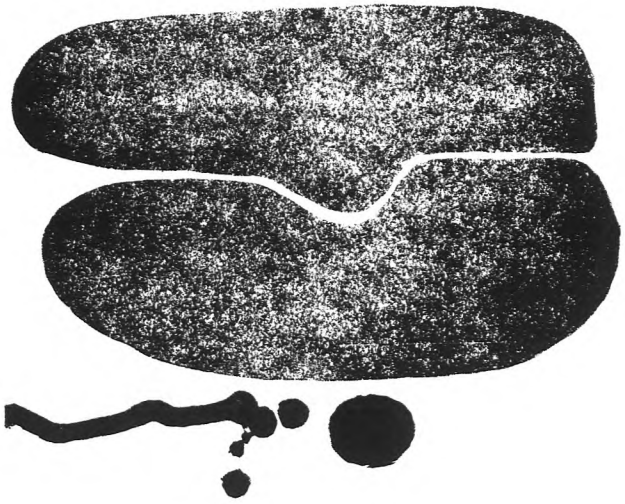
# Journal
of the
# Balint Society

2001



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# JOURNAL OF THE BALINT SOCIETY

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**Editor: John Salinsky**

**Editor emeritus: Philip Hopkins**

**Dr. Philip Hopkins**

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# The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is an annual residential weekend at Oxford, and there are occasional weekends and study days for elsewehere in the country.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

# Editorial

## Philip Hopkins

In this issue we celebrate the achievements of Dr Philip Hopkins as the editor of this journal for over 25 years - and as a writer about Balint and GP psychotherapy. Philip has now retired as editor but continues to take an active interest in the Journal and in the Society of which he was founder president.

From the very beginning, the Council of the Society recognised the importance of having a journal in which members could record their activities, put forward their ideas and report on their research projects. In the words of two of our founders, Max Clyne and Aaron Lask; 'the journal will be the medium with which the Society will talk to the Profession'.[1] To the best of our knowledge, ours was the first Balint Journal to appear; it was quickly followed by the Bulletins of the French and Belgian Balint Societies. More recently they have been joined by Balint Journals from Italy and Romania and since March 2000 by the German Society's Balint-Journal which is published an impressive four times a year. So far we have not managed to appear more than once a year, but publication is eagerly awaited by our faithful readers at home and abroad, thanks largely to the dedicated and inspiring work of Philip Hopkins.

A good way to appraise the scale of his achievement would be to sit down with a stack of back numbers of the Journal of the Balint Society[2] and browse through them. Complete sets are now quite difficult to come by, and even our own set is short of three early editions. Nevertheless, if your collection consists of only a dozen copies, once you start to look through them you will soon find yourself totally engaged and you might as well cancel your plans for the rest of the weekend. The articles in the Journal cover 30 years of reflection about the doctor patient relationship and the human condition from an impressive array of thoughtful, humane, wise and witty doctors and psychotherapists. We only have space for few recommendations; but here are some of the highlights from three decades of Philip's editorship:

The 1977 journal contained only three articles but they are all winners. Marshall Marinker gives the first Memorial Lecture on the theme of 'The Academic General Practitioner'; Michael Courtenay reports on his first experiences as a group leader; and Michael Balint himself begins, in the style of Jane Austen, a wonderful lecture on 'The Family and its Doctor'. This was delivered shortly before his death and you almost certainly haven't read it.

From the 1980s we would select Cyril Gill's characteristically modest and insightful Memorial Lecture, 'Tensions in General Practice' and Andrew Elder's realistic but inspiring account of 'Psychotherapy in General Practice'. Both are in the 1985 issue of the Journal. And from the 1982 issue we recommend Sally Hull's Balint Society Prize essay: 'Excursion to Maida Vale' which not only quotes Jane Austen but shows us very clearly the effect which a Balint group experience can have on a young doctor's understanding of her work.

From the 1990s journals we would draw attention to the work of Sotiris Zalidis who has provided us with a whole series of reports and reflections from the consulting room (1994, 96, 97, 98, 99). Together these articles give an absorbing picture of the developing work of a psychotherapeutic family doctor. And Michael Courtenay offers a brief but masterly summary of what we are about in the classic 'A Plain Doctor's Guide to Balint-Work' ( 1992). The 1998 edition, the last which Philip was to supervise personally, is fittingly the largest so far with 70 pages. It brims over with anticipation of the 1998 Oxford International Congress and includes the timetable of the Congress and abstracts of all the papers. Don't miss, either, the two essays by medical students, full of freshness and humanity for patients. They remind us of the importance of getting our message across to the younger generation.

In his editorials, throughout the years, Philip pursues a number of recurrent and important themes. He reminds us of the urgent need to attend to our patients' emotional needs as well as their physical symptoms; he defends Balint vigorously against attacks from the ignorant, the sceptical and those who think Balint is of historical importance only. He deplores the fact that the new academic departments of General Practice sprouting up in all our medical school are failing to include Balint in their curriculum for students. He pours withering scorn on the 'New Contracts' provided for GPs and asks if government knows what patients really want and need? Again and again he returns to the question of TIME. Doctors and patients need more of it to spend with each other. Philip never really signed up to the idea that 'six minutes' was enough. What does he think of the current state of general practice in Britain? In his 1997 editorial he quotes from *The Doctor, his Patient and the Illness*[3]: 'My diagnosis is that general practice is seriously ill, but the illness is benign'. 'Forty years on', adds Philip, 'our patient has survived, mostly due to a tremendous will to live, and the altruism of health service professionals. But the illness has been debilitating and has left scars, and the therapy has not always been focused.' He is saddened by

what he sees as a substantial loss of continuity of care and personal doctoring as a result of the growth of the primary care team and the handing over of out of hours care to co-operatives and deputising services. For him, the ideal family doctor is the single handed GP who cares for his patients emotions as well as their bodies. Most of us would probably argue in favour of the team approach and the less stressful life that goes with a good night's sleep. But we would have to admit that he has a point and he certainly practiced what he preached.

We hope that you will be encouraged to read or re-read Philip's editorials and all the other wonderful stuff to be found in his Journals. We are also publishing an early account of the GP as psychotherapist which he wrote for the Lancet as long ago as 1956 and a transcript of an interview in which he talks about his early days as medical student and doctor. Philip, we salute you. The Society offers you warm congratulations and a big vote of thanks.

### References


1. Clyne, M. and Lask, A.(1971) *The Organisation of the Meetings of the Society* (discussion paper presented to the Balint Society's AGM)
2. The Journal of the Balint Society (1971-2000) Issues 1- 28.
3. Balint, M. (1957) *The Doctor, his Patient and the Illness*. Pitman, London. 2e, 1964. Millenium Edition, 2000. Churchill Livingstone, Edinburgh.


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# The Balint Society Website

The Balint Society now has its own internet website.

The address is **www.balint.co.uk**

Unlike some addresses, this one is very easy to remember and to find.

When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress.
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on **www.balint.co.uk** you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to **www.balint.co.uk.**

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# An Interview with Philip Hopkins on 3 February 2001

Interviewer: John Salinsky

JS : Can we go back to when you first decided to go in for medicine?
PH: I was seven. I was lying in a bed in a nursing home. I had just had my tonsils out. The surgeon was such a nice kindly man. He came in the day after I had had the operation and said he had come to talk to me and tell me what they had done to me. I was all swollen and I felt terrible! I had had chloroform which was the anaesthetic of the day. He brought me a present, 'A Book of Heroes' - because I'd been very good. I thought he was such a nice man that I went home when my mother came to collect me and said: 'I want to be a doctor'. So she actually took me to see our family doctor and proudly announced that I had decided to become a doctor, and please, what should she do about it.
JS: There were no doctors in the family?
PH: No, my father was a dentist but not a qualified dental surgeon. I decided to train as both a dentist and a doctor. I qualified first as a doctor but I was called up into the army and of course I never went back. I studied at Guy's hospital in London. I can see it so clearly now. I found out where it was and I went there on a bus. I saw a very nice man and said 'I want to be a doctor' He said: 'you'd better see the Dean.' So I was ushered into the room of the Dean whose name was Evans. And at that time I had a very acute Welsh accent so we got on famously. He said, 'Hopkins, eh, well you've got a Welsh accent. Where are you from?' I said, 'Newport.' 'Oh', he said, 'my family lived in Newport'. So I was accepted on those grounds. He asked me if I wanted to be a dentist like my father. I said no, I wanted to be a doctor. He said 'I asked because we don't have any more vacancies for medicine but we could take you to do dentistry'. I was wondering what to do next when he said: 'you could do the double course if you like: dentistry and medicine and become an oral surgeon.' I said yes, please. He asked me did I play cricket? I said yes, although I didn't play very well. I started the following September.

My family's name originally was Kopkinski. My father's father when he came to England in 1898 I think it was, he found with a name like that it was rather difficult and he changed it to Kopkin. Later my father changed it to Hopkins .
JS: When you were at Guy's did you see yourself as becoming a GP eventually?
PH: No. No. My father wanted me to follow him and be a dentist.

When the war started we were given the choice of going straight into the army or waiting until we had qualified. I think only one boy wanted to go straight into the army. But as students, it was made clear that we ought to do something and I chose to be an air raid warden. Which meant mostly standing on the roof at Guy's at night. We had a rota, took it in turns to stand on the roof to kick off any fire bombs, incendiaries. When I think of it now it seems outrageous. We were young men, boys really, of 18 or 19, and we had to keep an eye out for incendiaries. If we saw one land on the roof, which they did, we had to kick it off.
JS Was there a period before they burst into flames which gave you time to kick them off?
PS: About ten seconds!
JS: What about your house jobs?
PS: I was a house surgeon and a house physician and then I went on to be a surgical registrar for a year at King George's Hospital, Ilford. And while there I got a notice that I was to do some military service. I was given a choice of going into the army, navy or air force. I didn't want to be in the air force and I didn't want to go sailing – mind you, if I had the choice now I'd say yes please, I'll go into the navy! However, I went into the army and I spent two and a half years in the Middle East. I had decided I wanted to be an orthopaedic surgeon and had started my fellowship. I worked for an orthopaedic surgeon who was very nice, kindly and paternal and I decided I wanted to do what he did! So I was posted as a graded orthopaedic surgeon to a hospital in Egypt.
JS: Did you enjoy orthopaedic surgery?
PS: Yes, I did – except that it was like bone carpentry and after a while I got bored with it. In the army I spent hours every week removing soldiers' ruptured cartilages from their knees and dealing with traumatic things.
JS: What got you interested in the psychological aspects?
PS: That's a good question. In seeing soldiers with backache – and of course a lot of them were wanting a good excuse to get back home – I was interested because I became quite aware of the emotional states of these soldiers. They were overseas, their wives were having babies back home. They had left them pregnant – some of them got letters saying that they were pregnant and when they worked out the dates it was after the chap went away and so on. I didn't want to spell that out to them, the more ignorant ones.
JS: Did you feel different from the other army doctors?
PS: What a good question. I did. You know, the regular army doctors would play golf in the afternoons and bridge in the evenings in the mess and I did feel very different from them. They enjoyed being in the army while I thought it was dreadful! I mean the job of an army doctor is to keep the troops on duty. If a chap came with a headache we gave him some aspirins and sent him back on duty. I spent three weeks on a course learning to be an army doctor. They gave us a slim instruction manual. It was very brief and to the point. I found myself listening to soldiers' tales of woe and how upset they were because they were away.

