme in many case presentations. If it is such an emotionally fatiguing experience for healthcare professionals that it comes up routinely in Balint groups, I can only imagine the impact it must have on students, who invariably see a patient just once. The thoughts of what could have happened keep coming to our minds because it is so hard to keep track of a patient once your rotation has changed and you have to give undivided attention and focused energy to someone else's story. When I am considering presenting a case to my Balint group, I struggle because each one has its own element of emotional significance, but each one is emotionally taxing because it is left incomplete. My Balint group, in which I am the only student, often presents a case where the doctor's great fear and guilt is about whether they did everything they possibly – and humanely – could for that patient. Another realm of the medical student-patient relationship is how there is only so much that we can do. Being assigned barely any responsibility compared to the rest of the team does not mean that we have it easy. I feel this, too, is similar to the helplessness that envelops any war zone. It isn't just the active role, but also the passive role that suffers; there is too much out of your control. It is just as frustrating at times to be on the sidelines, watching. As the team work their way through the treatment you,

the one who took so much of the patient's time, or who shook them awake for 7am rounds, just stand there, taking notes, making a learning opportunity of it. The great fear for us and our guilt is about whether we would be able to do anything at all and play our part. But we are assigned, specifically, to stand and observe.

This observation becomes much harder when a complex doctor-patient dynamic is unravelling. Of course we don't always get assigned to the more emotionally aware, verbally sophisticated or even politically correct physicians. When there is a clash, and I mean a clash, there isn't a good manual that tells us where to look. Learning so much about Balint, trying to be more cognisant, and making that daily effort, seems out of place when you walk into a consultation that is doomed. It may be a clinic visit where the doctor is too harsh, a counselling session where the information is too fragmented, or a post-operative follow-up where the pain is shrugged off. All those lectures and workshops come back to you, and the mnemonics play in your mind, telling you when to sign-post bad news and when to listen actively, like muscle memory for times when your brain freezes. But you cannot use any of it until it comes up in your exam. Because you may be able to be more tender, give fuller information, and re-evaluate pain management, but you are not authorized to do so. In fact, at times like these, most of us find comfort in blending with the walls.

Even opportunities for one-on-one discussions with the patient are limited. And when they do arise, most patients save details for the consultant. And so, when major revelations are made, from the Balint perspective, it is not so much the medical student-patient dynamic that needs to be explored but the doctor-patient-medical student dynamic. Others in the healthcare team, and those who accompany the patient, add to this list, making the scenario much more complex.

As more Balint groups that cater to students – particularly medical students – evolve, a major issue that I imagine will need addressing in nearly every group is the effect of student-doctor dynamics on how we relate to the case. Do strict

consultants make us bolt up our feelings? Do approachable consultants make us face our vulnerabilities more? And then I think of all those consultations where I have seen poor examples of communication skills, impatience and a lack of empathy from physicians. I wonder if we, without regular reflection, absorb these small acts throughout the day, and gradually lose the knowledge of our talks and workshops. At the same time, empathetic doctors have a lasting impression on us and we strive to be like them. How does this affect the way we perceive the dynamics of patient care? I have yet to explore this in detail, but I gather that it is often the doctor who discusses the emotional intricacies of the case with me outside the clinic room that I learn the most from. Indeed, there are many doctors who, like me, will reciprocate a story about an onerous encounter with another.

While such an exchange is also a great form of reflection – and is certainly cathartic in its own right – it seems less useful in learning how to process one's feelings. It would be like a Balint group where everyone shares a case, but the presenter is never sitting back. Giving it a word just helps us know it's real and lets us talk about it, which is essential if we are to properly process it. Before Balint, I don't think I would have figured out just how different my situation is as a student, compared to some of the other members of the healthcare team. Now, listening to the perspectives of healthcare professionals in my Balint group, I realize that their situation has shaped their perspectives very differently from mine.

Even though we do not just share cases in Balint groups, the idea of 'a story for a story' is not so far off from the Balint mission, it seems. During our Balint group retreat, when participating in a group of strangers after the comfort of being in the same group every Sunday, I realized that the cases presented here are not altogether that different from those presented in my regular group. I guess we all feel the same way at some level, and are intrigued and that the same things that might bring one of us pain tend to bring all of us pain. I gather that Balint groups do not just help us process a case after the fact, when we hear our group members

discuss it while we observe silence. Balint does, in fact, prepare us for similar situations that we might encounter ourselves, not just by making us more emotionally responsive, but also by widening our view of the human experience. We do not merely discuss a case – we try to put ourselves in the presenter's shoes (consciously or unconsciously) and then build resilience that we may need later on when similar feelings are evoked in us.

An old question for an old problem is: do students really need all this resilience? I have been asked this on multiple occasions when I share my experience with physicians not involved in Balint group work. My simple answer is, yes. My complete answer is, yes! Balint is not an exercise in 'digging out' vulnerabilities where there are none or conducting a pseudointellectual discussion with one's peers. It is a means of catharsis for all the built up emotions that healthcare professionals have been carrying around since the start of time or, more specifically, since they were medical students. If students are given so much practice before the first time they step in front of a patient, they really must be given the psychological support of the strains of such an encounter. Not just because it is my first, but such encounters have left a lasting impact on me because I have to, by design, adopt a passive role. Anything practice or guideline that suggests otherwise for a medical student is too vague, with little safeguards for our protection when speaking up. Even offering the simple flavour of empathy is not easy when patients do not realize they can, and that you are actively trying to connect with them on a personal level. Coupled with that is how this point-in-time memory has no start and no end. When combined, all of this leads to simply too many 'what ifs'. Yet, people think students really do move on, just like the physical transition from one ward to the next, or one patient bed to the other. But elephants can remember. The fact that we have memory – and good memory at that – of all these precious first experiences bottled up inside us is never registered, let alone the fact that we may actually find it hard, very hard, to move on.

The picture is not, however, that bleak. There are fleeting moments where our textbooks are right when they say that we may, by strange coincidence, be the very person the patient feels comfortable speaking to and confides in. While this is nothing short of the most rewarding ethereal experience, it brings with it a barrage of difficult tasks and handovers that make this experience wholly difficult for the student and the patient. I haven't experienced any Balint groups with other students so it is unclear whether these perks also make their way into Balint group discussions. I gather they do, like so many enigmatic cases, end with the whole group's unspoken consensus that it may well be a happy ending for the patient.

It fascinates me how a group, together, can manage to draw such optimistic conclusions from a case and, most of all, think in harmony. If Balint groups have so unifying a power to herd people together, I gather that the interpersonal dynamics of such groups has the power to translate into solid action in the future. Consider this: twelve students meet every month and discuss similar core issues. They process how the lack of continuity of care, the shift in our rotations and the difficulties of solely observing add to the already hefty psychological strain patient care has on us. Surely, in this case, one would start to think towards ways to correct some of these problems. I don't think I could ever reach this stage of intervention-oriented thinking if, like most, I never actively processed under guidance of a facilitator, to consider the complex dynamics operating in patient consultations.

I have used the words conclusion and intervention with great care, as I know for a fact that Balint groups do not intend to, and should not provide solutions. However, it is not the active proposition of a solution, but the discussion of shared issues that keeps one thinking long after the case is over. It fascinates me how we learn so much from a group when there is no conventional inlet of knowledge. We only share cases, something healthcare professionals do routinely, but somehow this time because we do not reciprocate the case with another as we so often do in

our conversations, we manage to nurture our minds from within. It is as if we become self-sustaining, and that's just a stone's throw from one form of resilience.

Would I like a group with fellow students? Yes, I certainly would. But being in a diverse group, with different disciplines and various training levels has its own pros. It somehow soothes my feeling of not being an active part of the healthcare team when I see how universal our struggles are. At the same time, it gives me some leeway to reflect independently as my own perspective is so different from the rest. I wouldn't go so far as to say that a group with professionals helps me mature intellectually. Maturity of this kind has nothing to do with the hierarchy of the team and everything to do with one's introspection, understanding of the self, and how much we try to exercise this muscle, like being in a Balint group. I can say that, compared to the start of the year, I have matured just as much as the others, and my difference in clinical experience has not caused any hindrance. As I said before, I do think that many healthcare workers do not perceive the dynamics of patient care as well as Balinteers do, and in that regard, I think it is the active application of all the lessons we learn in workshops and lectures that can make that final impact and translate into action. In many ways, Balint does just that.

I have a long way to go along the Balint path. I still use so many day-to-day examples to describe my feelings. But I guess that can only improve with practice. I have even started using the name to mean more than just Balint groups. I now use it as a verb too. I gather this semantics will continue to evolve as I find more and more use for Balint. As Balint expands to other populations, including other professions, the landscape, and perhaps the structure of the groups may change significantly. If, even within the healthcare profession, when comparing physicians and their student counterparts, the degree of complexity has greatly changed, as has the focus of the group, it will certainly evolve when it crosses over to other fields.

Suffice to say, Balint for students has a long way to go, too. It is a pressing need that is not being met as enthusiastically as it should, but, once such groups are up and running, I am certain that the most preoccupied of students will make time to attend these groups. If they face as many challenges routinely as I do, I imagine they would make the most of these groups regardless of other commitments. It should be, in my opinion, part and parcel of patient care experiences. Perhaps one day it will be. Until then, and to make it happen, we need to inculcate a sense of Balint into emerging healthcare professionals. The key to do that is by engaging more students. If given a flavour now, I'm certain there will be more uptake than can be expected by seasoned doctors with busy schedules and other priorities.

The case for Balint for undergraduate students is much worse off here in my home country. With just a handful of Balint groups operating throughout the country, the chances of regular groups for students remains slim. However, students should not naturally come after professionals when expanding Balint groups. They should be considered just as important a population that can benefit from reflection, and if any, a more vulnerable one too. Here, resilience is not routinely taught to medical students, and they find themselves moving from the lecture hall to the bedside overnight. There is little opportunity to learn and be proficient in healthy coping strategies ourselves. And while this may indicate a pressing need for Balint for medical students, most of them do not know what Balint is – having opportunities to participate in groups is a long way off. If the elephant in the room is not addressed soon, its effect on the wellbeing of students and their mental health will continually deteriorate, and the prospect of a healthy career will diminish even further.

But this is not a debate; it is an established fact that I have merely reemphasized. No matter how fast Balint grows globally and here at home, if students do not have adequate access to groups, at least those with other students,

Balint may not be as well established in healthcare workers as we would hope. This was, in fact, a more reflective exercise of my experience, and I would like to end on this note: has Balint changed me? In many ways, I am still camouflaged in the background of clinical experience, doomed to vigilant observation and lesser practice than I would hope. But without Balint, I would have accepted this fate and would have really moved on to the next patient bed. It was only when I paused to think amongst the chaos of healthcare that I realized the strange discomfort harboured in my being. Through the groups, I verbalized those feelings – a feat for me! I believe that, for me, this is the greatest milestone, as though I have learnt a new language to put words to feelings. And indeed I have. It is the language of Balint and the language of human experience.

Simpson-Orlebar, F. (2022). Too Much and Never Enough. *Journal of the Balint Society, 49: 179-188.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Too Much and Never Enough

Balint Society Essay Prize 2021 Joint Winner - Student

Felix Simpson-Orlebar[1]

[1] Student, University College London, London: zchafsi@ucl.ac.uk

Towards the slower end of an afternoon during the fifth week of my clinical training I met a young man in the open doorway of one of the Emergency Department's higher-security rooms. Though many months have passed since then, the sequence I witnessed and what followed have retained a striking clarity that I went on to present to the seven other members of my Balint group. In this essay I will detail the experience and my response to it, the discussion that my group engaged in regarding the case and the lessons that it left me with.

I heard him first. A loud and pleading male voice that cut through the bloops and buzzings of the majors' bustle. Again and again he repeated with a shaky firmness: "please bring me my shoes so I can go to the toilet please bring me my shoes so I can go to the toilet!". From a distance I observed him appeal, with increasing exasperation, to the decreasingly patient and unreceptive healthcare assistant (HCA) who had been tasked with keeping an eye on the newly-shoeless arrival. He was sitting, legs bouncing restlessly, on one of the weighted chairs that is a feature of both the soft-walled, camera-monitored, lockable rooms that are used for more unstable Patients.