When their wives were pregnant I used to write letters recommending that they be posted back home. I was called up by the commander of the hospital who wanted to know why I was sending so many men back home. I said of one that I felt his family needed him. 'The army needs him, too!' I was told. I was too soft-hearted for the army, I'm afraid.

JS: Were you affected by these stories?

PS: Yes, I was. I used to go around saying 'I'm not a soldier, I'm a doctor!'

Then I went home on leave and three months later my wife wrote to me and said I was going to be a father. So I was posted back home. Then I was posted to Egypt and my father in law helped to arrange for my wife to be allowed to come and join me so our daughter was born in Egypt. When I got back to London there were 60 other doctors all after the job I wanted in orthopaedics. So I took a year's appointment, six months as a surgical orthopaedic registrar and six months as a medical registrar.

Then we needed a family doctor and there was a nice doctor at the end of the road, Dr Harbinson, and I went to see him. We had a long talk about medicine and a possible career and I decided when I met him that I'd like to go into general practice. He invited me to go and sit with him to see what it was like – and then I did a locum for him and I liked it, found it was interesting and that was it. When I finished in the army I decided to go into general practice.

JS: had the NHS started yet?

PH: It started shortly after that. In order to have a practice I had to have experience. I was interviewed by an elderly doctor, Dr Arthur Rees, who needed an assistant – and I'd only been with him about six months when the poor chap had an acute coronary and died. The situation then was – this doctor's widow wanted to sell the house and move away and the opportunity was there to buy this house – and the practice with it. They added on £1000 for the value of the practice. When it was sold it was sold for half the annual income. This was before the Health Service.

JS: Was he another Welshman?

PH: Yes he was. Dr Rees. Extraordinary. I've just remembered.

JS: What was general practice like when you first started?

PH: It was just before the NHS started. The doctor had a panel of about 1400 patients for which he would be paid 7/6d each per year. But half of them left when they heard there was a new inexperienced doctor and registered with another panel doctor down the hill.

JS: How long was it before you began to see a lot of psychological problems?

PH: My first six months I didn't know what people were coming with. There was no training for general practice then. Have you read AJ Cronin's *The Citadel*? Well, it was just like that. In the army men came to me with a bad knee or a dislocated shoulder – I was very good at all that. But in general practice patients came with all sorts of multiple symptoms – and I quickly realised that the best way to get into all this was just to listen and not to ask so many questions.

JS: Did you find your consultations going on a long time as a result?

PH Well, yes. But being in Michael Balint's group helped me enormously.

JS: Some people said that before they joined the group they were really close to despair with general practice and didn't think they could carry on. Did you ever feel like that?

PH: I did, I really thought I'd pack it up, I'd go back and get a hospital job.

JS; When you went to see Michael Balint for the first time, what were you expecting? Were you expecting lectures on psychiatry?

PS; I was expecting him to advise me on what to do. Enid Balint opened the door and took me into their house. I said: 'Good morning, sir'. And he said 'Well, what do you want?' That was the first thing he said to me.

JS: Did you have a conception of what a psychoanalyst did in those days?

PH: Not a clue.

JS: Had you heard of Freud?

PH: Yes. Yes, indeed. And in fact his writings appealed to me very much because he helped me to sort things out in my mind. As an orthopaedic surgeon my practice had been entirely mechanical. I called myself a bone-carpenter. He gave a lecture on the psychological problems of general practice, and I was very impressed. And I loved his accent. He had this very appealing Hungarian accent. So I found myself in a group. We met at the Tavistock Clinic to begin with.

JS: On a slightly different subject, had you always been interested in writing? Because, of all the Balint pioneers, you were the one who inscribed the history and started the Journal.

PH: Yes, I had actually. My first paper was about a patient of mine who had attempted suicide and I'd washed her stomach out and revived her and I wrote it up in The Lancet and it was a very interesting case because I'd saved her life and she was very grateful. At first I thought she was going to be very angry with me. But after she'd taken all these aspirins she decided she didn't want to die which was why she let me wash her stomach out. Then I was called to see a patient with a painful leg who turned out to have a popliteal embolus and I did an emergency embolectomy. I wrote that up too. That was while I was a registrar at St George's Hospital.

JS: I think it would be interesting to reprint one of your early papers on psychotherapy.

*At this point the tape ran out and PH, SH and JS went out for a splendid lunch.*

# Psychotherapy in general practice

Philip Hopkins MRCS
General Practitioner, Hampstead

(Originally published in *The Lancet,* 1 September, 1956, pp 455-457,
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Many think that psychotherapy should be undertaken only by the specialist. I disagree with this and hold that the person best placed to use psychotherapy, and most likely to use it effectively is the general practitioner.

When people feel themselves to be ill they usually turn first to their family doctor. Before anybody else, he has a chance to recognise the nature of the illness, to choose the treatment, and to apply the treatment if it is within his competence. His attitude may influence not only the course of the illness but also perhaps the course of the patient's life.

We have all heard hair-raising stories of how patients have been treated as neurotics when in fact they were suffering from a cancer or some other form of physical disease. I believe, however, that at least as much harm may be done by accepting all presenting symptoms at their face value and by treating them with physical methods. In this way, the patient who has an emotional conflict may be encouraged in his false belief that he has a physical illness. With a psychotherapeutic approach, there is less danger of this happening and psychotherapy when needed, can be started without delay. This is important; for many patients are disinclined to consult a psychotherapist – let alone be treated by one. In any case, there is no necessity to refer all patients requiring psychotherapy to psychiatrists, even if there were enough psychiatrists to give it.

## WHAT KIND OF PSYCHOTHERAPY?

By psychotherapy I do not mean any one specific treatment. There are many forms of psychotherapy and, in the first place, they may conveniently be divided – as surgery is divided – into major and minor branches.

*Major psychotherapy* includes psychoanalysis and other forms of intensive psychotherapy, and clearly would be used only by the specialist and possibly by those few general practitioners who have had a personal training analysis. I am not here concerned with these methods.

*Minor psychotherapy* may be divided into two further groups of methods. The first includes the following:

Simple reassurance, either alone or after examination has excluded physical disease.

Reassurance together with prescribing of a placebo.

'Education' or explanation about some medical problem previously the basis of anxiety symptoms.

Sympathetic listening to the expression of difficult reality situations, or of resentments, discontent, aggressive feeling etc without any show of reproach or condemnation.

Support and encouragement to continue in the face of difficulty.

Guidance towards a happier and a fuller use of leisure and in the development of new hobbies and pastimes. Suitable books may be recommended for reading.

The bedside manner might also be placed under the heading of minor psychotherapy and there must be many other forms of this art. I do not doubt that these methods are used by all doctors in their day-to-day dealings with their patients, even by those who do not care to accept any connection with the word psychotherapy. The only doctor who can pursue his work without using some sort of psychotherapy is the one who confines himself to the study of the dead.

But these methods have one thing in common - they do not attempt to deal with the underlying emotional problems any more than the more usual physical treatments, though they do allow the doctor a fuller understanding of the patient as a whole person and not merely as the vehicle for an illness with symptoms.

The second group of methods of minor psychotherapy are more advanced but are still within the competence of any family doctor. They are consciously and deliberately applied with careful thought and attention to what is going on between the patient and the doctor. The aim is to focus the patient's attention on his mind, thereby helping him to understand his particular problems so that he can either find a way of resolving them, or, if this is impossible, of adapting his way of life to fit in with them.

These methods consist in discussing his problems with the patient in such a way that underlying emotional conflicts can be related to them. Where the patient denies problems or is clearly unaware of any conscious worry, it is necessary to centre discussions on the life situation at the time of onset of symptoms, or even of the whole life history, in order to discover possible motivation for his present-day behaviour and the development of his symptoms.

Essentially the aim is to encourage the patient to do the talking - the reverse of normal medical history taking - for the relevant material is in the patient's mind, and only the patient can produce it. It is surprising how often in this way possible solutions to the underlying emotional problems are found by the patient himself.

Repeated description of the symptoms should be gently discouraged and the discussion directed to what lies behind the symptoms. We do not necessarily want to know why the patient has a symptom, but rather what does he do with it or what does it do for him?

## PREVENTIVE PSYCHOTHERAPY

I tend to concentrate on the younger patients, because response does seem to diminish with age – though, when time permits, success maybe expected in many of the older ones, and particularly in women at the climacteric. But another reason for treating the young is that if they are enabled to cope with their own emotional problems they will be less likely to produce neurotic illness in their children. The family doctor is in a wonderful position to practice true preventive medicine along these lines. We all know how the infant and the child respond to an over-anxious parent, and one of the best rewards that I know is to see the change in the infant or child after simple psychotherapeutic measures have been applied to the mother or father. Similarly, the girl at onset of menstruation will benefit if her mother's faulty attitudes to sexual matters are corrected. Even the problem of failing lactation and breast feeding can often be solved by a combination of reassurance, lessons in the elementary physiology of lactation, and discussions of the mother's feelings of inadequacy or guilt.

## SYMPTOMS OF WHAT?

We family doctors should train ourselves, I think, to accept that people come to us only when they need help and therefore should not be regarded as 'just neurotics' or as nuisances. We should recognise that their symptoms may be masking emotional conflicts, and that it is these conflicts that need our attention - not the symptoms. We would then be in a position to try to deal with the causes rather than the effects. To return to the surgical analogy, none of us would think of treating abdominal pain without first diagnosing its cause: if it were found to be due to acute appendicitis we should hardly be content only to prescribe morphine. Yet it is commonplace in medical practice to diagnose anxiety, and then to treat this symptom -with some sedative or 'tranquilliser' – without having made any effort to uncover its origins.

If to the number of patients with psychoneurotic illness we add the even larger numbers of those with psychosomatic (or stress) disorders, it becomes positively alarming to contemplate the extent to which our prescriptions are expected to act as a substitute for the fuller understanding and the psychotherapeutic discussions the patient's need.

In 1945 I carried out a survey in my practice and found that 42% of my patients were suffering from stress disorders. (In *Modern Trends in Psychosomatic Medicine* Ed. D. O'Neill, 1955) Later I read Stephen Taylor's statement (in *Good General Practice,* published 1954) that 'claims that as many as a third of the GP's patients are suffering from neurotic illness appear to have arisen mainly because organic complaints have not been diagnosed.' I almost gave up practice. But instead I made a careful analysis of all the patients I had referred to hospital specialists and consultants during 1951-53. I was relieved, though not surprised, to find that, after full investigations, slightly over 30% were found to have psychoneurotic or psychosomatic disorders.

Here then is evidence for the scope for psychotherapy in general practice. If more is needed, one has only to turn to any newspaper or magazine, or even to the wireless and television, to see the amount of help that is forever being sought by the public for their emotional problems.

## TIME WELL SPENT

Shortage of time is the reason most commonly given for limiting psychotherapy in general practice. Admittedly, psychotherapy takes time; but in my experience this is time well spent and, in the long run, may even be time saved. A few sessions for psychotherapy may take up less time than seeing a patient for a few minutes, to prescribe a placebo, every week for months or years.

The following examples show how minor psychotherapy may be applied in general practice.

**Mrs A.B., aged 25,** with her tear-filled eyes would be recognisable to everyone, especially with her opening remarks: "I think I need a tonic, doctor, I feel so run down." On being asked what had made her run down and in need of a tonic she burst into tears and after some silent sobbing she told me how miserable she felt. She had been married only a few weeks, yet already she was so tired of working all day in her office and then returning to clean her flat and prepare her husband's supper. On the word 'husband' she again flooded with tears: after which, with little persuasion, she went on to tell me about difficulties she was experiencing with sexual intercourse. It was not difficult to help her with a full discussion and, when I saw her again two weeks later, all was well – though she was still working all day at the office and still doing her housework. It is over a year since the first interview and she remains well and happy.

It may be argued that to prescribe a tonic might have had the same effect. Perhaps this is so, but I do not believe it. But here is a patient who had been given a tonic without effect.

**Mrs B.C.,** a 27-year old social worker, had moved to London with her husband. She came asking for a further supply of a well-known tonic that her previous doctor had prescribed. On being asked if it had helped, she replied that it had not helped yet, but as she felt so run down and tired she was sure she should go on taking it. She had

come during a busy surgery, so I was glad to give her the full prescription; but I also gave her an appointment for a full examination two weeks later. At this next interview, she was no better and told me of her symptoms – giddy and faint feelings, breathlessness on stairs, and being jumpy and nervy. She had been off work for several weeks in 1947 with pulmonary tuberculosis: but examination was completely negative, apart from revealing her to be tense and anxious, and with all reflexes grossly exaggerated. We discussed her marriage, here work and, eventually, her feelings of insecurity due to her husband's insecure position as a student of architecture. She realised that she felt insecure when she had similar symptoms with her chest trouble. After a full discussion, I was able to reassure her that she did not need a tonic any more. She rapidly lost her symptoms after this.

I believe that in both these patients the repeated prescription of tonics could have encouraged a life-long habit of taking medicines, with frequent visits to the surgery and the development of illnesses at any and every crisis.

The next two patients are men, and it was necessary to encourage both to talk freely about themselves before the true nature of their illnesses became apparent.

**C.D., a stockbroker's clerk,** aged 52, first came to see me on April 17 complaining of a 'constant dullness in the pit of the stomach' for more than 20 years. He now feared that he had a gastric ulcer 'or something worse'. He had taken many medicines over the years with little benefit. When I asked him to tell me more about his troubles he expressed, saying that at that point other doctors just gave him a prescription, adding that 'his stomach was the trouble'. With encouragement, however, he described the work that he disliked so much; he bemoaned the fact that he had never married; he even talked of feeling as though he was 'full of frustrations'; and he lamented that he had never fulfilled his ambition to be a writer. Once he started I did not have to ask any questions and I found myself wondering what on earth anyone could do to help this poor chap. Examination revealed only anxiety. I told him of my negative findings and I added that there was definitely no evidence of an ulcer nor of cancer of the stomach. On the other hand, I went on to tell him that there was the positive finding of his anxiety about his physical condition together with an underlying depression about his self-expressed frustrations. We went on to discuss some of the ways in which he might make his life more interesting, and I prescribed some sedative tablets. He returned on May 1 to tell me how much better he had felt. I was taken aback, but managed to say that I was glad the tablets had helped, to which he replied he had only taken one of them and, as it had made his mouth dry, he had left the rest. He said he had been relieved to know he had no ulcer or cancer, and that after our talk he had joined a local club and felt he belonged somewhere at last. He is also taking a course in night classes on journalism.

**D.E., aged 23, a surveyor,** complained of constipation for a month associated with what he took to be haemorrhoids. He said that otherwise he was well. My attempts to find out why he should have become constipated a month ago were fruitless. Local treatment and dietary advice was given when he was found to have early haemorrhoids. Two weeks later, these had cleared, but he looked upset, and under a little pressure he admitted to not being able to sleep for the past three months. He could not account for this. In his brief account of his life I could find nothing suggestive of an unstable neurotic personality and it was not until I asked him whether he had any girlfriends that he told me that, about six weeks ago, he had broken off his engagement. At first he tried to say this was 'a lucky escape', but gradually he told me how, when away on business, he had been unfaithful to his fiancée and later developed what turned out to be a non-specific urethritis. This preceded his insomnia and the constipation had started when he began to wonder whether he might pass some venereal disease to his fiancée by kissing her. He avoided being alone with her and eventually decided to break off the engagement. I pointed out to him that the possible relation between the events and his symptoms, and he agreed that he should tell his fiancée the truth about everything. A week later he was able to say that his fiancée had forgiven him and that all was now well. In his own words: 'It's incredible. I feel 100% fit now and I've been sleeping normally.'

This case shows that we cannot believe the patient who tells us in the first interview that he has no worries. He may really believe this, or he may not yet be sure whether he can talk freely to us.

To return to women patients, many gynaecological disorders respond well to psychotherapy, which in my opinion should be tried before hormones and anything more drastic. Young women with amenorrhoea due to environmental stress usually respond to simple psychotherapy. Women with menorrhagia not associated with fibroids or other physical disease also do well with simple psychotherapy. The emotional origin of dysmenorrhoea is recognised, yet it is odd that psychotherapy is seldom used in its treatment.

**Miss E.F. is a shop assistant** of 24, who because of pain had spent one or two days in bed at every period since the age of 14. Her periods were irregular, 5-9 weeks apart, and were preceded for 2-3 weeks by severe headaches with feelings of tension. She had had every kind of treatment in the books except psychotherapy. There had never been any relief from either the premenstrual tension or the pains. Over a number of interviews she was able to discuss her attitude to her bodily

functions and to sexual matters, and she described the tremendous guilt she felt at the age of 14 when a boy friend tried to make love to her. Shortly after this her father had died and her next period was painful and set the pattern for subsequent periods. There were many conflicts associated with her attachment to her mother, her genuine religious beliefs and her feeling for the boy friend, who has remained faithful to her to this day. After the third interview she began to improve, and for the past 8 months she has been menstruating regularly and has been free from all symptoms. More important, she has matured and is soon to marry her friend.

This latter point is important. Psychotherapy does more than stop symptoms; it brings about changes in the patient's attitude to his life situation, and enables him to come to terms with himself and with his life so that he can make important decisions and, when faced with new problems, can deal with them instead of breaking down into illness. Some patients, instead of coming to me with fresh illnesses, now come and present an actual emotional conflict for discussion. Thus once rapport is established the patient no longer needs to present with masking symptoms but can openly come to his doctor with his emotional problems. If he still suffers from somatic symptoms, at least he has the insight needed to recognise their relation to his emotional state.

The use of psychotherapy in general practice may be limited where time is short; but with its help the doctor can unquestionably get nearer the ideal of treating patients and not merely their symptoms.

# The Current Status of Balint Groups in American Family Practice Residencies: a Ten Year Follow-up Study, 1990-2000

Alan H. Johnston, PhD; Clive D. Brock, MD; Ghassan Hamadeh, MD; Ron Stock, MD

## ABSTRACT

**Background:** In 1990 the first and to date only objective study of Balint groups in Family Practice residencies was conducted. Their prevalence, composition, leadership and function were reported. More recent studies cite the importance of Balint's contribution to behavioural science in family medicine without quantifying its influence. Methods: Surveys were sent to all 464 US family medicine residency program directors with one month follow up to non responders. Responding and non responding residencies were compared by chi square analysis to substantiate the representativeness of the responding sample. **Results:** Two hundred and ninety eight (64%) residencies responded. Almost half (48%) of US residencies responding are conducting groups and 40% of those residencies have more than one group. The frequency of Balint group meetings has shifted in the past 10 years. In 1990, 55% of groups met weekly; in 2000, only 15% of groups meet weekly. 65% of residencies require Balint participation. One third of Balint groups are conducted without a co-leader and the number of physicians leading groups is 22%, a decrease of 10%. 44% of groups are led by psychologists, an increase of 19%. **Conclusion:** Survey results are interpreted in light of standards established by the American Balint Society. The boundary issues between Balint groups and support groups are explored. The limitations that these boundary conditions impose on the study are noted.

## Introduction

From the 1970s small pockets of Balint or Balint-like groups have come into and out of existence throughout family practice residencies in the United States. Individual residency programs featuring Balint groups were profiled before 1990 in the articles of Scheingold & Brock.[1,2] However, the coordination of a sustained, national effort to spread the research, teaching and practice of Balint's work did not really begin until May of 1990 when the American Balint Society (ABS) was formed concurrently with the STFM national meeting in Seattle, Washington. The Society's ever expanding educational efforts from 1990 to 2000 and the defining values directing the American Balint Society's mission are described in a recent article by Johnson.[3] It was not until 1990 that the first and only article to date appeared defining the prevalence, composition, leadership and function of Balint groups in American family practice residencies.[4] More recent studies of the behavioural sciences in family medicine cite the significant contribution of Michael Balint without quantifying its influence in family practice residencies.[5,6] The following study brings up to date the evolving profile of Balint activities in American family practice residencies and reflects in part the influence of the ABS on Family Medicine.

## METHODS

In April of 1999 a comprehensive computerized list of Family Medicine program directors was purchased from the Society of Teachers of Family Medicine. In May a four page, two part questionnaire, a shorter more focused survey paralleling in some ways the one used in 1990 was mailed with a cover letter. The cover letter stated that the enclosed questionnaire was a ten year follow up by the American Balint Society attempting to assess the current composition, leadership and purpose of Balint training in US Family Practice Residencies. The directors were asked to complete the questionnaire as soon as possible or forward it to a person in their program who could complete it and return it to the first author. One month later, all programs from whom no completed questionnaire had been received were sent a second questionnaire with a new cover letter noting that this was a follow-up request to an earlier mailing. After phone calls to clarify ambiguous or conflicting responses the computerized data set on which the following summary tables are made was completed on January 29, 2000.

To check for bias several basic program parameters in the sample of those 298 programs that responded to the questionnaire were compared to the 166 programs that did not respond. The Directory of Family Practice Residency Programs, 1999 edition, was used as the source of program information.[7] Program structure, residency location, number of family practice centers per program, total number of candidates, year of initial approval (age of program), resident to faculty ratio and MD to other faculty ratio, were compared between the two groups. By chi square tests no significant differences were found between the two groups leading to the conclusion that the responding sample (64%) is reasonably representative of all US family practice residencies.

Part I of the questionnaire focused on whether residencies had Balint groups and, if not, had they had such groups in the past ten years. Reasons for groups' failure was sought as well as intentions to initiate Balint groups. If the program had no Balint group(s) the qustionnaire could be returned immediately without continuing to Part II of the questionnaire.