I initially adopted the curious caution I had begun to wear in the company of the ward's more volatile occupants. The scene unfolded as I stood observing from around the corner bend of the staff desks, surprised that this man, in a state of such clear distress and vulnerability, was being left to protest as though he were a disruptive schoolchild. I approached and the tense assistant, relieved to find a break from her vigil, explained Connor's (pseudonym) situation. He had come, at his mother's insistence, for fear that he may harm himself. As was the hospital's policy, his laced shoes had been confiscated on the grounds that they would provide him a ligature. Regrettably, the policy included no toilet visitations clause, leaving all involved caught in guideless stasis.

---

[1] Felix Simpson-Orlebar is a 5th year undergraduate student at University College London.

Connor hastened to add that he especially needed his shoes as the toilet floor had been spoiled by some unidentified liquid and that it was undignified to have to make the journey in just socks. At this, the HCA snapped round and reprimanded him: "If you're so worried about your dignity you wouldn't have threatened to pee in here!", gesturing at the dull room behind him. Not rising to the barb, Connor went on to read from his phone to the screen-gazers behind us that, as was clearly stated in the Trust's freely-available online principles, he was being treated in a dehumanising and therefore negligent manner. Surely, I thought, this would cut through the distracted fug that seemed to have filled the department. After all, maintaining a Patient's humanity is a fundamental of good medical practice with treating Patients 'politely and considerately' being one of the very first Duties of a Doctor, as outlined by the General Medical Council. Alas, his well-researched plea was met by its intended audience with blankness. Their attentions already committed elsewhere, there was no capacity to accommodate the needs of this physically healthy troublemaker.

It was at this point that, out of curiosity and the hope that a new ear might be of some use, I decided to approach and take the seat alongside Connor. He's 28 years old but has always lived with his mother and been distant from his father. He would like a partner but isn't in the right place to find one currently. He has been suffering bouts of mental difficulty since early adolescence and became fascinated at a similar age by pharmacotherapy, going on to qualify as a pharmacist, working as his mind permitted. This isn't the first time he's attended a hospital on account of psychiatric troubles, in fact he spent six of "the worst weeks of [his] life" in a specialist unit during his most severe episode.

The unit had been a truly awful place for him, he explained. He often felt as though not one of the strangers tasked with overseeing his recovery felt any shred of care or compassion for him or his fellow Patients. He said that many of them were desperately uninformed of the sorts of side-effects that they might expect

from their drug regimens and so he had taken it upon himself to keep them informed. He recalled how during his life as an Inpatient, discussions around the side-effects of the psychoactive drugs prescribed were often lacking, with strange and frightening subjective distortions omitted from consultations. He recounted a terrifying sensation that his mind had been stretched and torn away from his body during, and for many weeks after, starting one of his previous antipsychotics. The sincerity of his speech left me convinced that there was truth in his words. It was an extraordinary experience listening to Connor as he shared his detailed knowledge of the mechanisms and pharmacokinetics of chlorpromazine, fluoxetine, and haloperidol and his own mind-bending experiences using these therapies over the years. By the time we arrived at the lull marking the end of our discussions, more than 40 minutes had passed. His shoes had been returned, his calm restored and, as he got up to make his trip toiletwards, I thanked him for sharing his story and he me for "just treating me like a human being".

*

A moment of silent contemplation settled across our virtual meeting, the faces of my groupmates resting in thought. They had listened intently and without interruption. Shared by us all was a horror at the experience. In a place of healing, where the very act of attending hospital can be fraught with worry, to suffer so extensively over a pair of shoes seemed a useless betrayal of the Patient's trust and principles of care so basic as simple kindness. They began their questions of clarification - Where was his mother throughout this? Did he mention any support networks? How did the A and E Doctors respond to you speaking with the Patient? - before swiftly bringing their attention to the Patient himself.

Immediately the discussion centred on Connor. What a warped and confusing process to endure. Putting the desperate faith of your recovery into the

one group we're always told we can trust, only to be largely ignored and further tormented with disarming humiliation. An immediately central significance the group brought forward was Connor's mental instability upon arrival. The combination of rudeness and frigidity he faced would be enough to unsettle anybody. But Connor is not just anybody. He is an especially vulnerable cis-man who has fled to hospital for fear of what he might do to himself. The last thing he needs is a telling off. To learn that he had a history of being traumatised by his stay in a psychiatric hospital further strengthened both our estimations of how worried he must have been in the lead up to his arrival and our sympathies towards, what was for him, yet another negative experience in another professed temple of healing. Given the timeline, his prospects seemed bleak. In-and-out of hospitals, on-and-off different drugs. Where was the light at the end of the tunnel? It was hard to fathom the hopelessness that chronic mental ill health instils in its sufferers. We hoped keenly that some lasting resolution could be found for Connor and those like him. In the future, the others speculated, such a tarnishing of the Patient-Healthcare relationship would surely lead to later presentations and, tragically, worse outcomes for those whose faith in seeking help has been undermined. It brought the discussion to bear on what Connor's experience said about unfortunate trends that seem to permeate the current system.

That it is even possible to have an organisation that operates on the scale and with the intensity of the NHS is a miracle of human effort and a luxury afforded Britain by being one of the world's few, early-industrialising (and all the sorry rest) winners. Resources will always reach their limit. There is a number of beds, a number of Nurses, of Physiotherapists, ABG syringes, incontinence pads. Ever more prevalent, the 'pressures on the system' seems to have become a reporting cliché. It won't keep up, doesn't keep up and so, naturally, standards decline. Healthcare staff are people just as any other. Underpaid, overworked, gaslit without end by their own government and now carrying the additional trauma of

2020-21, it is unrealistic to expect Healthcare Workers to be consistently cheery and amicable. Who can really blame the HCA for not being able to contain her frustration? She's probably commuting to work from a rented apartment that she still has no ownership of after 10 years of bill-paying with her sister sleeping on the living-room sofa after being laid-off by the warehouse she used to work at, with their elderly father abroad who can't afford the stay-at-home carers he needs. The other staff in attendance weren't ignoring Connor out of spite. They were just trying to manage the many other, equally-deserving Patients who needed their help.

At the same time, some problems are better served in hospital than others. In the era of interventional healthcare it is possible to work pure magic for somebody who would otherwise reach their living end by a broken heart; but long and tortuous is the healing, if at all, for those that suffer from a broken mind. The latter simply is not as treatable under the current conditions. Connor needs a psychiatrist, better antidepressants, psychotherapy, a community gardening project, friends and who knows what else? But these sorts of resources are scant, if available at all. At last *beginning* to receive more of the sort of attention it needs, the provisions for mental health are still a way off from where they might be hoped to reach. With only the more extremely unwell Patients able to secure a bed, people like Connor are something of a loose end. Biochemically-speaking, he's fine. Agitated but otherwise normal, inflammatory markers low, examination unremarkable; he has nothing much to gain as an Inpatient. The best he might hope for is to be sent to another psychiatric unit, hopefully one where he wouldn't feel so alienated. There isn't really a place for Connor in a hospital. Just as he is one of society's outsiders, so too is he without belonging amongst the beds of the general and specialist wards.

Then there's the other great finitude: time. Connor came in distressed and he needed time to re-find his calm. On this occasion the treatment was cheap and simple: a conversation about this, that and the other thing that he's passionate

about. But it all costs time. It's not a procedure with a point of clear completion. In the emergency context, perhaps more than any other, the time of staff is spent with precision. The benefits of three-quarters of an hour chatting to one highly-anxious Patient will surely be outweighed by what might have been done with that time attending to physically-unwell others. The group saw the repercussions this would have for the emergency staff themselves. Efforts to help restore balance to Patients coming in with psychopathologies are often limited in their success. The feeling that their endeavours are wasted is erosive to Emergency Staff (nothing troubles a fixer like a Patient they cannot fix). As the experience repeats itself, a pattern is established and hope for such admissions dwindles. Eventually the sick of mind come to be regarded as 'difficult' Patients; their depressions unresponsive, their personality disorders refractory to treatments, their lives still in disarray.

And what of his mother? Though she had featured only a little in the conversation, she is surely one of the foremost figures in his life; his primary carer and closest relation. It must be tremendously worrying, the group concurred, to be the Parent of somebody so troubled. With Connor's employment unstable, any work that she might be doing would be their household's single income. Perhaps she had nervous hopes that Connor might be able to look after her in later life. Perhaps her responsibilities to him had made it hard to find a new partner after his Dad left. How might the experience of mothering such a vulnerable child affect your own capacity to have friends and enjoy a social life? It appeared likely to us that she may well struggle in her own ways. Psychopathology is often shared between family members and mercy knows she had her personal stressors. The potential to blame oneself (as a Parent), to imagine that you had failed to create a secure and nurturing environment, seemed unavoidably high.

Finally, the others considered my own position as a student. It had been strange to enter a situation where an antagonistic dynamic was already established between the Official and Patient. There's a certain degree of automatic synchrony

that one feels with a colleague (though I was not, in fact, working during this scenario). You trust in their position, even more so when interacting with a Patient who is not in sound mind. It was startling, therefore, to find myself without faith in the composure of the HCA. Their attitude seemed uncaring, cruel even. An error in the system. An anomalous result.

The group speculated too on how my relationship with Connor might have impacted on my assessment. Fundamentally, I had left his company with the pleasant feeling of having had a positive impact. Unthinkingly, I had allied myself to him, feeling proud to have helped him, to have understood when there was nobody else to. He trusted me and so I trusted him. Had events transpired differently my conclusions would surely too have been altered. If, for instance, I had left his company after a muddled and anxious ramble; his mood much unchanged, my sympathies would have instead been with the encumbered emergency Doctors and Nurses; stoically persisting in their work despite demoralising failure.

Ultimately, I'd let my first-time success go to my head and cloud my objectivity. I imagined the benefit of our discussion to be enduring but for all I knew he could have woken up the very next day in exactly the same state, our conversation long-forgotten. Take his account of the staff in the psychiatric hospital. I had totally given myself away to sympathy with his story of cold and unhelpful workers but what if that hadn't been the case? I had viewed his interference in the counselling of the other Patients in a positive light but was that such a logical conclusion? It just as well could have been the case that what he told the other Patients had frightened or confused them, led them to mistrust the psychiatric teams and hindered their chances of recovery. How could I know that he really was a registered Pharmacist? Perhaps it was a self-aggrandising delusion, installed to give him some much-needed confidence. Yes, I had found him to be superbly well-informed but, as his pin-point scoping out of the hospital's

guidelines demonstrated, the relevant information is rarely more than a few taps away. A good clinician would hope to maintain a balance between healthy scepticism and emotional receptivity and it seemed I had veered more to the latter.

No lull this time but we all knew by the clock that the time for discussing the case was over. In the months since then, and over the course of writing this essay, I've begun to find myself wondering what changes might have spared Connor the most searing of his troubles. The ugly choreography of what came to pass whilst I was in his company seems symptomatic of a system gasping for better organisation and funding. A and E was never going to be the right place for him but where else could he go? The work of crisis teams and mental health charities like Mind are invaluable. The difference that an intervention can make is dramatic, but to *prevent* these problems from ever gathering pace in the first instance is surely the direction in which meaningful improvements truly lie. There has never been a more urgent time to look for and implement more effective, alternative approaches in healthcare. Might a new emphasis on prevention be it? Connor had been left to fall deeper and deeper down society's cracks for most of his life. His situation is one shared by an agonised and unrepresented population of modern Britain. More than a pill they would benefit from investment into their local situation. Such questions are to be answered by communities and their representatives. For the developing medical student the power of reflection lies in the new insights that the process shows you.

The group's discussion helped me to step outside of myself and to appraise the situation from a more objective perspective. At points it had been embarrassing to come to terms with the idea that I had let myself be carried away on a stream of unchecked compassion, leading me to give a disproportionate amount of weight to a single view. It taught me the value of working with a group that I can trust. Being able to be vulnerable made for a more accurate and honest evaluation of the

experience and taught me the value of collegial discussion. Not only can you be open about your mistakes with peers but you can be a better Doctor for it.

Mason, K. (2022). Dr White and the Seven Homo Sapiens. *Journal of the Balint Society, 49: 189-199.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Dr White and the Seven Homo Sapiens

Balint Society Essay Prize 2021 joint winner

Katy Mason[1]

[1] Consultant Psychiatrist, in Medical Psychotherapy: Katy.j.mason@doctors.org.uk

Once upon a time in a land not so far away, two souls lived in a castle. The stories of how they lived there were very different.