Part II of the questionnaire was to establish the composition and numbers of Balint

TABLE 1
VALUES DIRECTING BALINT TRAINING/RESEARCH

| Goals to Be Achieved | Goals to Be Avoided |
|---|---|
| Spontaneous case presentations: omissions, emotions, slips of the tongue, and metaphors | Assigned presenter and defined format for presentation |
| Relationship focused on two whole people coping with an illness | Treating a sick patient: ICD-9 or DSM-IV status explored |
| Group is to imagine and explore experience of presenter with one patient | Case generalizations and treatment protocols are discussed |
| Group process is monitored to see how it parallels the doctor-patient relationship | Group activity is judged by product or prescription for treatment |
| Leader diverts group from psychologically probing presenter | Therapy group explores psychological structure of presenter |
| Quality of group process is analyzed only if it is obstructing group task | Training group focuses on all group process to highlight small group dynamics |
| Training for the professional ego (What kind of doctor do I need to be for this patient?) "....a considerable though limited change."[8] | Psychotherapy for the personality (What kind of person do I want to be?) |

TABLE 2

BALINT GROUPS IN U.S. FAMILY PRACTICE RESIDENCIES IN 1990 AND 2000

| **Survey Year** | **1990** | | **2000** | |
|---|---|---|---|---|
| **Number and Percent** | **N** | **%** | **N** | **%** |
| Programs Surveyed | 381 | 100 | 464 | 100 |
| Respondents | 354 | 93 | 298 | 64 |
| | | | | |
| With Balint | 66 | 19 | 144 | 48 |
| Residencies With: | | | | |
| One Group | | | 87 | 60 |
| Two Groups | | | 33 | 23 |
| Three Groups | | | 20 | 14 |
| Four Groups | | | 4 | 3 |
| Without Balint | 288 | 81 | 154 | 52 |
| Would Like One | 69 | 24 | 8 | 5 |
| Plan One in 1 Year | | | 9 | 6 |
| Had One | 33 | 11 | 33 | 21 |

groups, frequency and duration of group meetings, professional role of leader(s), how leaders were trained and how they maintained their leadership skills. Finally, several questions on a Likert scale were used to identify the goals of the Balint group. These items were developed around a set of values directing Balint training and research. (Table 1)

## RESULTS

Table 2 summarizes Part I of the questionnaire and compares where possible to variables assessed in the 1990 survey. The number of residencies reporting a Balint group has more than doubled from 1990; increasing from 66 programs (19% of all programs) to 144 programs (48% of all programs). Forty percent of the programs responding are conducting more than one Balint group. 21% of those without Balint groups had one in the past ten years and 6% planned one in the coming year. Very few residencies without Balint groups bothered to check or write in reasons for their failure or absence in the residency. The most frequently cited reasons were lack of resident interest, lack of faculty interest, the shortage of time and Balint group leaders leaving the program.

Table 3 summarizes 2000 data from 142 residencies and 228 groups, and where possible compares it to 1990 data of 66 residencies and 115 groups. No peer groups of only medical students were found in the recent sample and by far most Balint groups were of mixed membership with the highest percent of groups containing first, second, and third year residents, 64%. The percent of faculty and community MD Balint groups changed little. The distribution of numbers in Balint groups remained fairly constant with 73% consisting of 5-10 members. However, what seems to have changed most markedly is the frequency of meetings. In 1990 55% of groups met weekly; in 2000 only 15% met weekly. While in 1990 11% of groups met monthly, now, in 2000, 48% of groups meet monthly. The duration of Balint groups remain fairly constant over the past ten years with about half of the groups lasting for three years or the duration of the residency. It seems that Balint group participation is now required by more residencies, 65%, than in 1990 when Brock and Stock estimated "approximately half of the 66 residency programs required Balint group membership."[4] In 1990 and in 2000 there is no way of knowing how effectively this requirement is enforced.

Table 4 summarizes data on leaders and co-leaders. In 2000 33% of the groups in the sample operated without co-leaders. The number of family physician leaders decreased by 10% over the past ten years and the number of psychologist leaders increased by 19% over the same period. The percent representation of other professionals in Balint groups changed little. From 1990 to 2000 the number of family physician co-leaders decreased by 9% and the number of psychologist and psychiatrist co-leaders decreased by 10%.

Table 5 summarized the 2000 data on leaders' method of study and peer review. Reading together with STFM workshops and other leader consultations seem to be the chief methods of studying Balint leadership skills. Few leaders seek consultation on their leadeship outside their programs. To varying degrees leaders seem more consistently to seek feedback on group process from their co-leaders. Only 52 persons cited formal intensive leader training as an avenue of studying Balint group leadership. Yet, we know that over 250 faculty have attended Balint Leader Intensive workshops.

Table 6 summarizes the average ratings on a 5 point Likert scale of possible Balint group objectives. Where possible, the ratings of objectives in the 1990 survey are compared with those of the 2000 survey. Of those objectives that were the same in both surveys, the same items were ranked in the top 5.

1. Understanding the patient as a person.
2. Determining effect of doctor's personality on the illness.
3. Providing support for residents.
4. Helping physicians resolve professional role conflict.
5. Determining effect of patient's personality on illness.

The ranking of the objective, "provides support for residents" dropped 4/10 of a point from 1990 to 2000. Unavailability of the 1990 survey data made performing a t-test impossible. Consequently, it is not possible to say whether or not this is a statistically significant decrease. However, if one groups the 2000 survey data into two sets, those with formal Balint Leadership training (A) and those without formal Balint Leadership training (B), a significant difference is noted in the rating of only two objectives: "provides support for residents" and "helps physicians resolve professional role conflict". Thus, over time or with formal training the objective of providing resident support is viewed as less important in the overall objectives of the Balint process.

Similar objectives were rated lower in the 1990 and 2000 surveys. It is apparent from these ratings that those conducting Balint groups both then and now realize that they are not an appropriate venue for teaching psychiatric terminology, the use of psychotropic medications, training in family therapy and management strategies or counselling strategies for psychiatric illness.

## DISCUSSION

There has been an important increase over the past ten years in the number of residencies offering Balint groups. During this same period, the American Balint Society has offered 40 training opportunities ranging from 2 hour seminars to 4 day intensive leadership training workshops.[3] Over one half of the respondents have attended one or more of these training

TABLE 3
BALINT GROUP CHARACTERISTICS IN 1990 AND 2000

| **Survey Year** | **1990** | | **2000** | | | |
|---|---|---|---|---|---|---|
| **Number and Percent** | **N** | **%** | **N** | **%** | **N** | **%** |
| Mixed | 63 | 55 | 108 | 47 | | |
| Peers Only | 52 | 45 | 120 | 53 | | |
| | | | | | | |
| **Participants** | | | | | **Mixed** | |
| Med Student | 1 | 2 | 0 | 0 | 10 | 4 |
| PGY1 | 19 | 36 | 49 | 21 | 119 | 52 |
| PGY2 | 14 | 27 | 32 | 14 | 128 | 56 |
| PGY3 | 13 | 25 | 30 | 13 | 117 | 64 |
| Faculty | 3 | 6 | 9 | 4 | 44 | 19 |
| Community MD | 2 | 4 | 0 | 0 | 4 | 2 |
| | | | | | | |
| **Members in Each Group** | | | | | | |
| Less than 5 | 9 | 7 | 25 | 11 | | |
| 5-10 | 87 | 76 | 167 | 73 | | |
| 11-15 | 11 | 10 | 31 | 14 | | |
| >15 | 1 | 1 | 5 | 2 | | |
| Unknown | 7 | 6 | | | | |
| | | | | | | |
| **Frequency of Meeting** | | | | | | |
| Once a Week | 63 | 55 | 34 | 15 | | |
| Twice a Month | 30 | 26 | 58 | 25 | | |
| Once a Month | 13 | 11 | 109 | 48 | | |
| Every Other Month | 1 | 1 | 0 | 0 | | |
| Unknown | 8 | 7 | 0 | 0 | | |
| Variable | | | 26 | 11 | | |
| Blank | | | 1 | 0 | | |
| | | | | | | |
| **Duration** | | | | | | |
| 3 Months | 3 | 3 | 2 | 1 | | |
| 6 Months | 2 | 2 | 1 | 0 | | |
| 1 Year | 35 | 30 | 57 | 25 | | |
| 2 Years | 14 | 12 | 36 | 16 | | |
| 3 Years | 42 | 37 | 74 | 32 | | |
| Unknown | 19 | 16 | 3 | 1 | | |
| For the Duration of Training | | | 55 | 24 | | |
| | | | | | | |
| **Participation** | | | | | | |
| Voluntary | | | 61 | 27 | | |
| Required | | | 148 | 65 | | |
| Other | | | 18 | 8 | | |
| Blank | | | 1 | 0 | | |

opportunities. How are these educational offerings related to an increased number of residency Balint Groups? Even with the increasing presence of Balint activities in residencies and the educational offerings of the American Balint Society one program director wrote on his returned questionnaire, "Don't even know what a Balint group is."

Balint groups are one very effective venue in which to explore and experiment with physician role clarification. Certainly, however, a Balint group meeting only once a month (48%) or meeting weekly for only a year (25%) is not sufficient time by American Balint Society standards. Protected time and space together with experienced leadership, including family physician role models, are necessary to create the trusting community within which professional growth can occur. For group work to progress from the examination of impossibly difficult cases to understanding how the individual group member's idiosyncratic or habitual way of being stuck with specific kinds of patients or medical conditions group cohesion is necessary. The American Balint Society has judged that sufficient group cohesion and trust probably can not be achieved when the group meets any less than twice a month for at least two years.[9]

The American Balint Society is concerned about the ongoing, continuing education of Balint leaders. Only 23% of the sample had attended an intensive leadership training workshop. 74% of the leaders or co-leaders do not receive feedback on their leadership from anyone outside their residency and one third of the groups surveyed have no co-leaders. When these data are further modified by the fact that approximately 12% of the time co-leaders don't review group process, one must seriously question how the paradigm of learning is being met: experience plus feedback. The Society would recommend that all Balint leaders and co-leaders seek formal Balint training and that physician and behavioural scientist work in tandem. They each have significant insight to contribute to an understanding of clinical practice and group dynamic processes.[10] We were pleased to note that of the 228 Balint groups surveyed 146 had family physicians serving either as leader or co-leader.

Finally, the perennial question must be addressed, "Is a Balint group a support group?" This question asserted itself very early on for the respondents to the questionnaire. These are some of the comments that they wrote in the margins when attempting honestly to report what was going on in their residency:

TABLE 4

COMPOSITION OF BALINT GROUP LEADERS
IN 1990 AND 2000

| **Survey Year** | **1990** | | **2000** | |
|---|---|---|---|---|
| **Number and Percent** | **N** | **%** | **N** | **%** |
| | | | | |
| **Leaders** | | | | |
| FM | 25 | 32 | 50 | 22 |
| Psychologist | 19 | 25 | 100 | 44 |
| Social Workers | 15 | 19 | 38 | 17 |
| Psychiatrists | 4 | 5 | 9 | 4 |
| Psychoanalysts | 5 | 7 | 7 | 3 |
| Other | 9 | 12 | 23 | 10 |
| Blanks | | | 1 | 0 |
| Total | 77 | 100 | 228 | 100 |
| | | | | |
| **Co-Leader** | | | | |
| FM | 28 | 51 | 96 | 42 |
| Psychologist | 10 | 18 | 19 | 8 |
| Social Workers | 6 | 11 | 12 | 5 |
| Psychiatrists | 8 | 15 | 11 | 5 |
| Psychoanalysts | | | 2 | 1 |
| Other | 3 | 5 | 10 | 4 |
| No Co-Leader | | | 76 | 33 |
| Blanks | | | 2 | 1 |
| Total | 55 | 100 | 228 | 100 |

They are better called "personal awareness groups" and are case focused only a percentage of the time; although, they have the title "Balint".

We have a support group for interns – previous behavioural science faculty called it a "Balint group" but it was not.

We have a "monthly discussion group" focused on residents' personal and personal-clinical issues but it is not a Balint group.

From a formal letter attached to a survey questionnaire, the following is excerpted:

I am writing to explain a few of my responses to your American Balint Society survey. First, I completed the survey for the groups we run, although we regard them as Balint-type groups rather than formal Balint groups. The faculty made a decision about a year-and-a-half ago that a more informal style and somewhat more participative leadership met the needs of our residents better and was more compatible with the climate of our residency. Since we are not trying to run a true Balint group, I do not know if you wish to include these responses in your study.

These respondents' comments point to the confusing boundary between residency support groups and Balint groups.

A survey of family practice residencies in 1992 found that 72% of all programs offered support groups for residents.[11] It is estimated that 25% of internal medicine residencies provide formal means to address physician stress, including support groups.[12] The focus of a support group is on the personal and emotional experience of professional life, helping group members grow in self awareness and effectiveness. The goal is to provide physicians-in-training the opportunity to share and reflect on the meaning of these experiences in a safe environment, receive feedback about their behaviour, and make discoveries about themselves. Self awareness becomes fostered through becoming understood, having feelings validated, and emotionally supported by a group of peers. The results are less stress and anxiety, less sense of isolation and helplessness, and presumed less "burn out".[11-15]

TABLE 5

HOW BALINT LEADERSHIP SKILLS ARE ACQUIRED AND MAINTAINED IN 228 GROUPS*

| **Study Methods** | Alone | With Other Techniques |
|---|---|---|
| Reading | 22 | 209 |
| Formal Training | 2 | 52 |
| STFM Workshop | 2 | 115 |
| Sharing Transcripts | 0 | 22 |
| Other Leaders | 1 | 98 |
| Co-Leading | 0 | 44 |
| Other | 8 | 63 |
| | | |
| **Do You Review Group Process With A Co-Leader** | | |
| None of the Time | 18 | |
| Some of the Time | 66 | |
| Most of the Time | 46 | |
| All of the Time | 26 | |
| | | |
| **Do You Receive Outside Feedback On Your Leadership** | | |
| None of the Time | 153 | |
| Some of the Time | 45 | |
| Most of the Time | 2 | |
| All of the Time | 7 | |

*All items were not consistently responded to making it impossible to establish one denominator and percentages for each item.

Creating a safe forum in which discussion can be held is a common thread for both support groups and Balint groups. As a result of sharing intensely held emotions, a deeper sense of bonding is likely to occur. However, the content of the discussions vary significantly between the two groups. Support groups are oriented toward personal and emotional self-disclosure whereas Balint groups are case-oriented and the focus is on the doctor-patient relationship and how that relationship might be affecting the treatment of the illness. Both groups espouse not to be "therapy" groups. Although it has generally been thought that Balint groups have a supportive function, support has not been the focus or purpose of the traditional Balint seminars. As the current survey data indicated there was a statistically significant difference between those respondents with formal Balint training and those without formal training as to how they rated the item "provide support for residents". (Table 6)

The role of leaders in Balint groups and support groups may be quite different.[16,17] Dornfest et al have contrasted the role of a Balint group leader with that of a personal and professional development group leader. They have observed that leaders self-disclosure in Balint groups is not typical and when done is usually focused on "professional role" self-disclosure.[17] The Balint leader, on the other hand, almost never tries to reduce the anxiety of a group. In fact, a reasonable level of anxiety is a "necessary condition" for the group to do its work. The Balint leader may direct the group at times in a way that raises the level of anxiety, yet maintains a safe environment for the trainees.

In residencies without adequate professional and personal support programs it is reasonable to believe that Balint groups will be induced into partially fulfilling the goals of such programs. Consequently, it is most important for Balint leaders to be clear as to what goals they are pursuing when offering to lead Balint groups in a specific residency setting. Otherwise, they will be triangulated with the residents just as residents are when attempting to act out heroic roles with their patients: trying to be friend, father, mother, son or daughter as well as physician.

Finally, the authors note the most significant limitation of this study revolved around the very issue of Balint group vs. support group. 298 different respondents judged the groups of their residencies to be or not to be Balint groups. If a panel of expert Balint leaders were to visit the 298 responding residencies would they agree that 48% of them were conducting Balint groups and not groups of some other variety? Only further controlled studies will clarify this question.

The authors wish to thank the American Balint Society for financially supporting the costs incurred in surveying all American family practice residencies and the costs of data entry. We also want to recognize the helpful review and feedback on this article provided by Dr. William Hueston.

This paper was first published in *Family Medicine*, the official Journal of the Society of Teachers of Family Medicine (USA).

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TABLE 6

RATING THE OBJECTIVES OF BALINT TRAINING IN 1990 AND 2000

| **Survey Year** | 1990 | 2000 | 2000 | |
|---|---|---|---|---|
| **Number of Groups** | 115 | 228 | A | B |
| Understand the Patient as a Person | 4.3* | 4.5* | 4.5* | 4.5* |
| Provide Support for Residents | 4.6 | 4.2 | 3.9 | 4.7[+] |
| Learn Management Strategies for Specific Psychiatric Illnesses | 2.4 | 2.4 | 2.3 | 2.4 |
| Help Physicians Resolve Professional Role Conflict | 4.5 | 4.3 | 4.2 | 4.5[++] |
| Better Understand Psychiatric Terminology | 1.0 | 1.6 | 1.6 | 1.6 |
| Acquire Better Understanding of Psychotropic Medications | 1.0 | 1.4 | 1.5 | 1.4 |
| Determine Effect of Patient's Personality on Illness | 4.1 | 4.1 | 4.1 | 4.1 |
| Determine Effect of Doctor's Personality on Illness | 4.4 | 4.5 | 4.5 | 4.5 |
| Learn Counseling Strategies for Psychosocial Illnesses | 3.0 | 2.5 | 2.5 | 2.2 |
| Learn Family Therapy | 1.9 | 1.7 | 1.7 | 1.6 |
| Determine Role(s) assumed by Doctor in Managing a Specific Patient | | 4.4 | 4.4 | 4.5 |
| Resolve Personal Conflict | 4.0 | | | |
| Understand Specific Psychiatric Processes | 2.3 | | | |

*AVERAGE SCORE ON A 5-POINT LIKERT SCALE WITH FIVE INDICATING THE MOST AFFIRMATIVE RESPONSE: 1= NOT AT ALL IMPORTANT; 5=VERY IMPORTANT

A FORMAL BALINT LEADERSHIP TRAINING

B NO FORMAL BALINT LEADERSHIP TRAINING

[+] $P < .0001$

[++] $P < .05$

# Difficult Adolescent Consultations: a pilot project

A presentation to the Balint Society on 6th March 2001 by Dr. Christopher Donovan (CD) and Dr. Heather Suckling (HS)

1. Introduction: Why Adolescents? Why this Project? (CD)
2. Methodology (HS)
3. Examples of two consultations (CD and HS)
4. Difficulties encountered: a Balint perspective (HS)
5. Summary and conclusions (CD)

**Why Adolescent consultations?**

- There are many unmet needs in this age group (10-19 years). These are illustrated in Figure 1.
- We are an ageing society (one in five is over the age of 65 years) therefore every adolescent is important for economic reasons, not just for humanitarian ones. Adolescents need support (which many do not receive) if they are to survive their teenage years and become adults who are economically productive and responsible citizens and parents.
- At a time when attempts are being made to improve our medical services it is important to remind managers that outcome is influenced as much by process as by structure. How professional staff interact with young people is central to improving their perception of the service.

The Royal College of General Practitioners' Adolescent Working Party organised a conference on the subject of communicating with young people in 1999. Seventy professionals attended and put forward many explanations as to why consultations with this age group are often seen as difficult. It was suggested at the Conference that, as most of these explanations were speculative, research into real consultations was needed to identify the areas where problems occur.

This paper is a summary of a pilot study which attempts to do that.

**Figure 1**

- Children and adolescents (0-19 years old) constitute a quarter of the UK population.
- There are 3.6 million adolescents aged 10-14 years in the UK.
- There are 3.4 million adolescents aged 15-19 years in the UK.
- An adolescent visits a GP on average 2-3 times per year.

**Key facts about adolescents:**[1]

- The UK has the highest rate of pregnancy among under 16 year olds in Western Europe – *seven times* higher than the Netherlands.
- Among 15-25 year olds in the UK and Ireland, the Samaritans report a rate of *two suicides per day* and *one attempted suicide every half-hour.*
- In the UK 45% of crime is perpetrated by those under the age of 21 years. Much of this is drug-related.
- Among 5-15 year olds, 20% of males and 15% of females rate themselves as having a long-standing illness. 15% of adolescents suffer from some form of psychiatric condition.

**Methodology**

We agreed to use a qualitative method of research and decided that a Balint group would be the most appropriate format as it focuses on the interaction between the doctor (or other health professional) and the adolescent, and the emotions engendered.

Enid Balint[2] said "The value of a Balint group is facilitate observations" and Sally Hull[3] referred to its use "in capturing and amplifying the observation of the doctor-patient interaction revealed in the group".

At the first meeting the nature of a Balint group was explained, the ground rules were agreed (with particular emphasis on confidentiality) and the Aims and Objectives clarified. (Figure 2)

The group then decided on the practical procedure for each session. (Figure 3)

**Figure 2**

**Aims and Objectives**

**Aim:**

- To improve the communication between health worker and adolescent by studying the interaction between them.

**Objectives:**

- To look at *actual* consultations with particular reference to the Doctor (Health worker) - Patient (Client) relationship.
- To identify common themes / difficulties in the consultation.
- To identify the feelings engendered in both the doctor (health worker) and the group.
- To draw together general features which might help in future consultations.

**Figure 3**

**Practical Procedure**

- Presentations were to be only of consultations with adolescents.
- At the end of each case the group would attempt to identify the following:
  1. The emotions engendered in the presenter.
  2. The emotions engendered in the group.
  3. Themes and difficulties in this case.
- At the end of the session the group would attempt to identify themes which are common in consultations with adolescents in general.

**Case 1: discussed by CD**

*Patient: Mary, 16 years old, white.*
*GP: British, white, female.*

Mary opens the conservation.
Mary: "I have acne. My Mum says there is a pill I can take which is good for it."
GP: "There is a pill for acne. Why do you think your mother suggested it?"
Mary: "I have a boyfriend."
GP: "Do you think that your mother wants you to be 'a little safer'?"
Mary makes no reply.
GP: "Have you had intercourse?"
Mary: "Someone forced me into it." She looks embarrassed.

Then the GP added "as the acne was not bad I gave her the choice of three things: topical or oral antibiotics or the pill. Mary was working so the cost of the prescription concerned her. For this reason she chose the pill because she said she wouldn't have to pay for it."

The GP continued: "we talked about whether she wanted to have sex or not. I said it was her choice. She did not say much. I did most of the talking, saying my standard piece when prescribing the pill. She ... she seemed a little awkward about it, and I got the impression it was her mother's suggestion rather than something she was concerned about."

The GP concluded: "We talked about smoking – they all smoke. I told her she must stop and that was that. Fairly standard request and consultation."

**Emotions engendered in the GP:**

- Sympathy towards the young woman.
- Frustration.
- Parental feelings.