Dr White came to the castle every day. She didn't sweep the halls and make the dinner, but she did jobs that sometimes felt very similar. She carried a magical black box, and the Beings in Charge of the castle could use magic to transport her round to where she was needed. The people in the castle changed around a lot, and were an eclectic mix. It was a strange life that Dr White sometimes liked very much, particularly the interesting beings that she met. However, at times she found it very tiring, particularly when she needed to work throughout the night, transported around by her little black box.

Once, it was late at night. The moon shone brightly through the windows and the world was quiet. She found that her little black box zoomed her off to a room where she had not been before. She found herself face to face with the other lady. The lady is someone who we have met many times, in many guises. The lady is sometimes feared and sometimes thought to have great power. Often both.

The Lady saw Dr White enter. Dr White saw The Lady. They looked at each other. Their eyes fell upon an apple which was on the table. Dr White knew that the Beings in Charge of the castle would want The Lady to eat the apple. The Lady knew that the Beings in Charge of the castle would want The Lady to eat the apple. The Lady was not minded to acquiesce to the whims of the Beings in Charge of the castle. She did not eat the apple. Dr White knew why she had been summoned to the room. The Beings in Charge wanted The Lady to eat the apple, and they wanted Dr White to make sure that she did. Dr White tried to soothe and coax The Lady. The Lady was wise to this. The Lady refused to eat the apple. Dr White pleaded. The Lady refused to eat the apple. Dr White showed The Lady the beauty of the apple, the tempting red outer layer, the crisp, juicy flesh within. The Lady refused to eat the

---

[1] Katy Mason is a Consultant Psychiatrist in Medical Psychotherapy at the Lancashire and South Cumbria NHS Foundation Trust.

apple. Dr White felt increasingly impatient. She wanted The Lady to eat the apple. As the tension within her mounted, she caught the eye of The Lady who said "I know you, I know what you're like. *You* only want me to eat the apple so *you* don't get in trouble with the Beings in Charge. Don't pretend that this is for my benefit". Dr White felt as though she had been shot with a poison dart. A poison which sent a surge of sparks through her body. She felt her muscles tense, her jaw clench. Before she knew it, she had thrown the apple at the Lady and vanished from the room.

Doctor White found herself in the grounds of the castle, walking through the woods. She started to feel cross with herself, as well as The Lady. She felt confused. Why had The Lady shot her with a poison dart? Why had the lady not eaten the apple? A small voice in her ear niggled at her, perhaps a remnant of the poison dart…did she, Dr White, want The Lady to eat the apple, or was she merely a puppet doing the bidding of the Beings in Charge?

Doctor White suddenly came across a little cottage in the forest. Although the castle was ancient, the world she lived in was the newest it had ever been. She found there were seven Homo sapiens in the castle, all of different shapes and sizes. And all glorious in their own way. These Homo sapiens introduced themselves, and of course dear reader, they are our old friends; Bashful, Sleepy, Happy, Grumpy, Dopey and of course, Doc. Another Homo sapiens called Sneezy gazed down from a moving portrait on the wall.[2]

Dr White threw herself down in the nearby chair. The Homo sapiens formed a circle around her, and asked her to unburden herself of her troubles. Dr White talked about The Lady, The Apple, The Beings in Charge. The Homo sapiens nodded. After all, they too worked in the castle, and had experience of the perils and adventures had by the one holding the little black box. Sleepy was particularly

[2] In this era, Sneezy is banished from the magical land but is able to be part of our story through the power of magic.

interested in the timing of the adventure, and whether the poison in the dart had a particularly strong effect when combined with the moonlight. Grumpy felt that the poison was one commonly encountered in the castle, and was…grumpy about that. Bashful talked about how difficult she would have found the situation, and her worries about the Beings in Charge, and the faceless Beings-In-Charge-of-the-Beings-In-Charge who everyone knew had great powers. Dr White started to wonder about why she had wanted The Lady to eat the apple so badly. It started to feel like the poison was irritating her less, that although she still wondered about why she had wanted The Lady to eat the apple, though she felt less cross and annoyed with herself and The Lady. The poison stopped feeling like sparks and more like embarrassment, guilt, sadness. Dopey sat deep in thought until Doc gave a prod. Dopey then said "I wonder what The Lady thought about you?" The Homo sapiens and Dr White paused.

Sneezy sneezed. The others looked up towards the portrait on the wall and Dr White noticed an object beside it. Dear Reader, this object has had many names through time, but I will today name it a looking glass.[3] Dr White looked at herself in the looking glass. But this was no ordinary looking glass… with Dopey's word's echoing in her head, she saw a different side of herself. She saw her power as the one holding the black box, who she was to the Beings in Charge, her future…
Her dazzling, dazzling future outside of the castle.

Dr White started to think about the poison. The poison that had made her want to run, to get as far away from The Lady as possible, that made her throw the apple and leave. The sparks danced within her body. "I wonder" said Dr White "where The Lady got this poison from?" She started to think about the poison and the ingredients making up the sparks; embarrassment, guilt and sadness.

[3] Other words used over time include "Mirror" and "Selfie".

Grumpy started to think about his grumpiness, and how sometimes he seemed grumpy to others, but that actually, he didn't want others to stay long enough to notice when he was feeling inadequate and subsequently embarrassed. He realised he did not know a lot about how The Lady spent her days before she went to the castle, and how she would feel about going there instead.

Bashful thought about how sometimes she felt guilty about not doing as well as she thought she should, and it made her want to hide away. She wondered if The Lady had left anyone behind to go into the castle, and how she might have felt about that.

Sneezy thought about his exile, being away from his friends and family in the other realm. He thought about how sometimes people remembered him when he sneezed, and how for a moment or two he was at least noticed and he did not feel as sad. He wondered when The Lady felt noticed, or whether she ever did.

They all wondered about The Lady's story, and became curious about the poisoned dart, and the alchemy that takes place when someone is taken to the castle. What was the purpose of the dart?

Doc said something that they all found a little bizarre, something about feelings. That was just Doc, Doc said strange things sometimes. Doc also decided that it was time to get back to their jobs across the castle estate. Dr White walked slowly back through the forest.

And here dear reader, we will end our story for now. The Lady, Dr White, the Beings-In-Charge, the Beings-In-Charge-of-the-Beings-In-Charge and our seven Homo sapiens friends did live ever after, sometimes happily, other times less so. And things shifted, and moved, and changed, and didn't change. All at once.

Reflections

Thank you for taking the time to read this heavily disguised short story. I feel that in the interests of the Balint group's honour, I should highlight that no apples were

thrown at patients in the real version of this story. However, it is important to allow ourselves a little artistic licence at times.

Writing this short story, attempting to parallel the story of Snow White, I was struck by a number of different reflections. The relationship between two females appeared central to this story, and notably the role of "Doc" is side-lined.

I noticed my discomfort in casting the patient in the role of the "witch". I thought a lot about this, and did not do this lightly. In the story of Snow White, envy is a key theme. This envy had been a key theme elicited in a Balint group that I was facilitating, and had taken the junior doctor somewhat by surprise. The reflection that the patient may have felt envy towards her, took a while for the group to come to, possibly because envy was never expressed directly to the doctor. After some reflection, I realised that it was vital that the patient was cast in the role of the witch, and the doctor as Snow White. Society is becoming a lot more tolerant and compassionate about mental illness, but the Balint group in question made myself and the group more able to see that the role of the psychiatric patient remains a painful one. There may be less stigma, but the patient still loses their autonomy and is in a position of vulnerability. In the group, as in the story of Snow White, one character is naïve to her privilege, whilst the other is consumed by envy of this privilege. The difference between the story above and the tale of Snow White, is that the character of Dr White uses the resources around her to try to understand the mind of the other rather than maintaining a position of a passive and helpless recipient of the envious assault. She pays more attention to what it might be like for the other to experience her. She uses the group to translate the "poison dart" in something that she can make sense of. The key feature of this group was the doctor becoming aware of her own functioning mind, her autonomy, and how much disparity there was between her and the patient in these regards. It left her more able to understand and feel compassion, and to make sense of the feelings of embarrassment, guilt and sadness. She started to understand that the feelings

evoked in her may be the result of a projective process between her and the patient, and that she could try to use this understanding to first repair, and then build their relationship.

A second reflection I had was about how I had skirted over the role of "Doc". As you have probably guessed by now, "Doc" was the Balint group facilitator. I noticed that I had been somewhat bashful (with a small "b"!) about giving myself a role, any significance. From experiences I have had myself I think that this is an important issue. There is considerable potential for those involved in leading groups with a psychoanalytic focus to be in a position of being either idealised or denigrated. We can be seen as someone who can read minds, someone from another world, a crone, a mystic, a Shaman. Our very presence can sometimes stir things up in the unconscious, both exciting and intimidating. Individuals can project feeling of immense power onto us, which can result in us being revered, hated or both. I have always been taught it is important to not become too identified with either of these positions. Idealisation can quickly switch to denigration. Although being idealised is a somewhat seductive position to be in, we are not relating authentically when we are in this position. It is phantasy rather than reality.

It is important not to take on, accept and identify idealising projections. However, it is also important to recognise what we do offer in the position of being a Balint group facilitator. We offer people a place to feel safe with their feelings, to feel heard, to talk about who they are, and what their work means to them. Doctors usually provide these spaces for others rather than themselves. We all have our own valencies, and reasons for being drawn to this profession. Some of us may find it more familiar to do the listening and provide the care rather than being cared for and listened to.

In a Balint group, the focus is on the doctors and their feelings. We are offering someone a space which is usually the reverse of what is given to doctors. It is not inconceivable that being provided with this kind of space might mean quite a

lot to some doctors; that by being in the Balint group they develop an internal sense that how they feel might actually matter. The Balint facilitator, as someone who provides this, has the potential to become someone of significance.

As part of writing this piece, I have reflected on the doctors in the past who provided me with a space where I received attentiveness and was listened to, where the purpose of the meeting served my needs. It was a useful exercise. Remembering how awestruck I was by the consultant neurologist who made me a blackcurrant herbal tea whilst we were talking about my fourth year student project in his office…. Me! A medical student! The supervisor in my early training years who treated my first case of imposter syndrome by advising me that "you definitely won't get it if you don't put your name down". I don't remember much more about her, but I regularly hear her voice ringing in my ears, and I have had so many opportunities as a result of this advice. Reflecting on my past medical relationships was a strange exercise, identifying where all the quirks and idiosyncrasies of my practice come from: aspects of the way that I work that I hadn't realised came from someone I had known years ago. Some people have meant a huge amount to me, and others I could barely remember their names (I might remember once in a blue moon because they made up a snappy medical mnemonic). The very nature of medical training means that we move around our attachments a lot, and a Balint group facilitator may be an attachment figure spanning several blocks of training. Without a doubt, the most painful trip down memory lane concerned a female Balint group facilitator (I have permitted myself some artistic and creative licence here, as my characters have mastered the art of disguise) who reacted with bewilderment and contempt when we were discussing my sadness at the ending of that particular doctor-doctor relationship. Where is the line between a positive and useful attachment which hopefully the doctor will internalise and make use of, and an idealising, eroticized attachment? I cannot even begin to explain how it feels when someone in that position offers you a hasty suggestion of a pathological

attachment. It is several years since the event, and hearing her name is like the psychical equivalent of standing on a three-pin plug. Thinking back to my attachments over the past ten to fifteen years of my medical training has made me realise how mixed these attachments have been – that the level of attachment is not particularly related to my own attachment style, but according to what I have felt I have been given, and offered, by that person.

Balint group facilitators offer individuals a unique space. Ideally, the members of the group will start to internalise the group, to start to consult with the group in their head. "What would Sleepy say?", "I remember when Grumpy had this situation!" And of course, "Doc, what would Doc say?" I hope that, in the Balint groups I run, my members would remember me saying that it is not strange to have feelings; that it is expected that in this job. They would at times feel sad, embarrassed, guilty and insignificant. And that metaphorical apple-throwing incidents are survivable, and even something it is possible to make sense of and to use as a learning experience. For some members this may mean very little; it could feel very ordinary and commonplace to others. But it is important to remember that for some members, this may be one of the few developmental experiences that they have had where they have received this message. They may reject it. Or it may be something that they draw on throughout their career.