"I felt like I usually do in these situations: it's like a routine. I tend to go through the same sort of things. My heart goes out to them because they are progressing almost too rapidly for themselves. They obviously feel they ought to be 'doing it', but I'm not sure they want to."

**Emotions engendered in the group:**

- Sympathy for the young woman.
- Uncertainty.
- Anxiety.

The group members recognised, from their own experiences, and shared the doctor's feeling expressed in "my heart goes out to them". This they felt, made it more difficult for her to play the medical role. She said the decision about whether to have sex must be the patient's, but she did not raise the fact that Mary was forced into sex. The group felt that she gave away her own opinion by saying "they are progressing almost too rapidly for themselves".

The group felt that Mary is still using her mother to do the requesting, even though she is not present in the consultation. How much is the mother actually involved?

The group wondered if the GP should be looking behind the request for a hidden agenda. Maybe the acne and the cheap prescription are all there is to this consultation. The group felt that there are times when GPs see sexually active behaviour behind every female consultation. This can be an embarrassment for some adolescents.

However the group also expressed the view that for those who are sexually active and not on contraception it is important for the GP to help the patient to reveal the situation.

One member of the group thought it might be easier for adolescents to ask directly for contraception at a Family Planning or Brooke Clinic, as in General Practice they feel they need a presenting ticket.

The group wondered about the effect of the GPs gender on the consultation. If Mary's GP had been male would she have been inhibited about talking about sex and left with a cream for her acne?

The group felt that the personality of the GP was the most important factor, but gender also impacts on the adolescent's willingness to disclose her real problem.

**Difficulties in this case:**

- Is sex behind this consultation?
- How far should the GP probe to find out?
- What is the mother's role (even though she is not present in the room)?
- There is conflict between the professional and parental roles of the GP.

**General Themes:**

- Is sex behind all consultations with female adolescents?
- The mother (parent) is in the consultation (even if not physically).
- Conflict between the professional and parental roles of the Health professional.
- Is the gender of the health professional significant?

**Case 2 discussed by HS**

*Patient: Richard, 16 years old, white.*
*GP: British, white, female working in a rural community.*

Richard lives with his mother and three sisters. His parents are separated and he sees little of his father who has another family. His older sister had a baby, as a teenager, three years ago. The family lives in a small village where the bus service has been discontinued, making it difficult for him to meet other young people socially.

The GP described five contacts with Richard two with the practice nurse and three with the GP.

**Contact 1.**

His mother brought Richard to see the practice nurse because he:
was "suffering from insomnia"
was aggressive to her and to his younger sister
would not get up for College in the morning

would not tidy his room and argued a lot.

His mother admitted that she did not know how t deal with feelings which women do not have.

The nurse referred him to the GP.

**Contact 2.**

Again Richard was brought by his mother, but the GP did see him alone for part of the consultation.

He complained of difficulty in sleeping since doing his GCSEs the previous summer. He said he went to sleep at 2 a.m. and woke at 8 a.m. He felt tired during the day. He had felt better in the holidays but at college he felt worried and had reduced his workload "because of the stress". He denied using drugs and the GP, feeling that he was depressed, gave him a leaflet about depression and a Directory of Services for Young People which included a free-phone number, a list of counsellors and information about sexual health services.

**Contact 3.**

The third contact was with the practice nurse and again his mother brought him. They were arguing because he would not get up for college in the morning. Richard felt that he could not manage his college work, he was studying Information Technology, but his mother had understood from his tutor that he was capable.

The nurse suggested strategies for avoiding conflict.

**Contact 4.**

Richard and his mother came to see the GP. They both agreed that he had symptoms of depression, including low mood, low self-esteem, poor sleep, poor appetite and loss of interest. The GP gave him a questionnaire which he completed. She felt that this confirmed the diagnosis of depression, so she prescribed lofepramine and referred him to the local Child and Adolescent Psychiatrist. During this consultation "the boy" was co-operative. He and his mother disagreed about his level of aggression and his sister's contribution to his fights with her (he felt she "wound him up"). The GP described Richard as being reasonably easy to talk to and his mother let him talk. He did not see aggression as a problem.

**Contact 4.**

Richard came alone to see the GP for a follow-up appointment. He said he was feeling better and back at College. His mother now left it up to him whether he tidied his room and they were arguing less.

His mother had not made further contact with the surgery.

There was no mention of whether or not he took the antidepressants.

**Emotions engendered in the GP:**

The GP did not talk about her feelings, but when asked admitted to experiencing variously:

- Impatience.
- Annoyance.
- Frustration.
- Anger.
- Agitation.
- Relief.

She felt that Richard was not keen to open up, but responded to direct questions (rather as she had done). She thought the absent father was significant and that his lack of a male role model made it difficult for him to manage aggression. She thought it might have been better for him to be seen by a male doctor, but he did not want to transfer him once they had formed a relationship.

She felt that he did not have much personality but she liked him and felt that he had communicated non-verbally. He seemed to respect his mother who had made attempts to help him and had come up with one or two ideas.

This time he had come on his own and negotiated when he would come back and had given his GP permission to share the information. She felt that this "said a lot".

**Emotions engendered in the group:**

- Sympathy (for the presenter).
- Uncertainty (with concern about "not knowing").
- Frustration.
- Curiosity (was there more which Richard was not disclosing?).

One member felt the consultations went smoothly and was puzzled by his mother's referral to aggression when he seemed so passive. Another commented on Richard's willingness to come to the GP, he was like a small child and apparently amenable. Would he go to the psychiatrist willingly? If so, alone or with his mother?

The group felt that Richard acknowledged that there was something in him which was not quite right; what this was the group did not discover, was it to do with his sexual development? How does he feel about the physical changes, his sexual urges and aggressive feelings?

Would he have chosen to see a female GP? Would he be able to talk about masturbation or his sexual orientation? The group felt that he would return as there was something which he could not yet verbalise.

The group speculated: was he doing badly at college? Does he think he might be homosexual? He may be worried about things at home or angry with his father.

The group acknowledged that it did not know and had to tolerate not knowing. One member wondering if Richard was suppressed rather than depressed and ashamed of his feelings. Another mentioned recent press reports about the underachievement of boys in our society.

Some group members felt frustrated by the inability to identify the problems, but others felt that the GP's interventions had worked in a positive way and congratulated her on keeping

the relationship going while the psychiatric services had not been helpful so far.

**Difficulties in this case:**

- Is Richard depressed or suppressed?
- The group feels there is more to this case, what is it?
- He appears to have difficulty in talking about his feelings.
- Is his behaviour acceptable? (Is the room tidying important? Is it his problem or his mother's?)
- It is difficult for the doctor (and the group) to tolerate not knowing.
- Does the gender of the GP affect the case?
- Does the absence of his father affect Richard's self-esteem and his ability to deal with aggressive feelings?
- The doctor is asked (by the parent) to "do" something.

**General themes:**

- Adolescents find it difficult to understand, let alone talk about their feelings.
- Is it reasonable to expect adolescents to describe their private world to an adult?
- Certain behaviours may be less significant to the adolescent and doctor or health worker than to the parent.
- Whose problem is being presented?
- Doctors and health workers have to tolerate not knowing while continuing their relationship with the adolescent.
- The gender of the health worker may be significant, for example when discussing sexual matters.
- The absent father (or parent) may affect the adolescent.
- "Something must be done."
- The parent is often present in the consultation, either physically or in the mind of the doctor / health worker and/or adolescent.

**Difficulties encountered in this study (HS)**
**Problems with the group:**

1. **Lack of a consistent group.**
   There were thirteen potential group members but only four, including the two leaders and the researcher were present at all six group meetings. The membership varied between six and nine.
2. **Lack of Balint experience.**
   Some members had no Balint experience and most only limited experience in a GP Registrar group.
3. **Too few meetings.**
   Only six groups were held because of difficulties of time and place.
4. **Time of the meetings.**
   These were held in the evening, after evening surgery so that members were tired. The meetings were held at the Royal College of General Practitioners but travel would be difficult and time-consuming anywhere in London.
5. **Leadership difficulties.**
   As a leader I was torn between leading a "proper" Balint group and trying to meet our research objectives. Both leaders, each on one occasion, presented cases. We did this because of the shortage of cases presented (as not all group members were seeing patients/clients). The discussions following were useful but we were aware that we were breaking the rules of group leadership.
6. **Lack of expertise in qualitative research.**
   We are indebted to Zoe Walker, the researcher, but she was the only person in the group with this expertise.

**Difficulties with the material.**

1. **Defining a "consultation".**
   Initially there was confusion about whether a presentation should include only single encounters or a number of encounters. The group decided that this choice should be left to the presenter.
2. **Difficulty in leaving the case.**
   The group went on discussing the case when we were trying to identify emotions and themes.
3. **Group behaviour reflecting the dynamics of the case.**
   There is sometimes a tendency to deal with the clinical or superficial aspects of the case, reflecting behaviour in the consultation. On occasions the group was "adolescent".
4. **Defensive behaviour in the group.**
   An example of this was the readiness of the group to congratulate the presenter on a job well done, or comforting the presenter rather than exploring the case in more depth.
5. **Difficulties of the editorial group.**
   A group of four undertook the responsibility of writing up the project. There was considerable difficulty in arranging meetings and summarising the group discussions.

**Summary of results (CD)**

All consultations require the communication skills of putting the patient at ease, active listening, building trust, using open questions, allowing sufficient time for responses, as well as giving clear explanations. However as a result of this pilot we can identify some factors which make consultations with adolescents different from those with adults. Here are a few examples:

- **Difficulties in verbalising feelings.**

Part of the developmental process of adolescence is moving away from confiding in adults – keeping personal feelings private, or confiding them to one's peers, or a diary. In adolescence it is particularly hard and acutely embarrassing to verbalise these private feelings to an adult professional, whom they may regard as a friend of their parents. This is made worse by the fact that most adolescents have limited experience of consulting on their own.

One way of dealing with this embarrassment is to present a physical condition to the GP as a ticket of entry, in order to have time to assess whether it is safe to raise the real problem.

- **The parent's "presence".**

In most consultations with adolescents the parent is either present or in the mind of the patient (and/or health professional). In both these cases we learnt as much about the mother's feelings as those of the patient. This can make it hard for the health professional to distinguish where (or to whom) the problem belongs and to avoid getting the problems of the parent and of the adolescent intertwined. Equally the "presence" of the parent can inhibit young patients from revealing their inner world, even when they are consulting on their own, fearing that confidentiality may be broken or that their parents may find out about their difficulties.

- **Time limits.**

The amount of time available in a typical NHS consultation means that the GP may have difficulty in identifying the adolescent's real problem. Michael Balint[4] said: "... listening is a much more difficult and subtle technique than that which must necessarily precede it – the technique of putting the patient at ease, enabling him to speak freely". In the case of adolescents their embarrassment may be so great that even the process of putting them at their ease may take several consultations and until trust in the doctor has built up they will be unable to speak freely.

The shortage of time may lead the GP to resort to direct questioning. To quote Michael Balint[5] again, "if the doctor asks questions in the manner of medical history-taking, he will always get answers – but hardly anything more".

Another temptation is for the professional to deal with the ticket of entry, taking it at face value. In the first case the GP did not do this with Mary's acne, but might have done so and thus missed the underlying problem. Strangely, it may be the GPs who do leave time for deeper problems to be revealed who find the greatest difficulty in the consultation.

- **Pressure "to get it right".**

Despite recognising the difficulties, the group members felt it was their responsibility to understand the adolescent's problem in the limited time available and if they did not get it right "a whole young life might be ruined". When things did go wrong for these patients, the professionals tended to blame themselves. For example, when a young patient did not come back, this was thought to be due to failure to develop a positive relationship.

- **Strong emotions.**

Adolescents create strong feelings in adults and health professionals are no exception. In the group we heard of many of these feelings, indeed it was the first time that some of the GPs had been able to share these with colleagues. They found it helpful to be able to share these feelings in a professional setting.

There are three difficulties which I would like to highlight:

1. The difficulty which GPs experience, especially if they have known the patient as a child, of slipping into the parental role rather than retaining the professional one.
2. The strong urge of the health professional to avoid opening Pandora's box for fear of finding huge problems within. This may be due to time constraint, or lack of confidence probably due to lack of appropriate training. The GPs who presented the two cases above demonstrated this by:
   - not asking about Mary's comment that she had been forced to have sex
   - not exploring Richard's sexual feelings.
3. The fact that most professionals working in Primary Care (certainly GPs) do not have supervision results in them having to carry very heavy feelings for many months or even years, a fact that was demonstrated in this group.

**A final comment from CD.**

It is my personal view that if our profession continues to ignore the factors which make consultations with adolescents particularly difficult, the high statistics of unmet needs in this age group will continue. This pilot has led me to believe that there is a need for fuller research into the subject of "difficult" and "successful" consultations with adolescents. This would encourage greater understanding of the importance of the process of consulting and thus enable the health professionals to provide more effective help for young people when they hit real problems.

I wonder if such a challenge might be picked up by the Balint Society.

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# 14th Michael Balint Memorial Lecture:

## Balint groups and psychoanalysis: what have the Romans done for us?

**John Salinsky**

*given on 24 April 2001 at the Royal College of General Practitioners*

Madam President
Friends, Romans, Countrymen,

In this lecture, I would like to consider the relationship between the Balint group movement and psycho-analysis.

The Balint movement began with a historic collaboration between psycho-analysis and general practice. Ever since his days in Budapest in the 1920s Michael Balint had been interested in the medicine of the whole patient. His father had been a GP and young Michael may even have done a few surgeries for him. He knew that a whole patient approach was needed especially for psychosomatic problems and he wanted to share the insights of psycho-analysis with family doctors and indeed all other doctors. In Budapest he opened what was called a poly-clinic at which regular meetings were held for non-analyst doctors.[1]

As we know, in London he met Enid who became his collaborator and his wife. Between them they developed the Balint group method and they were joined by some enthusiastic analysts at the Tavistock Clinic.

The Balints and their colleagues wanted to offer some much-needed psychological help to general practice. In return, the GPs taught the analysts a good deal about what went on in every-day life in the surgery. Both parties were impressed. But it was the GPs who really benefited. The doctors who took part in the groups began to feel that that their work was at last making some sort of sense. The book *The Doctor his Patient and the Illness*[2] became a best-seller. It did a great deal to make the discipline of General Practice more respectable.

Soon everyone had heard about Balint - but not everyone approved. Many doctors thought that sitting in a group once a week and discussing patients was too time consuming and introspective. They thought it was self-indulgent and tended to produce in the group members an unhealthy tendency to attribute everything to sex.

Balint groups were much more easily accepted in continental Europe than in Britain. Even Balint himself was a little discouraged. In an interview with Philip Hopkins,[3] Balint was asked 'how would you feel we can best interest other doctors in your attitudes in Britain?'

Balint replied: 'very difficult, because we are considered as quacks'.

But the doctors who had been fortunate enough to take part in Balint groups were not deterred, any more that Freud in Vienna in 1900 had been deterred by disapproval of psycho-analysis.

Our Society was founded in 1969 with the aim of continuing the work and spreading the ideas. Continuing the training for those who wanted it and doing more research. It was not founded as a memorial to Michael because he was still alive at the time. Nevertheless, with his death early in 1970 the need to find ways of keeping the Balint flag flying must have seemed more urgent.

Today, 31 years later, we still have a Balint Society and there are still Balint groups although you may have to look hard to find them. But survival has been a close run thing and our Society has had to struggle very hard to prevent the General Practice establishment from consigning Balint to an honourable mention in the history books. The leaders of our profession now say complimentary things about us - but always in the past tense. I think we have been put in the history books several times but we keep jumping out again and saying: look, we are still here, we are alive.

Yes, there are still some Balint GPs around in the UK and they are making what I think is an important contribution to GP education. But with very few exceptions the groups are led by GPs and not by analysts. The analysts seem mysteriously to have disappeared. Interestingly this is not the case in European countries such as France, Belgium, Italy and Germany. I shall talk about them a little later on. But in the UK for practical purposes, the Balint movement seems to have lost its connection with the psycho-analytic movement. The questions I would like to explore this evening are firstly how did this happen? And secondly does it matter? Have we lost something vital - or are we really better off without our psychoanalytic connection?

The second part of my title is: what have the Romans done for us? I hope the point of this will become clear as I continue. But if, when I've finished, anyone is still wondering what the Romans have got to do with it, will they please come and have a word with me.

### BACK TO THE BEGINNING

Michael and Enid Balint were psychoanalysts who wanted to make the discoveries of psycho-analysis available to the community as a whole: not just to the small number of people who undergo personal analysis.

You could say that they had a mission to do this. They were also deeply interested in what general practitioners did. They were impressed by the long and deep relationships which were possible in general practice. They wanted to find out more about these relationships and how they functioned. If only the doctors could learn to understand their patients and themselves a little better there would be a tremendous potential for treating emotional problems and psychosomatic illnesses. But how were they to educate the GPs

in psychoanalytic ways of thinking? Michael had realised while he was still with Ferenczi in Budapest that it was no good giving them lectures.[1] Instead he adapted the Hungarian method of group supervision for trainee psychoanalysis, applied it to a group that Enid was already running in London for marital case workers - transferred it to GPs - and the Balint group was born.

I have described the Balint movement as a collaboration between psycho-analysis and general practice. We sometimes say that we have two parents, a general practice parent and a psycho-analytic parent. This, in itself is a very psycho-analytic way of looking at it. But was the partnership really an equal one? An outsider studying our history would notice that the analysts were always the leaders and the family doctors the group members. It was the leaders who invited the GPs to come and benefit from the education the analysts could provide. The analysts were the teachers and the family doctors were their students.

Furthermore, the analysts would meet for seminars afterwards in which they discussed the progress of the GPs in psycho-analytical terms. Among other things they would discuss the group members' unconscious processes such as their transference to the leader. So the GPs are not just students; to some extent they are seen by their teachers as analytic patients. On the whole, our analyst leaders don't make interpretations about what is going on in the group. They don't mention the Oedipus complex. They don't even use the word transference. But their psycho-analytic knowledge and experience is always there in the background, giving them a very special way of looking at and listening to the doctor-patient relationship. Those of us who are convinced of the value of the psychodynamic approach will see this way of looking as enormously valuable – a unique key to understanding both our patients and ourselves. Our sceptical colleagues might say, but where's the evidence that it does any good? Why not teach them to do cognitive psychotherapy instead?

But what ever you think about the ultimate benefit to patients there is no doubt that the GPs could not have learned to look at unconscious processes in the consultation by themselves.

Michael Balint and the other pioneers must have imagined that there would always be a psycho-analyst leading and teaching and maybe treating every group. Of course the idea that Balint group doctors were there for 'treatment' was always vigorously denied. And the more disturbed or needy doctors were excluded, where possible by the 'mutual selection' interview. Nevertheless the phrase: ' a limited but considerable change in personality', the ultimate aim of the training is very suggestive of treatment. As long as psycho-analysts were interested in leading Balint groups the original relationship could be maintained; but in the UK this has not been the case for many years. There are still three analysts who come to our Oxford weekends. But two of them are retired and there are no younger ones coming forward. Most of our ongoing groups now are in Vocational Training Schemes and the leaders are almost all GPs. How did this change happen? It was Enid Balint who decided that it was permissible for a GP to be a group leader. Not just any GP, but someone who had been a member of a group led by Michael or herself, had a good grasp of the ideas and was willing to receive some supervision at the group leaders' workshop. It was a wise decision because there was already a shortage of analyst leaders.

Why did the analysts drift away? Why were they not replaced by younger colleagues? I can think of a number of possible reasons. Some place the responsibility with the analysts and some with the GPs.

As far as the analysts were concerned, we could suggest that most of them were never all that interested in working with GPs. Psychoanalysis is such an absorbing subject. Most analysts see a very small number of patients in a life -time and they work in great depth. General practice on the other hand is wide and diffuse. You can never reach the degree of understanding of a person that is possible in individual therapy over several years. Working with GPs might not be very exciting. The majority of trainee analyst these days are not medically qualified. Maybe it is not a doctors' thing any more.

When we look at the GP side there is a good deal of evidence that we deliberately rejected the analysts. You may not be aware that according to the constitution of the Balint Society, non-medical analysts are not accepted as full members, only as Associates. Members have to be medically qualified and 'preferably engaged in general practice'. The Society was founded by GPs and mainly for GPs. Why was this so? You will have to ask the founder members, some of whom are happily still with us. My guess is that they were afraid that they would be swamped not just by analysts - but therapists of all kinds and descriptions - who might hijack the Society and take it away from its true path and purpose. And also I think they wanted to feel that they had grown up as psychologically educated family doctors and were able to stand on their own feet.

There is another factor, related to that one and perhaps even more important. The policy of the Society in the last 20 years has been to play down the connection with psycho-analysis. It's a bit like the Labour Party playing down the connection with Socialism. The old doctrines, the theoretical beliefs, seemed to set us apart from our fellow GPs as a group of rather weird people, obsessed with the idea that every unexplained symptom was the result of frustrated sexual desires. The Balint Society members in the 1980s felt that they really had something important to offer their fellow GPs. But if anyone was going to listen, it was vital to present their ideas in an acceptable way. Talking about psycho-analysis seemed unlikely to win many votes.

So we re-invented ourselves as 'New Balint' and marketed curselves to the GP educators, the trainers and course organisers. You want communication skills? You want good doctor-patient relationships? You want to be able to cope with heart sink patients and avoid burnout? Come to us. Don't be afraid. We are not weird. We are just the same as you. We don't go in for navel-gazing and pointless introspection any more. We don't even tell patients that their sore throat is a psycho-sexual disorder. Well, not very often. You'll find that the people who sit in our little groups are jolly good, sensible chaps like yourselves. It's just a matter of being a bit more sensitive to the human side of medicine and GPs have always been good at that. It 's quite easy to see that this policy would not attract many analysts. Some would argue that it has actually alienated a number of GPs who might have really valued the insights of an analyst leader. The person who put this point of view to me, himself an analyst, also pointed out that the policy of playing down the analytic connection has not been such a big success. There seem to be fewer Balint groups than ever.