Writing this made me realise that I also need to reflect on how easy it can be to underplay my value in order to avoid the dreaded identification with an idealised object. From my own experiences, I know that dismissing an attachment as being pathological and idealising can completely undermine the trust that has been built up as part of the safety of these spaces. There are many times in my working week when, in my mind, I head to the rooms of important figures in my medical education for support or advice. Some I draw on more than others. Certain emotional experiences will make me inadvertently head for the female Balint group facilitator referred to earlier. In those moments I am looking to draw on that

relationship for the sense of safety that I need. Every time this happens, the office door remains shut and impenetrable. The act of denying that the relationship should have had any significance has meant that the relationship never internalised.

This creative piece led me to reflect on four women and the relationships between them. Dr White, The Lady, Doc and some of my own versions of Doc. These relationships were all significant and important. They were initially of significance by virtue of their roles and what they represented to each other, but also deepened as they started to understand each other and each other's position. Balint groups are a great place to understand the doctor-patient relationship, and in this much disguised case, the group spent an hour exploring and making sense of a five minute interaction. They learnt to not underestimate what they might represent to a patient, and how this might be something very painful. On top of this, we also have doctor-doctor relationships. I and my clinical partner from medical school (who is delighted to be included in this essay, disguised or not!) have not seen the neurologist referred to earlier since 2007. I text my clinical partner whilst writing this piece and asked him to describe the neurologist for me. I didn't even need to ask whether he would have remembered him. His response "he was just such a cool guy in every way!" Did we idealise him? Absolutely. Do I remember the stress of the fourth year medical school projects and how wonderful it was to have someone in authority offer me some care and compassion during that time? Of course I do. It is impossible to know what this encounter did for us, but my clinical partner now runs a twitter account with thousands of followers advocating for medics less senior than him, and I spend a large proportion of my week facilitating Balint groups.

I found writing this essay really challenging, and it is something I will continue to reflect on. It is so difficult to know what impact a Balint group is having on someone, as it is not often the case that they tell us. We are doctors; we are used to transient attachments, and to my knowledge most people reflect on the impact of the comings and goings of these relationships privately. I realised during writing

that there are many people from my medical training that were significant to me, but I never mentioned it for fear that it would be received as something transgressive.[4] I also realised how uncomfortable it can be to think about your own significance. I believe in the importance of Balint groups; I have had my own experience of someone underestimating the significance of their own role and how it felt to be on the receiving end. But despite this example making it abundantly clear to me not to do that, Doc was but a minor feature of my own narrative. Doc Senior is definitely not the villain in this story. Balint groups are a great way of developing a culture where doctor-patient attachments and relationships are acknowledged as being of value and significance. Writing this has made me acknowledge and think more about the *doctor-doctor* relationships and the potential for these to become useful and positive internal experiences. There is considerable nuance between these experiences and unhelpful idealised ones.

[4] Finally I know how to cast the inconvenient "Handsome yet Creepy Prince" who I did not manage to weave into my re-telling of Snow White.

Austin, I. (2022). My Balint Experience: A Reflection on Medical Care for Non-Binary Individuals. *Journal of the Balint Society, 49: 200-206.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

My Balint Experience:
A Reflection on Medical Care for Non-Binary Individuals

Isobel Austin[1]

[1] Foundation Doctor at York and Scarborough NHS Hospitals Trust: isobelaustin210@gmail.com

I recently observed a Balint group as part of my psychiatry placement, an experience I found interesting and useful in my role as a medical student, but also emotional and eye-opening on a more personal level. I have reflected on this experience in the form of a letter to my sibling, alias 'Al', who had recently 'come-out' as non-binary.[1] I believe by reflecting on my Balint experience I will be able to be a better doctor to individuals who identify as non-binary, and I wanted to share this with Al. I hope you enjoy reading about my experience and find it as educational as I did.

*

Dear Al,

I know you've just 'come out' as non-binary, and how brave a step that's been for you. Trying to explain your pronouns and change of name to people must be so hard, especially when education about non-binary and trans identification is lacking. Things that I take for granted, like finding a toilet without hassle, have become near-impossible for you, making you feel isolated from and misunderstood by society. I wish things were easier for you. Until recently, I felt I had a good understanding of the struggles you face. However, I've had an experience which has enlightened me to the difficulties non-binary individuals can have when accessing healthcare services. I wanted to share with you my experience and what I've learnt from it. I want to tell you how I will use this experience to become a better clinician for individuals such as yourself who so often feel marginalised and misunderstood because of our actions in healthcare.

[1] Isobel Austin *(she/her)* is currently working as a Foundation Doctor at York and Scarborough NHS Hospitals Trust. She wrote this essay as a medical student, after reflecting on the shortcomings in medical care of non-binary individuals. She hopes to raise awareness of ways we can all improve medical care for people who identify as non-binary.

I recently attended and observed a reflective session – called Balint – on my Psychiatry placement at uni. In these weekly Balint sessions a different team member brings a case to discuss – often about an experience they had treating or interacting with a patient – giving them the opportunity to discuss with colleagues what went well or what they found difficult. During this particular session, a clinician (alias 'Doc') was kind enough to share their experiences treating a patient who had recently been admitted to their unit. Let me tell you a bit about this patient, whom I will call 'Q'.

Caring for Q

Q was a young adult, about 19 years old, who had been admitted to a mental health unit for support with their eating disorder. They had a diagnosis of 'Anorexia Nervosa', an illness where an individual restricts their food intake to keep their weight at very low levels. Unfortunately, Q had become dangerously malnourished and so came to the unit for care. Q was also struggling with gender dysphoria. Their assigned sex and gender at birth was female, but they identified as non-binary, assigning themselves to neither solely male or female gender. They'd recently had top surgery, where breast tissue was removed, and used 'they/them' pronouns, as well as having legally changed their name to a gender neutral one.

During Q's stay in hospital, they met Doc. Doc took a medical history from Q, and Q also required a heart tracing to check their heart's function due to their low food intake. To carry out the heart tracing, Q was asked to remove their t-shirt so that Doc could place electrode stickers on their torso. Doc reflected on and discussed the difficulties they had during their interaction with Q during the Balint session I observed.

Doc's experience

Doc stated they struggled to know how to address Q, in terms of pronouns. Initially Doc felt that using 'she/her' pronouns seemed most appropriate as Q appeared more 'feminine' to them, and Q's medical notes stated Q was 'female', having been assigned as female at birth. However, when carrying out the heart tracing, Doc noted the surgical scars and lack of breast tissue from Q's top surgery, which made Doc feel it may be more appropriate to address Q using 'he/him' pronouns, having assumed Q was transitioning from female to male. However, Doc later learnt that they had upset Q by misgendering them, as Q identified as non-binary and used 'they/them' pronouns.

Doc reflected about how they felt out-of-depth and confused in choosing which pronouns to address Q with, and continued to struggle with which pronouns to use during the Balint session. Doc was upset that they'd upset and offended Q, but felt helpless to know how to behave differently in future, admitting they weren't aware of non-binary identification, gender neutrality or the use of 'they/them' pronouns to address people.

The response of the group

The Balint group had varying responses to Doc's reflection, which opened up a discussion on care of non-binary individuals. Doc was praised for being brave enough to share their story and the difficulties they faced in caring for Q. Many individuals empathised, confessing their own confusion regarding non-binary identification and pronouns. It was encouraging that some individuals partaking in the session corrected Doc when Doc misgendered Q, and tried to educate Doc about non-binary gender identification, and the importance of using the correct pronouns when addressing a patient. Some team members also voiced their frustrations at Doc for this 'ignorance' and the impact this will have had on Q's care and wellbeing.

My own reflections

I was incredibly upset to hear about the difficulties Doc had and how they will have impacted Q's experience of healthcare – I couldn't help but think of similar experiences you've had, and how much they've impacted your own wellbeing. I was also disappointed that there'd been such a gap in Doc's education that they had so little awareness of non-binary as a gender identity, and frustrated that Doc had not taken it upon themselves to learn more. However, I was grateful to, and admired, Doc for bringing this experience to discuss at the Balint session. It was brave and helped us all learn more about and discuss such an important topic. I also realised the worth of Balint for giving clinicians an opportunity to share difficulties they have had, and how we can all learn during these sessions. Finally, I felt grateful that I had learnt so much about non-binary identification from you, Al, but I must admit I was also frustrated with myself. As an impartial observer I didn't feel like I could interrupt the discussion and share my knowledge about the topic, and experiences of those who identify as non-binary being misgendered. With hindsight I wish I'd done so.

This experience also made me reflect on my own clinical practice. How would I have acted had I been in Doc's shoes? More importantly, how will I learn from Doc's struggles to provide better care for others like Q in the future? I considered what you would've wanted me to do in Doc's role, and I've come to some key conclusions about how I will strive to improve the care of future patients like Q as a healthcare professional of the future.

Improving care

Education

Doc reflected that they felt completely out of their depth trying to address Q correctly, having minimal knowledge about non-binary identification. Through observing the Balint session, I realised that not all clinicians know much about this

topic. Therefore, education built into healthcare systems would be ideal. My experience observing Balint showed it to be one such valuable educational experience. Furthermore, as clinicians, we should take any opportunity to share knowledge and educate each other, as I wish I'd done during this Balint session. This may be as simple as discussing experiences treating non-binary individuals or correcting a colleague who has misgendered a patient.

Never assume, just ask

Sometimes it feels intimidating to ask a patient how they would like to be addressed. However, much of Doc's stress could have been assuaged by asking Q how they'd like to be addressed. It has become commonplace to ask patients what name they like to be called, and I think this case highlights the importance of including preferred pronouns in these opening questions. By asking preferred pronouns, a healthcare worker is less likely to make assumptions that could upset a patient and damage rapport. This may make them feel misunderstood, as was the case for Q.

Change documentation in healthcare

Having said this, in Q's medical notes their gender was documented as female, the same as their assigned sex at birth. This sort of documentation makes clinicians more likely to incorrectly assume an individual's gender to be the same as their assigned sex at birth. It is important to check how a patient identifies themselves to avoid this. Documenting gender identity and preferred pronouns in medical notes is also crucial to prevent these difficulties from occurring. If pronouns had been documented Doc wouldn't have felt the need to try and guess Q's preferences.

Non-judgmental communication

Through my experience, I appreciated the importance of non-judgemental communication between colleagues, and the value of Balint in facilitating this. The Balint session I attended shocked and saddened me, as I heard of the impact on Q of Doc's struggles in treating them. However, Doc was incredibly brave in sharing their experience, thoughts and feelings with the Balint group. We all benefitted from their honesty. The group discussion that followed was a valuable learning experience, as we discussed how to improve care of non-binary patients. I saw first-hand Balint's role in providing a safe space for an open discussion about important topics. I truly believe it will have helped all who attended be better clinicians for non-binary individuals in future.

Thank you for letting me share this experience with you Al. I hope you see the ways in which I will endeavour use what I have learnt to help improve care for non-binary individuals.

Your loving sister,

Isobel (she/her)

Khalid, N. (2022). Covid Shifts. *Journal of the Balint Society, 49: 207-210*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

Covid Shifts

Natasha Khalid[1]

[1] MD, Wright Center, Scranton, Pennsylvania, US: natashakhalidrehman@gmail.com

When we were hit with the coronavirus roller coaster last year, most of us stepped into this unchartered territory with a lot of zest and hopes to find the cure and somewhere our true calling. In this disturbing atmosphere, I also walked in wholeheartedly.

This pandemic at that time had taken the world by a storm and everyone was affected by it — physically, emotionally and financially.

I always remember my second COVID shift as an ICU appointed physician. Something about that day has never been equivalent to other days no matter how tough they have been physically and mentally.

I was appointed to do the morning shift in the COVID ward of our respected hospital. The unit is a negative pressure area and, to us doctors, that was comforting as we embarked on the Icarus flight.

"You don't enter here without wearing personal protective equipment," said a familiar voice. As I looked closely, I recognized him as one of the staff from the intensive care unit whom I can barely identify with all of the layers he has over himself. We all look the same here. I was assisted with putting on my goggles, shoe covers, then a head cover, followed by a respirator and face shield, then gloves, and then a blue gown over my entire person. The number of layers made it hard to breathe and hard to walk. Nevertheless, I persisted.

As soon as I entered, I could hear alarms ring and I rushed to see a patient who was a physician diagnosed with COVID pneumonia, desaturating but not agreeing to intubation. "If we intubate you now, it will help you," exclaimed the anesthesiologist. The patient replied, "I need to prolong time — I don't think I will come back." This patient had most likely acquired the virus from one of his

[1] Natasha Khalid, MD, is a Geriatrics fellow at the Wright Center, Scranton, Pennsylvania. She has a special interest in narrative medicine. She received her medical education and training in Pakistan. During her time at the Indus Hospital Network, she has written about her interests for *The Express Tribune* and *Kevin md*.

patients. Knowing the process of intubation and its associated complications, he could be anything but optimistic about the situation.

However, the process of ratiocination has reached its conclusion and intubation was to be done. It took us a good two hours to get his consent, and once he made up his mind, he wanted to write down his will.

This was case number one.

The code alarm rang and we sprinted down the hall with the crash cart. CPR for 10 minutes — the patient was revived. Thankfully. This patient had returned from a religious congregation where many had been exposed to COVID-19. Now he's here, in the intensive care unit. Even after reviving him — with his deranged blood gases and impending respiratory doom — we had to do an elective intubation. As I approached him to explain the process and its importance, he also decided to write down his will. He was intubated successfully.

Both my patients were in different rooms. Leading different lives, belonging to different sects, living in different cities. How strange that after both heard about being put on a ventilator, they acted the same.

I practiced for seven years after graduation and saw many patients die for a variety of reasons. Never have I ever come across someone asking us to wait so they can pen down their will. A will that talks about loans, return of goods, finances to distribute, things that would be worrisome for their children later. This was thought-provoking and disturbing. It seemed like I announced death to the living.

As the day passed, there were more intubations, more deaths, more recoveries. Everything took a pause in the last hours of my shift.

Something felt horribly wrong and painful. It is still difficult to pin down the components leading to it. However, the pessimist in me had come down to two painful truths:

1) Doctors do not always have the treatment modalities in spite of their wishes. We are challenged by the development of the disease.

2) Sometimes physicians have no answers or words to heal in a situation that seems unpredictable and the optimal role of a good imagined physician is difficult to keep.

Perhaps I came to medicine with the illusion that doctors always know what to say in horrible situations and always have a cure. Maybe COVID-19 itself is a disease that makes you lose optimism despite how much you may practise it in life.

I realized that the masses are devouring the flow of information that reaches them from all walks of life: Facebook, WhatsApp, television, Twitter. It is haphazard, information disseminated from people who lack knowledge of the workings of medical practice. People truly believe that they will die of COVID regardless, and there is no returning from the ventilator.

We physicians know how illness progresses. We know the prognosis of patients requiring a ventilator. We know that if there is a cardiac arrest during the course of COVID, the prognosis is grimmer. Based on that knowledge, we make our decisions.

At the end of my shift, I talked to one of my colleagues who accompanied me through the many trials of the day. Both of us were fearful as healthcare workers embarking on this Icarus flight. Fear of being thrown in a battle unarmed, without protective equipment. Fear of taking the virus home and acquiring it ourselves.

As people make jokes about toilet paper, panic shopping and quarantine activities, I wish I was someone rejoicing the fruits of boredom rather than standing for 12 hours straight seeing people die, uttering their last words to me instead of their loved ones. While we are in the trenches, our communities need to stay home to prevent the spread. Even if you amplify the number of beds and ventilators, who will run the show if we get sick?

Abramson, S. (2022). The Best Physicians are Destined to Hell. *Journal of the Balint Society, 49: 211-213.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

The Best Physicians are Destined to Hell

Scott Abramson, MD[1]

[1] Retired Neurologist, Kaiser Permanente, Northern California: scottabramson1947@gmail.com

'The best physicians are destined to Hell'. This is a famous teaching of the Mishna, which in the Jewish faith is the commentary on the Torah, our Bible. Now why would the Holy Book of the Jews make such a statement? Well, it turns out this is about arrogance. And it is about humility. The 'best' physicians, as we all know, may also be the most prideful. They may not realize they need help. And if they do realize it, their macho self-assurance may prevent them from asking. And for this, they may fail their patients.

Perhaps there is some truth in this. Most of us have had moments where in our professional lives, we have not reached out to colleagues, for fear of looking stupid or of feeling incompetent. Of this, I know I have been guilty.

Mea culpa.

But this teaching may be true in another way. Sometimes when we, 'the best physicians' are suffering from emotional exhaustion and staring burnout in its charred face, we ourselves don't reach out. We don't ask for help. For many of us, the story of our professional lives is this: we face overwhelming workloads, long hours in the hospital, and even more hours at home with our hospital computer (nicknamed my 'Laptop Lover' by my wife.)

We spend countless, frustrating hours doing clerical work that a medical secretary could do. We cancel dinner dates with spouses and friends. We miss our kids' soccer games and music recitals. But, in the face of this overwhelming pressure, what do we do? How do we respond? Most of us do what we always have done. We put our heads down and work harder. We plow through. We suck it up. We tough it out because 'when the going gets tough…' (you can fill in the blank.) We are made of grit, backbone, pluck and spunk. We are not quitters. We

[1] Scott Abramson, MD, retired after 40 years as practicing Neurologist at Kaiser Permanente in Northern California. More stories by Dr Abramson can be found in his new book, *Bedside Manners for Physicians and Everybody Else. What they don't teach in medical school (or any other school)* (Covenant Books).

bite the bullet, swallow the pill, pay the piper. We do all this, but we don't ask for help. We persevere in silence. And while we may tough it out, our flame gets dimmer. We see (or maybe we don't see) the beginnings of Burnout.

So, if there is a kernel of truth in all this for anyone, please reach out to someone: a trusted colleague, a loved one, a Physician Well Being committee member, the Employee Assistance program, a psychiatrist, a counsellor in your faith community, a Balint group, SOMEONE.

Maybe the 'best physicians' are 'destined to Hell'. But if you, my physician brothers and sisters, feel like you are headed toward this destination, please heed this warning: Do not take this journey alone.

And if you see your fellow physician brothers and sisters heading down this path, think about lending a helping hand, a warm shoulder, or a listening ear.

Remember: Friends do not let friends become 'the best doctors'.

Brew-Girard, E. (2022). A Curious Case of Countertransference: Reflections of a Junior Psychiatry Trainee. *Journal of the Balint Society, 49: 215-219*.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

A Curious Case of Countertransference: Reflections of a Junior Psychiatry Trainee

Elsa Brew-Girard[1]

[1] Speciality Trainee, Bristol, UK: Elsa.BrewGirard@somersetFT.nhs.uk

Setting up for my first medical student Balint group of the term, I felt quietly confident. I rearranged the tables and chairs – carefully set out in neat rows facing the screen – into our usual circle, and turned off some of the harsh tube lighting, trying to make the room feel slightly less 'clinical' – somewhat of a challenge in a hospital.

With my UK Balint society leadership training fresh in my head, I felt an excited anticipation at what this group might bring. I remembered the challenges I had faced leading my two previous groups, reassuringly shared by my peers leading similar groups: poor attendance, uncommunicative students, a limited tolerance of silence. My co-leader, a fellow core psychiatry trainee, and I had navigated these issues with the support of our supervisors and the groups had responded well. Nothing I couldn't deal with again, I thought.

As the students slowly filed in to the room, I was shocked – there were so many of them! A scramble to find more chairs quickly ruined the calm and collected first impression I had hoped to make. As expected, the students looked clearly perturbed at the circle formation waiting for them. They exchanged some anxious glances and nervous laughs as they took their seats, and I tried not to appear too flustered, aware of the twelve faces now turned expectantly towards me. Of the twelve, I noticed there were eight men– not a gender ratio we are familiar with in medicine these days, especially within psychiatry.

The students had had their introductory lecture, so after a brief recap of the structure and rules, I opened the floor to any potential presenters. I was met by the usual downcast eyes, shuffling of feet and silence, but eventually one of the

---

Dr Elsa Brew-Girard is working in Bristol as a specialty trainee in Older Adult and General Adult Psychiatry, having completed her core training in 2021. She has a keen interest in medical education, holding the position of Associate Tutor for North Bristol within the Undergraduate Teaching Faculty for Psychiatry at the University of Bristol in 2021-22. She continues to be a part of the management group for the Medical Student Balint Scheme at the University of Bristol, as well as leading her own medical student groups.

students came forward and presented her case. A consultant had invited her to sit in on a clinic. The first patient presented a valuable learning opportunity, the student was told, due to the presence of acute psychotic symptoms. The patient, having initially said he did not want a student to sit in, grudgingly withdrew his objection when the consultant explained the importance of teaching about mental health. The student felt very uncomfortable, believing the patient had been left with little choice, and had not truly consented to her being there. She wondered whether the patient was too unwell to fully understand her role, and worried her presence may have intimidated him, as he was not very communicative during the consultation.

This case brought up some common themes from medical student Balint groups, well documented in the literature (Torppa et al, 2008; O'Neill et al, 2016). I found myself thinking about how we might best explore the idea of patient and doctor 'sides', and the medical student identity. I foresaw a familiar discussion about the feelings of uselessness often encountered by medical students, as they perceive themselves as almost parasitic, leeching off the patients they clerk in for their portfolios, or the consultations they witness, and mistakenly feeling they can offer nothing positive in return.

As the student was presenting her case, one of her peers started eating a packet of crisps. Very loudly. As she was still presenting, another got up to re-fill his water bottle from the nearby sink, which involved walking directly through the circle to the other side of the room, and back again to resume his seat. How rude! I thought. How disrespectful!

As the discussion began, I was unprepared for the intensity with which some of the students attacked (the only word I feel really does the process justice) the case. This was clearly an opinionated group, who were not afraid to challenge each other. While this made for a lively discussion, the students were soon talking over each other and I felt the situation was rapidly spiralling out of control. I started to

feel warm, and noticed my palms were sweating. Most of the group fell silent as four of the most outspoken members moved on to the topic of the patient's capacity. We suddenly found ourselves discussing hypothetical 'what if' scenarios involving refusal of life saving treatment in a military situation – how on earth did we get to this? There was a sense of trying to find the 'right' course of action, with two students dismissing another's suggestion as 'wrong'. In trying to encourage the students to consider other perspectives, I found myself getting drawn into the discussion. I tried a different tactic, gently bringing the patient and the case back into the picture, but the students continued with what was quickly turning from discussion into debate.

Noticing the increasingly shell-shocked expressions of some of the silent members of the group, I decided it was time to intervene more firmly. Thanking the students for their input, I noted we had digressed somewhat from the case, and suggested we think about things from a different angle: how might the patient have been feeling in this situation? I was completely ignored by one student who appeared to have appointed himself group leader. 'Come on guys, what are the ways in which we define capacity?' I was speechless.

Eventually, we found our way back to the case, and discussed some more familiar themes. Had the student considered her presence might have been reassuring for the patient? After all, we knew very little about him. What part did the consultant play in all of this? The session finally drew to a close.

As the students filed out, I stayed seated for a while and tried to make sense of what had just happened. My overwhelming feeling was of anger. The arrogance, the presumption of those students! I had never experienced anything like it. I couldn't stop thinking about it over the next few days, and although the initial emotions settled, I was left with a feeling of anxiety. Did I do something wrong? What could I have done differently? How was I going to stop this happening again?

Having had a week to digest my thoughts, and still struggling to make sense of things, I attended supervision with mixed emotions. I hoped the discussion with my supervisor and peers would give me some clarity, but in the back of my mind I worried that I might be judged negatively: had I overreacted? Had I just handled the situation poorly? As I gave my account, I was comforted by the raised eyebrows and incredulous gasps of my peers. It was nice to see people bristling in the same way I had! The acknowledgement that this had been a very difficult situation came as a flooding sense of relief, and I felt some of my anxiety ebbing away.

My supervisor was particularly interested in this anxiety I had been left with – what was that about? I tried to articulate it: a sense of loss of control perhaps, a deviation from the predictable towards the unknown. A deeper worry that I was not good enough, not up to the task; the old 'imposter syndrome' rearing its head. And then, a simple question, but a powerful one. How did I think the students might have been feeling? That clarity I had been hoping for suddenly presented itself – having been so caught up in my own anxieties, I had been unable to see how closely these might have been mirroring those of the students. Was the act of nonchalantly eating crisps in fact an attempt to break some of the tension? Was the student leading the capacity 'tutorial' just trying to regain some control over an unknown situation, an unpredictable learning environment? The hypothetical scenarios, the right and wrong thinking; were they simply ways of trying to categorise things neatly into familiar boxes? I felt overwhelmed, and a little chastened – the students' arrogance had been anything but.

To have had this learning experience so early on in my training I think is invaluable. We are primed to notice transference and countertransference during our interactions with patients, but I had not considered how important a role it might play in this setting, or indeed others. I have since found myself thinking about MDT meetings, peer teaching sessions, with more awareness and a greater

understanding. I hope that this is something I can continue to carry forward into my clinical practice.

References

O'Neill, S., Foster, K., Gilbert-Obrart, A. (2016). The Balint group experience for medical students: a pilot project. *Psychoanal Psychother, 30*: 96–108.

Torppa, M.A., Makkonen, E., Mårtenson, C., Pitkälä, K.H. (2008). A qualitative analysis of student Balint groups in medical education: Contexts and triggers of case presentations and discussion themes. *Patient Educ Couns, 72:* 5–11.

Jablonski, H. (2022). The Doctor, Her Patients and the Gifts: On the Meaning of Gifts as Reflected in Balint Group Work as Training-with-Research. *Journal of the Balint Society, 49: 220-234.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

The Doctor, Her Patients and the Gifts: On the Meaning of Gifts as Reflected in Balint Group Work as Training-with-Research

Henry Jablonski[1]

[1] MD, MSc, Sweden: drhjab@gmail.com

Introduction

Discussing *the gift in clinical praxis* brings the expression of Michael Balint *'the patient´s offer'* to my mind. I believe it is fruitful – as a way of reflecting on the relationship – to see the patient as consciously and unconsciously offering his troubled body and soul to the doctor as a gift. The patient hopes or/and fears some kind of response, in exchange to what he is offering.

The patient´s offer – that´s his gift!

A basic uncomplicated exchange could look like this, interpreted by me as the doctor: 'You offer me a severe sore throat, fever and a deteriorating general condition. This gives me the opportunity to feel useful and competent (and thus to earn my living in a decent way), and I give you a diagnosis, a cure and assurance in return'. A gift during treatment can be seen as some kind of interference or intervention in this basic relational exchange. As a clinical doctor you will have to relate to a gift from a patient whether you want it or not.

The daughter of an experienced GP said: 'Mom, you ought to make an exhibition of all the strange gifts that you have received over the years from your patients. It would be amazing.' The idea of such a Doctor´s Museum of Gifts – real or imaginary – is challenging. Just think about the size of it!

Such a museum should – apart from the exhibited gifts themselves – contain:

- the story of the patient;
- the story of the doctor-patient relationship;
- the reflective story 'What were you actually feeling about the gift, Doctor? That is, if you would allow yourself to feel!';
- the meaning of the gift in a deeper sense, reflecting its symbolic significance for the doctor-patient relationship.

[1] Henry Jablosnki MD, MSc, is a psychiatrist and psychoanalyst in Sweden.

The meaning of gifts is from time to time brought up in Balint group work. It came to my mind that it would be worthwhile to investigate this theme specifically.

Design

I suggested to a Balint group of very experienced GPs working in areas with a large immigrant population – in our 8th and final semester of cooperation – that we all should write down a story or two about gifts and that we should look at them along our usual way of working. Some members sighed. I could sense their unspoken objection: 'Don´t you think we have enough many things to do already in our offices, but to write you stories?'.

I insisted reminding them of a couple of stories about gifts told in the group over the years. They agreed, after all, this is indeed a meaningful theme. For two and a half sessions we discussed eight reports on gifts – seven from the GPs and one from me, a psychoanalytically orientated psychiatrist.

The reports have been modified to prevent any identification of the patients. I will one day report on this work more extensively.

A model for assessing the meaning of the gift?

I suppose I share with many of you the impulse to systematise when you look into a clinical material. Often this should be done explicitly beforehand to merit the name of scientific inquiry.

Thus, scientifically, in the conventional logico-empiricist sense, this is a pre-study. You could look for parameters judging the meaning of the gift in the Doctor-Patient–matrix. It would be multi-dimensional since the gift and its relational context is often complex. From these cases and from others I could go on and try to develop a more systematic view.

But, if you see (as I do myself) this study as a narrative and hermeneutically based exploration, you are justified to let systems crystallise gradually, discovering and mapping the variety of patterns of exchange of gifts along the way. This cannot be done in a vacuum though. You must account for the frame of reference including your values and the theories that you are applying to your study. Remember Michael Balint´s expression 'training cum research'! It points at the possibility of designing the group work itself as a research project. The British Balinters have demonstrated this beautifully (see collections such as *What are you feeling, doctor?* and *Six Minutes for the Patient*). So accordingly, both ways – the logico-empiristic and the hermeneutic –merit to be labelled scientific enquiries.

A small but significant etymological remark

The Swedish noun *gåva* has the same etymological origins as the English *gift* and the German *Gabe*, deriving from *to give, zu geben, att giva*. But it is fascinating that the Swedish noun *gift* also means *poison* – indicating the universal ambiguity of a gift. It can be both a blessing and a curse. But in either case, it can be felt as 'an offer that you cannot refuse'. Often this will constitute the starting point of Balint case work – the doctor vaguely feels that he is trapped. (In Swedish *gift* also means *married*. Maybe this also could be linked to the ambiguities in too many human relationships.)

Cultural and professional attitudes towards gifts in Sweden

There is something appealing and nice about receiving gifts. The code of conduct towards gifts in a Swedish born and Swedish medically trained doctor –whether he became a GP or went somewhat astray and became a psychoanalyst – is governed by the fact that Sweden culturally and legally is a non-bribing society. There are very strict rules – so strict that they are difficult to abide to even for a very conscientious doctor. As a public servant you are not supposed to receive gifts. Gifts are un-Swedish and looked upon with a certain reserve. Doctors are aware of this and many have overly conscientious fears of being suspected of bribery by receiving even small gifts.

The national health system pays the publicly employed doctor well enough so that he, as opposed to doctors in some other countries, does not have to think about money when meeting with his patients. They do not have to give us gifts nor pay us extra money to get the state of art medical treatment. When I try to look at this from the outside, I see a culture both of puritanism, and good intention, decency and a preserved innocence. The latter I like very much.

The difference in attitude towards gifts between a psychoanalyst and a GP derives, I believe, mainly from the significant differences of our working situations. The GP has to improvise during the consultations, scan over and swing between a wide range of tasks and considerations. She often does not know what the next meeting will have in store. She knows that she is short of time and that there are a lot of things she needs to address in the spare minutes she has – or does not have – between her patients. She tries to focus on, negotiate and define the very essentials of the meeting with her patient. Consequently, she treats gifts – unless they are exceptional – as marginal phenomena and, so as not to waste too much time and staying friendly, would say: 'Thank you so much', meaning more OR less: 'OK, I really do not know what to make out of this right now, but let us go on with our business'.

The gift will both literally and mentally be shoved into one of the drawers of the desk of our busy GP. Hopefully she will not be too distracted by this concrete gesture of the patient. So, forgetting rapidly about the gift is a frequent emergency exit (defence mechanism) for the GP. At least on a conscious level. Still, I hold a strong belief that the GP–patient relationship is affected by gifts, much more than my experienced GP colleagues would prefer to recognise. And they sometimes find me annoying (mostly in a constructive way, I would hope).

The psychoanalyst, in contradistinction to the GP, works within a quite rigid framework. He knows more or less by a few minutes (and so does his patient) when to start and when to end a consultation. Regardless if the gift can be expected or come as a surprise, he would look at it as part of the mental exchange between the doctor and his patient, an integrated part of their relationship, and always think of the symbolical significance and the messages embodied in the gift.

As a psychoanalyst/psychotherapist I have a range of inner questions when a gift is offered to me. (I do not always have to ask my patients for the answers). I suppose as a GP you relate to some of these inner questions, to others not.

- What does my patient feel and desire by giving me this gift at this moment?
- How is my patient affected by the way I am receiving his gift? How is he reading my reactions?
- What are my feelings about this gift from this patient at this moment?
- Should I just accept it wrapped up or open it?
- Should I just let the gift lie there between us for a while until we have talked it over, and then make up my mind?
- When should I comment, i.e. make an interpretation of the significance of the gift, for the patient, for our relationship, in relation to very important circumstances in the life of the patient?
- Should I accept it or should I reject it? How should I tell why I cannot accept it?
- How much of my spontaneous feelings and thoughts should I share with my patient? (I have to face reality – I have a bad 'poker face', so absolute neutrality does not exist in my consulting room anyway.)

A remark on the cases

The two cases that I am going to discuss cannot reflect the full complexity and the wide range of issues presented in these two and a half sessions during which we discussed all the gift cases. But to my mind they are representative for a difficulty that all these experienced female GPs were struggling with. One of them concluded: 'I think we are all struggling with our *Eager-to-please-syndrome*. And we do not like to confront ourselves with situations which are contrary to that. That is what we are working on so much here in our Balint group.'

It is important to note that five out of the seven GP cases presented could be labelled as 'poisoned' gifts, with a main (conscious and unconscious) purpose to corrupt the doctor by enticing, seducing, openly bribing, belittling her, etc. Only two cases were expressions of 'love and appreciation' – the most moving one (and

very complicated) I will *not* present to you today. This bias might not be quite that heavy in clinical daily life. After all, cases brought to a Balint group do not reflect the total composition of the doctor-patient relationships at a doctor´s surgery. *But the overall estimate of these doctors was that the 'poisoned' gifts dominated their practices.* This is a good enough reason to discuss this issue from the *aspects of mental health and prevention of burn-out in doctors*. It may be indicative of a general problem in the Swedish national health system which is not only confined to gifts.

I also have a premonition that some of you, reading these examples that I am going to present, might think that the doctor is naive. I do not. I am quite convinced that each and every one of us have such examples in our 'mental clinical archives'. The offers by the patients and how they are received by the doctors will much depend on the personalities and hidden agendas. A by-stander usually thinks more clearly because of lack of involvement. If we were the intelligent, back-seat-driver of our own private and professional lives, we would seldom get trapped. And when we do we would get out of the trap very fast and never be caught again. Life would be efficient and we would be spared a lot of frustrations, surprises and … a good part of life itself. And we would not need any Balint group either. Since such a reliable inner agent is lacking, the Balint group gives us an option to learn from experience and mistakes. 'Little by, little by, little' as Dusty Springfield sings.

Case 1: The doctor as an emotional alchemist

'This is a man in his 60s who came the other day for control of his diabetes and some other ailments. I have known him for years. He is from Lebanon originally and speaks Swedish perfectly. Yet, on this occasion his younger wife came along. When his wife comes along – that is when I get the gifts. I think this is the reason why she is there. On previous occasions I have received strange small cheap-looking souvenirs from Lebanon, or chocolate Santas and Easter hares. One of their sons is the owner of a candy store.

Occasionally, a transitory thought passes through my head: 'What do they want in return?'

When I saw them last time this autumn a medical student was sitting in with me. The wife picked up four knitted tablets from an ordinary plastic bag from a cheap chain of stores. And a small knitted cloth. She said it was a delayed summer present. I thought it was a cheap and good present and thanked them. And they went home.

The medical student did not look concerned or surprised. He said his mother is working at the Migration Authority and she also often gets gifts.

I brought the pieces home. My youngest daughter suggested that I could get rid of them by bringing them to the Midsummer flea market of our community of country house owners. So, I brought the stuff to the country house. As I was cleaning I noticed a small table. The knitted cloth fitted perfectly and now it is on the table. I felt good about that.'

Discussion in the group

The presenter clarified that she is also the doctor of the wife of the patient. She emphasised that she got along well with the husband patient and actually therefore found it quite difficult to understand what the wife was doing there. The group was wondering why the woman would have to bring the gifts for her husband. Was it something cultural? Was the man too shy to bring them himself? There were also some speculations that the wife might be worried about the health of her husband. Maybe she needed to control that he was given proper attention by his doctor. But these viewpoints faded away.

Then followed questions about *when* these items were given and *how* they were handed over by the wife. It seemed they were given arbitrarily over the seasons – a chocolate Santa Claus for summer, an Easter Hare for the autumn call. Never wrapped up as gifts but rather handed over in a small plastic bag or picked up from one, just as had been done with these knitted items. It was clear they could

not have been purchased from the same store that the plastic bag came from – a low price hobby and tool store.

I asked the group: 'I wonder – from which one of these two patients does the gift come?' The group seemed to agree that it was the woman. The presenter then recalled that the woman actually had an appointment in the week to come. Thinking more about it she wondered whether this might be the pattern – that gifts were given *in advance* before the appointments of the wife patient. What would her appointments usually be about? It seemed they were connected with prescriptions and the certificate for the sick list – her being partially or fully unable to work from time to time. The woman was fairly healthy though, the doctor commented.

The discussions swung to the contents of the gifts again. Could it be that the woman brought candy and chocolates from the store of her son that were too old to be sold. The presenting doctor commented that such a thought had indeed crossed her mind because the chocolate tasted really awful (she actually said 'shit', which was not part of her ordinary vocabulary). She often threw it away.

The tone of the discussions had so far been tentative and low pitched – a kind of beating around the bush. Now, there was some more energy in the discussions and the reactions of the presenter.

Were these really gifts as a token of appreciation and gratitude? Could one really explain the junk quality of what was given to the doctor as a cultural idiosyncrasy? Would she have brought such stuff to a Lebanese doctor during her stays in her native country?

The presenter found the discussion interesting. She became aware of her wondering what would be the reason for the call of the wife in the week to come. 'At any rate – it was nice that the cloth fitted the table in my summer house,' she concluded.

Comments

It seemed to me that the doctor unconsciously/automatically had disregarded these junk presents, as they had an embarrassingly depreciating quality, which became evident in the group discussions. Even worse, one could suspect the purpose of the gift was to prepare for the visit of the woman herself in the following week. This was a pattern that the presenting doctor had avoided to become aware of. The low-pitched atmosphere in the group when discussing the case seemed to reflect our wish to mitigate the pretentiousness and the concealed manipulative attitude of the donor towards her doctor. The quiet satisfaction of the doctor about the cloth touched me. It seemed to be an expression of relief. She has a sort of humble kindness inherent in her personality. At least and at last, with this cloth, she had finally managed to convert the pile of 'shit and junk' heaped on her over the years into something plain and useful to herself. That seemed to be a way subconsciously to recover her self-esteem and to stand the patient.

The group discussions were a painful re-interpretation a re-evaluation of gifts and relations which I felt that the presenting doctor could not absorb to its full extent immediately. But as she always does, she would have to digest these matters for a while. But she became immediately alerted that one intention by this fairly successful, healthy and well-to-do woman patient probably was to buy her off cheaply. And she recognised at that moment that it is not compatible with common sense for a doctor to give authorised support to the kind of social benefits this patient used to ask for. But as she and many GPs know, once you get on that road with a patient, you can get stuck in a track, from which is difficult to move. Handling becomes a routine without much thought about whether it is realistic or not. Thinking about it, though, makes the doctor aware of the bad ('shit') taste in the mouth.

Case 2: Doctor or daughter?

The presenting doctor is Balkan-born, speaking excellent Swedish with a slight accent:

'This is a woman from my native country that I have known for many, many years. She is in her mid-70s and very frightened and obsessed by the thought of dying in a cerebral haemorrhage. One of her sisters did. She came to me very often in very anxious states, and she called me by phone. We always speak in our mother tongue. She was frequenting other doctors and hospitals very extensively too. It is very hard to find a good medication against her elevated blood pressure. She always complains and reads about side effects. She checks her pressure at home. At the slightest elevation she increases her medication on her own.

I discussed this patient in our Balint group more than a year ago. You remember, the consultations dragged on, often for more than double the time that I had allocated. There was always something more, though I always take that into account beforehand. But it was never enough, always more questions and worries. I often had to interrupt her to end the session. After discussing it in the group and thinking of her as an abandoned child who was anxious, that there would never be another meeting again with her caretaker, I started seeing her on a more regular and scheduled basis, once a month, once every two months. Overall, I do not think that I have spent more time with her than before. But my patient seemed to calm down and she is not going to the hospitals and to other doctors as much as she used to before.

My patient thinks that a brand-new medication will work a miracle. But then again when she reads about the side effects she does not dare to try them. She experiences herself as very sick. But she looks very agile and takes long walks daily for at least two hours.

Over the years she used to bring me some typical cakes from our home country, a few in a little bag.

On one occasion she brought me at least 60 of them! She had baked them herself, she confided. She told me sternly I should not share these breads with my colleagues or with the staff at our centre. They were for me only! I could put them in the freezer at home.

I felt uncomfortable, yes, uncanny. The enormous amount and the forced intimacy in the prohibition to share all these breads with others. I told the patient this was far too much, but I accepted them. I gave some of the bread to the staff members. Since then my patient has not given me any bread at all. When she visits me, she complains that she no longer has the strength to bake.

I have been thinking quite a lot about these cakes and the uncanny feeling. It just became too much!'

Discussion in the group

The group discussed the exclusive demands of this patient towards her doctor and the doctor´s feeling of 'too much-ness'. The group recognised that the doctor felt much sympathy and concern for her patient. She really felt sorry for this woman in exile. The discussion in the group a year before had helped the doctor to structure the treatment and it had helped. The patient seemed calmer and her overall use/abuse of medical care had diminished. But it also seemed to have stirred up a stronger transference in the patient onto her doctor, a mother-daughter-relation. The presenting doctor nodded affirmingly. Indeed, the patient liked her doctor. She was grateful but also demanding and possessive. The presenting doctor – I was about to write 'daughter' – felt trapped. Though she cared a lot, it seemed she had a need for a certain distance to her patient. There was nothing wrong with the cakes. They were most homely (German: *heimlich*) to the doctor as opposed to her uncanny (German: *unheimlich*) feelings. She recognised being emotionally locked up in a conflict between her strong feelings for her patient and her guilt for not allowing the patient to be too close. This was strongly reinforced by the controlling, anxious

and 'never-be-pleased' attitude of the patient met by the contrary impulse of her doctor – a wish for a certain degree of distance/independence in her way of caring.

Comments

In short, this case illustrates the complications of a loving relationship. The bread-baking had increased after the patient had been given regular visits. Now it seemed the patient felt rejected on a personal level (stopped baking). She must have sensed as she gave the cakes to the doctor, that she would *not* keep them all to herself and her family. But still the doctor-patient relationship survived this disappointment. The considerable improvement in the past year in handling the hypertension and the severe anxiety of the patient was *not* affected. In fact, the patient could continue to make good use of her caring doctor. The doctor could cope better with her daughter-feelings (transference and countertransference). It should be added, though we did not discuss in the group in connection with this case, that in the past year, the doctor had returned to her native country to tend for and bury her own mother. I think that might have made it more difficult for her to handle the strong emotional impact that this particular patient had on her.

Concluding remarks

I thought it was an interesting project in the course of regular Balint work to make a thematic study, in this case on gifts. I would also strongly argue that this kind of specialised study/research can highlight important issues in daily GP practice and function as a pre-study for research on a larger scale or be combined as a multicentre thematic study, involving several Balint groups.

References

Salinsky, J.V. and Sackin, P. (2000) *What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation.* Radcliffe Medical Press: Oxford.

Balint, E., Norell, J. eds. (1973). *Six Minutes for the Patient – interactions in General Practice*. London: Tavistock Publishers.

Salinsky, J. (2022). How to Study Your Doctor.
Journal of the Balint Society, 49: 235-237.

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

How to Study Your Doctor

John Salinsky[1]

[1] Balint Groups Leader, former President of The Balint Society UK: jvsalinsky@aol.com

If I wanted to find out what a new doctor was like, I wouldn't ask their colleagues.[1] I'd go and talk to their patients. Or, better still, I would start a Balint group made up of patients who would be invited to present their doctors. I have not so far managed to start such a group but, many years ago (Salinsky 1989) I did write a paper about a fictitious Balint group for patients. I read the paper to a meeting of French and British doctors, and one of my colleagues provided a simultaneous French translation. The English title was *Did I talk too much? A Balint group for Patients.*

Most of the audience seemed to see the joke but there was a sizeable minority who weren't sure and were heard to ask each other, '*C'est une blague, n'est ce pas?*'.

It is my view that in order to discover what is really going on in the patient-doctor relationship we need to start Patient Balint Groups (PBGs) where patients can go to discuss their doctor-patient relationship. Has this ever been done before? Michael Balint and colleagues wrote a book called *A Study of Doctors* (Balint, M. et al, 1996) but it was all about doctors assessing other doctors. No one asked what their patients thought.

Earlier on, there was a wonderful book called *Doctors Talking to Patients* by Patrick Byrne and Barrie Long (1989) which consisted of live recordings. The private conversations between doctor and patient were transcribed for all GPs to read. Most of them made me feel embarrassed for my colleagues; although, I have to say that some were very funny. Yet a small minority of the doctors actually listened to their patients respectfully; and could truthfully be said to use a 'counselling mode' in which the patient did most of the talking.

[1] John Salinsky is currently leader (with co-leader) of local Balint groups for the last 15 years. GP Principal (1972-2018). Past Programme Director, Whittington GP Training (including Balint groups). Past president of The Balint Society. Past editor of The Journal of the Balint Society. Past treasurer and secretary of the International Balint Federation. Honorary founder member of the American Balint Society.

So where do we go from here? My suggestion is that several of our senior Society members should set up a new Balint Research group. They will engage a professional ethnographer who will interview a sample of patients who have been presented to the group. This has been done with trainee GPs but not the patients themselves (Pinder et al 2006). When the report is eventually written we shall, at last, be able to read what is really going on, at both conscious and unconscious levels, in the hallowed privacy of the Consultation.

References

Balint, E. (1987). Research, changes and developments in Balint groups. In Elder, A and Samuel, O. eds. *While I'm here, doctor.* London: Tavistock Publications, 95-102.

Salinsky, J. (1990). Habe ich zuviel geredet? – Eine Balint-Gruppe fur Patienten. German translation by B Carriere. In *Die Balint-Gruppe in Klinik und praxis*, Band 5, Berlin, Heidelberg: Springer-Verlag.

Balint, M., Balint, E., Gosling, R. and Hildebrand, P. (1966). *A Study of Doctors: Mutual selection and the evaluation of results in a training programme for family doctors. Mind and Medicine Monographs.* London: Tavistock Publications.

Byrne, P. and Long, B. (1989). *Doctors Talking to Patients. A study of the verbal behaviour of general practitioners in their surgeries.* R Coll Gen Pract, London.

Pinder R., McKee, A., Sackin, P., Salinsky, J., Samuel, O., and Suckling, H. (2006). Talking about my Patient: the Balint approach in GP education. Occas Pap R Coll Gen Pract, London.

Still image from the *Balint Groups* short film by Judit Szekacs-Weisz and Raluca Soreanu (2018), based on BBC footage on Balint groups produced in 1970. Michael Balint leads the group.

Salinsky, J. (2022). An Interview with Michael Courtenay, 2004. *Journal of the Balint Society, 49: 239-250.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

An interview with Michael Courtenay by John Salinsky (2004)

April 18th 2004

JS: May I take you back to your first meeting with Michael Balint. How did that come about?[1]

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?

---

[1] First published 2004, Vol. 32, *Journal of the Balint Society*.

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 co-leader...

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 distinctively 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 was 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 semiprivate 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**n**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 protégé 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 the 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 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.

Soreanu, R. (2022). From the Archive, Enid Balint to Wolfgang Loch: Co-leadership, Transmission and the Boundaries between Psychoanalysis and Medicine. *Journal of the Balint Society, 49: 251-255.*

JOURNAL OF THE BALINT SOCIETY, VOLUME 49, 2022

From the Archive, Enid Balint to Wolfgang Loch: Co-leadership, Transmission and the Boundaries between Psychoanalysis and Medicine

Raluca Soreanu[1]

[1] Department of Psychosocial and Psychoanalytic Studies, University of Essex: raluca.soreanu@essex.ac.uk

A Commentary on the Letter from Enid Balint to Wolfgang Loch, 16th February 1977, London[2]

A letter from Enid Balint to Wolfgang Loch[3] shows the role Enid Balint played in the preservation of Balint groups and in continuing the tradition after Michael Balint's death. Enid and Michael collaborated in the work that led to establishing the group method. Seven years after Michael's death, we find her at the heart of the training, and at the heart of organising ways for the groups to continue to 'travel' around the world.

The letter also gives a clear image of the organisation of the profession in the early days, of the centrality of the institution of co-leadership in the transmission of the craft, and of the substantive conversations on the boundaries between psychoanalysis and medical practice, which continued after Balint's death, and of Enid's take on some aspects of leadership technique.

Rather than attempting to define or draw the boundary between psychoanalysis and medicine, Enid Balint invites her interlocutor, Wolfgang Loch, to think about this question on his own terms and formulate his own answers. She reminds him that the position of the doctor working within the Balint tradition is not one of purposefully looking for 'deeper' material, or prompting further elements of the patient's history; instead, she draws attention to the importance of the 'flash' (which Gearóid Fitzgerald discusses in the pages of this issue, in his

---

[1] Raluca Soreanu is Professor of Psychoanalytic Studies at the Department of Psychosocial and Psychoanalytic Studies, University of Essex, and psychoanalyst, member of Círculo Psicanalítico do Rio de Janeiro. She is leading the five-year multidisciplinary project 'Free Clinics and a Psychoanalysis for the People: Progressive Histories, Collective Practices, Implications for our Times' (FREEPSY), funded by a UKRI Frontier Research Grant. She is Academic Associate of the Freud Museum and Editor of the Studies in the Psychosocial series at Palgrave.

[2] The Balint Archive is held by the British Psychoanalytical Society.

[3] Wolfgang Loch (1915-1995) was one of the most significant German-speaking theorists of psychoanalysis after the Second World War. He held the sole Chair for Psychoanalysis position ever to be established in Germany. Loch was a prolific writer, having left over one hundred published works.

article 'The Courage of Our Stupidity' or Developing the Discipline of Being a Balint Group Leader', pp. 28-37) and to the importance of the patient herself arriving at her own insights.

For our contemporary Balint practitioners, the letter opens key questions, such as: in the process of training as Balint leaders, how important is the proximity of trainees to the experienced Balint leaders who have been part of the early groups? What is the place of this particular kind of co-leadership in transmitting the Balint tradition?

The text of the letter is reproduced below:

> Dear Wolfgang,
>
> Thank you for the letter of the 11th of February. You are quite right in thinking that the Balint Group Leaders who are not analysts have all been in groups for much longer than two or three years although there is one now who we are thinking might make a leader after three years. In addition, before they are leaders they have to be co-leaders either with Tom Main or me, or possibly as time goes on with the two non-analyst leaders, Mike Courtenay and Cyril Gill, for a year or two – probably two – before they can take their own group. Oddly enough however there is one leader who has not had this amount of experience, and is not and will not be accepted as a leader of Balint Group yet, who appears to be very good indeed. He is leading a group outside London. He is not invited to our workshops where only authorised leaders are accepted, but we are wondering whether to accept others who are doing good work in the provinces so that we can keep an eye on their work. Max Clyne is not a Balint leader as he has not been a co-leader with one of us.

Now about the problem of what is medicine and what is psychotherapy. It is indeed a very subtle line to draw. All our work with doctors is based on an examination of the doctor/patient relationship and, of course, on the transference and counter-transference. We only study the overt manifestations of transference and counter-transference, i.e. what is obvious and is not inferred by a knowledge of the unconscious. Should we call this psychotherapy? I really don't know. It might be a good thing if, at the Conference itself, you took a different attitude from me, and we could debate the differences. Is "holding" psychotherapy? I doubt it unless it is the holding of a part of the self which the patient is not aware of and the doctor is. It is true that in the early days we spoke about the possibility in short term focal therapy to dive under the defences, i.e. to penetrate some aspect of the defensive organisation. However, I think this was never discussed in the G.P. setting but more in the focal psychotherapy setting by analysts.

There is no doubt, however, that doctors can sometimes do this in their surgeries and this is the kind of thing that we described when we talked about "flash" (I prefer your word "episode") and I agree with what you say in your last paragraph, and think that there are patients who need to keep their main defensive organisation intact, but whose "core personality" can be cared for or even penetrated by their G.P. without his even being aware of what he is doing. I find, in fact, that quite a lot of the work that I do with the young trainee doctors is to help them to become aware that this is what they are doing and this appears to help them to do the job better and not to turn [them] into "detective inspectors", i.e. the old fashioned type of psychotherapist or history taker. Not to try to dig deeper. The patients themselves then have episodes of insight.

I shall quote you, of course, and use your observations in my paper. The cases I have taken to illustrate my theme illustrate this idea very well. In my view, however, it should perhaps be called psychotherapy when the doctor is aware of what he is doing and of the reasons why he wants to do it (i.e. his counter-transference), although I still long to call even this medical practice.

I would like to have your views on this.

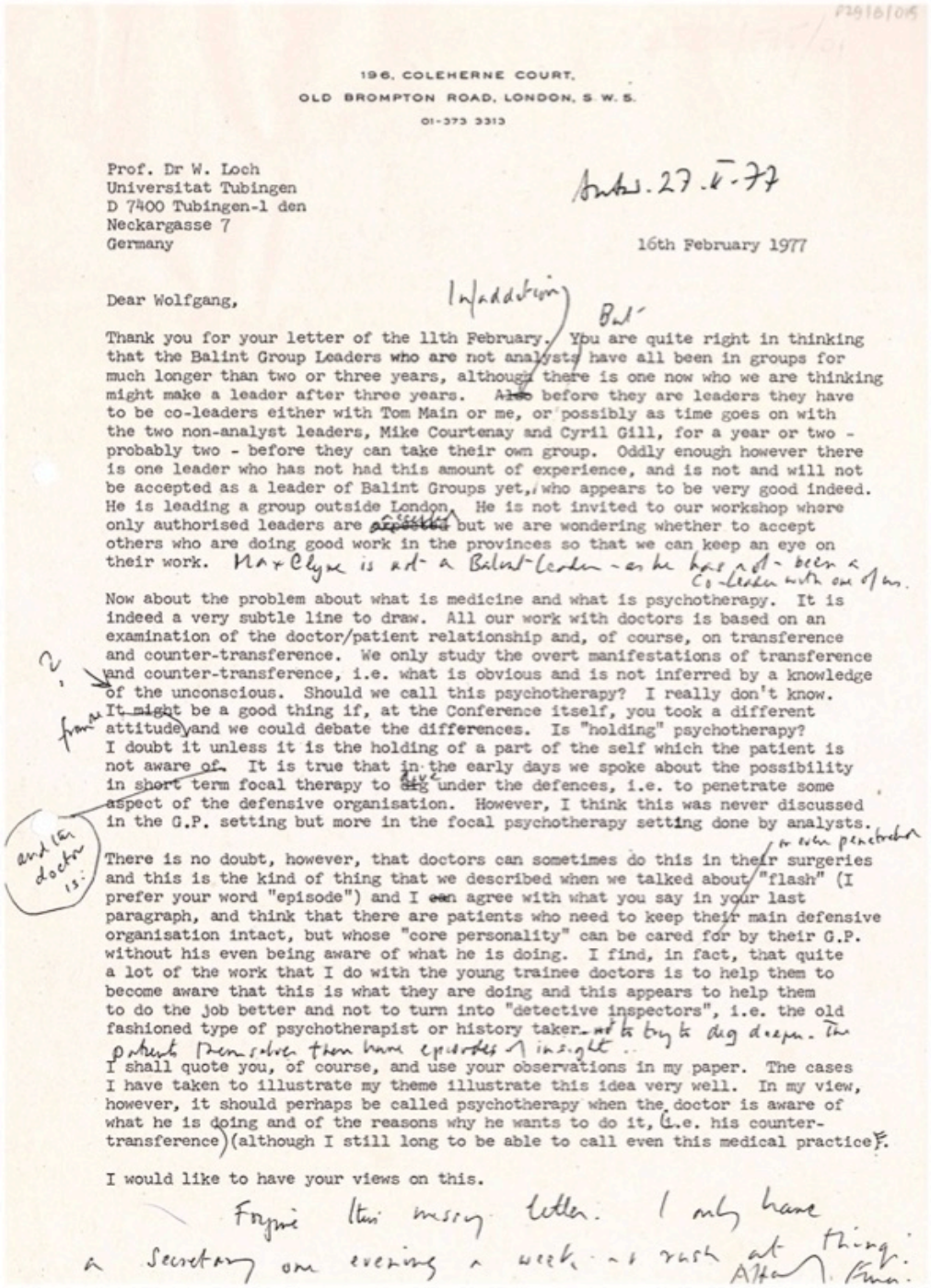
Forgive this messy letter. I only have a secretary one evening a week – a rush at times.

Enid

16th February 1977. *English*

Author Note

The author would like to thank Ewan O'Neill, Judit Szekacs and the Archive Committee of the British Psychoanalytical Society. The writing of this commentary was supported through a Wellcome Trust Fellowship in the Medical Humanities (Grant 200347/Z/15/Z).



196, COLEHERNE COURT,
OLD BROMPTON ROAD, LONDON, S.W.5.
01-373 3313

Prof. Dr W. Loch
Universitat Tubingen
D 7400 Tubingen-1 den
Neckargasse 7
Germany

London. 27.4.77

16th February 1977

Dear Wolfgang,

Thank you for your letter of the 11th February. You are quite right in thinking that the Balint Group Leaders who are not analysts have all been in groups for much longer than two or three years, although there is one now who we are thinking might make a leader after three years. Also before they are leaders they have to be co-leaders either with Tom Main or me, or possibly as time goes on with the two non-analyst leaders, Mike Courtenay and Cyril Gill, for a year or two - probably two - before they can take their own group. Oddly enough however there is one leader who has not had this amount of experience, and is not and will not be accepted as a leader of Balint Groups yet, who appears to be very good indeed. He is leading a group outside London. He is not invited to our workshop where only authorised leaders are ~~accepted~~ but we are wondering whether to accept others who are doing good work in the provinces so that we can keep an eye on their work.

Now about the problem about what is medicine and what is psychotherapy. It is indeed a very subtle line to draw. All our work with doctors is based on an examination of the doctor/patient relationship and, of course, on transference and counter-transference. We only study the overt manifestations of transference and counter-transference, i.e. what is obvious and is not inferred by a knowledge of the unconscious. Should we call this psychotherapy? I really don't know. It might be a good thing if, at the Conference itself, you took a different attitude and we could debate the differences. Is "holding" psychotherapy? I doubt it unless it is the holding of a part of the self which the patient is not aware of. It is true that in the early days we spoke about the possibility in short term focal therapy to dig under the defences, i.e. to penetrate some aspect of the defensive organisation. However, I think this was never discussed in the G.P. setting but more in the focal psychotherapy setting done by analysts.

There is no doubt, however, that doctors can sometimes do this in their surgeries and this is the kind of thing that we described when we talked about "flash" (I prefer your word "episode") and I ~~can~~ agree with what you say in your last paragraph, and think that there are patients who need to keep their main defensive organisation intact, but whose "core personality" can be cared for by their G.P. without his even being aware of what he is doing. I find, in fact, that quite a lot of the work that I do with the young trainee doctors is to help them to become aware that this is what they are doing and this appears to help them to do the job better and not to turn into "detective inspectors", i.e. the old fashioned type of psychotherapist or history taker.

I shall quote you, of course, and use your observations in my paper. The cases I have taken to illustrate my theme illustrate this idea very well. In my view, however, it should perhaps be called psychotherapy when the doctor is aware of what he is doing and of the reasons why he wants to do it, i.e. his counter-transference (although I still long to be able to call even this medical practice).

I would like to have your views on this.

Forgive this messy letter. I only have a Secretary one evening a week - & rush at things. Affec. Enid.

Letter of Enid Balint to Wolfgang Loch, 16th February 1977.
Source: The Balint Archive, held by the British Psychoanalytical Society.