## HAS BALINT ALMOST VANISHED IN THE UK?

It's true that the traditional group for mature GPs has almost disappeared. Instead we have groups for GP trainees and registrars. These GP groups with very few exceptions are led by GPs. The leaders are course organisers. There are some old ones like me who were trained by analysts or first generation disciples. Or young ones who were trained by people like me. There are some who don't seem to have been trained by anyone. These groups for young GPs in training are very important because they represent the future for Balint work in this country. For practical purposes there are no other ongoing groups. This is what we have. This is where New Balint is alive and growing. Only a minority of training schemes have Balint groups, but there is a good deal of interest among course organisers in what we are doing. The ACO (Association of Course Organisers) provides an opportunity at its annual conference for delegates to take part in a Balint group. We hope to encourage more course organisers to start groups in their courses. We even have ambitions to interest psychiatrists and hospital doctors in the benefits of the Balint group.

What do the GP registrars think of their Balint group experience? When we ask them – which we do – we find that most of them enjoy it and appreciate the opportunity to talk about their difficulties with patients in a supportive non-threatening environment.

But is a group led by a couple of GPs a proper Balint group?

And if it isn't does it matter?

We seem to be getting on all right and having fun. Do we really need an analyst?

Some of you may think that is an outrageous statement. How can this fellow stand up at the Balint Society and suggest that psychoanalysts are not needed?

Has he no respect for his psychoanalytical parent?

Well the answer is: I do have respect, but, as your analyst would say, I also have ambivalence. Sometimes I wish they would go away and leave me alone.

Wouldn't it be nice if parents would just disappear and let you do things your own way?

Then I look round and I discover – my goodness – they have gone! I must be omnipotent. This is really scary. How am I going to manage without them?

And then I think: well, what have they really ever done for me?

## HERE COME THE ROMANS

And this – to change the metaphor – is where the Romans come in.

I am sure you remember the Monty Python film: *The Life of Brian*.[4]

A lot of this film concerns the conflict between the citizens of Judea and their Roman masters. You could say that the Romans thought of themselves as a superior civilisation who had a lot to offer the simpler minded Judeans. The Judeans on the whole seem to accept their lot. But there are discontented elements who would like to get rid of the Romans. And in the film the unfortunate Brian finds himself getting mixed up with them.

There is a wonderful scene in the film in which one of the political dissidents, a character called Reg (who I think is the leader of the Popular Front for Judea, but it may be the Judean Peoples' Front) asks his fellow citizens in Judea the question: what have the Romans ever done for us? . He expects them to say 'Nothing!' But, disconcertingly, they keep coming up with examples:

I'd like to just play that scene for you: if you are reading this you should remember that Reg is played by John Cleese.
(film extract)

Reg: What did they (The Romans) ever give us in return?
Judean:The aqueduct!
Reg: Oh, yeah. They did give us that.
Judean: And the sanitation!
Reg: Oh, yeah, the sanitation.
Loretta: Oh yeah, the sanitation, Reg. Remember what the city used to be like?
And the roads!
Reg: Well, yeah. Obviously,the roads. I mean the roads go without saying, don't they. But apart from the sanitation, the aqueduct and the roads..
Commando: Irrigation.
Others:Medicine; Education.
Reg: Yeah, yeah. All right. Fair enough.
Judean: And the wine.
Yeah, yeah, that's something we'd really miss, Reg, if the Romans left.
Someone else: Public baths!

Loretta: And it's safe to walk the streets all right now, Reg.
Judean: Yeah they certainly know how to keep order. Let's face it, they are the only ones who could in a place like this.
Reg: All right, but apart from the sanitation, the medicine, the wine, public order, irrigation, roads, a fresh water system, and public health, what have the Romans ever done for us?
Xerxes: Brought peace!
Reg: Oh Peace? Shut up!
(end of film extract)

Now, if you are following my little analogy, the analysts are of course the Romans and the GPs must be the Judeans. Well, setting aside the fact that many of us are or were Judeans, this is not Judea, this is Britain. And it seems that our psycho-analyst Romans have packed their togas and abandoned us. But how much of their culture, their way of life has remained? In the 5th Century AD the Romans retreated from the British Isles and went back to continental Europe. It is interesting, though not necessarily relevant, that they departed from Britain without leaving much of their culture behind. There were a few little groups who continued to value the life in the elegant villa, drinking wine and enjoying under-floor central heating. They were called Romano-British. You might think of them as the Balint Society of their day, a tiny but proud minority, continuing loyally to uphold the values of their masters. But the majority of the British didn't bother. They picked up the old British way of life where they had left off and forgot all about the Romans. Soon they were facing invasions of Angles Saxons and Jutes; and Danes and Vikings. Bringing with them communication skills, videos and cognitive psychotherapy: a totally different culture. It is also interesting that the Latin language had no lasting impression on the mother tongue in Britain. The Latin element of English only came in much later with Norman French and medieval French.

According to the historian Norman Davies[5] the Romans left only a few roads, a few ruins, a few genes and Christianity. And even that persisted only on the Celtic fringes until the arrival of St Augustine 200 years later.The Romans went back to the mainland to defend their empire; and that brings me to the situation with Balint in continental Europe and the rest of the world, where things are very different.

## WHAT HAPPENS ELSEWHERE?

If you go to France or Belgium you will find that Balint group leadership is still in the hands of psychoanalysts. Some experience of psycho-analysis is an important part of the training requirements. You don't absolutely have to be a practising analyst to be an accredited leader. But you are expected to have had some sort of education in psycho-analysis including a personal analysis. In Germany, Balint is more successful than anywhere else in the world. Taking part in a Balint group is a part of medical education from student level onwards. GPs can be accredited as psychotherapists with extra training and taking part in a Balint group is part of the training. The group leaders are not always psycho-analysts but most of them are, and all are expected to have had some personal psychotherapy. In Sweden, leader training has been established for 2 years[6] and it is run by analysts. The curriculum includes lectures on psychodynamics and psycho-analytic theory.

In the USA, on the other hand, there is a different situation. Balint training for young family doctors is flourishing. Groups are spreading to more programs across the country. Balint leader training is carried out by the American Balint Society. If you ask about psychoanalysts they look rather puzzled. They explain to you that there aren't any psycho-analysts any more except perhaps in New York. Who are the leaders of these American Balint groups for residents? Some are physicians who teach family medicine teachers (like GP trainers) and at least half are what they call behavioral scientists. A behavioral scientist in family medicine is someone with a training in psychology or social work who is there to teach psychological skills and awareness to family medicine residents. These psychologists already know about family medicine. They need to learn about how to lead a Balint group and this training is provided by the American Balint Society. The behavioral scientists have a psychological education. They are often trained in systems theory or group therapy. Very few have a training in dynamic psychotherapy. But they have a good working knowledge of the subject; they may use it with patients and some will have had personal therapy on psychodynamic lines.

Most of these clinical psychologists have never been in a Balint group until they became leaders. The program director in Oklahoma or Kansas City says to his head of behavioural science: I've been hearing a lot about these Baylint groups. We should have one too. Why don't you go on a course and learn all about it and then set one up here.'

Some analysts and some of our Balint GPs will shake their heads sadly and say whatever it is they are doing it can't be Balint. Is it or isn't it? I have taken part in plenty of these groups over the last ten years and it certainly looks like the real thing to me. I think that they are doing an excellent job. They now have group leader training programs and a serious accreditation process involving training, assessment and supervision which they have to go through before the American Balint Society will accept them as certified Balint group leaders.

Now I'd like to look at the situation with our own vocational training groups.

Who is leading our Balint groups for GPs in training? At first they were led by a cohort of GP course organisers assisted by a few psychotherapists who had worked with Enid and Michael. Enid thought if someone had worked with an analyst something would rub off or be

absorbed by the GPs which would be sufficient. They were like a first generation of disciples who had had personal contact with the founder. But now they are getting old or dead and are being replaced by the generation they have taught. But for this third generation, a psycho-analyst is like a mythical beast. They have never been anywhere near a psycho-analyst, let alone worked in a group with one. They have certainly not had personal analysis themselves, or very exceptionally. We don't mention the word psycho-analysis when we train them in case it gives them a fright and they think they are joining a cult.

## WHAT REALLY HAPPENS IN BALINT GROUPS?

Do our young doctors learn psychological skills?

Do they achieve a greater awareness of the way patients make them feel?

Do they acquire confidence in dealing with a wide range of emotional and psycho-somatic problems?

Do they undergo a small but considerable change in personality?

Well if you're lucky all of those might happen, but not straight away.

GP Registrars who find themselves in Balint groups in our courses do not usually have a choice. There is no question of selecting those most likely to benefit. Balint, where it exists, is simply part of the curriculum. And this is as it should be. We don't say: no, dermatology isn't for you, you haven't the right temperament. We say, you are going to be a GP so you will need to know a bit about skins whether you have an aptitude for it or not. Now we say the same about communication skills. And where it exists, we say the same about Balint.

Now it is actually quite hard for most young doctors to become interested in the emotional content of the doctor- patient relationship. They have a lot of very heavy defences which serve to protect them from experiencing too much emotional pain themselves. Unfortunately the training they receive as students and house officers encourages them to become even more defensive. They are afraid of making mistakes and being humiliated by senior hospital colleagues. They feel threatened by difficult or demanding patients whose pain they can only dimly perceive. And they feel threatened by their own feelings.

I think there are three levels or stages of development in the Balint group process as it exists in our GP training groups.

LEVEL ONE Support for the doctors. General practice can be bruising for a young professional and hospital medicine is even worse. The Balint group may be the only place where it is possible to talk about what a hard time you are having with those patients who have really difficult personalities. Unlike grand rounds and other teaching situations where the doctor has to present a case, she is listened to respectfully and with warmth and sympathy. No one says why didn't you do the serum titanium. They just say: 'You poor thing. That patient treated you really badly. You should get rid of him.' So the doctor is supported by the group and her wounds are bandaged. She feels the group is a place where she belongs and is valued as a person. The patient, unfortunately, is regarded as the enemy.

LEVEL TWO is about treating patients as human beings: learning or re-learning empathy. Progress to this stage often depends on a few well-chosen words from the group leaders. Our job at this stage is to re-interest the group in the idea that the patient is a person who had parents and a childhood, relationships in the world outside the surgery or the hospital. To remind them that they wanted to become GPs at least partly because they were interested in people.

LEVEL THREE. Only after this stage can we move on to level three in which the emotional interactions between doctor and patient and their hidden dimensions can be explored and thought about.

In my experience, a group does not progress smoothly from level one to level three over the course of a year. More often the level is constantly moving up and down in every session: a series of advances and retreats as defences are lowered and then raised again. One hopes that in the course of a year, as the group grows up, more time will be spent at the higher levels.

Perhaps I can illustrate this with a case from my own VTS group.

This case was presented by one of the SHOs who was coming to the end of her 6 month psychiatry post, two weeks before going into General Practice.

The doctor presented a case of a 63 year-old man, a ward patient, who is lonely and depressed and suffers from tinnitus. He likes to be in the ward where he chats to the other patients and reads two books, one of which is 'Zen and the art of motor cycle maintenance.' The team really want to discharge him but he is reluctant to go. They are worried that, at home by himself, he might commit suicide. All sorts of treatments and services have been set up for him including a 'befriender', a day centre, cognitive psychotherapy and treatment for his tinnitus. At one point he was sent home on leave - but he preferred to spend the day back in the ward.

At first everyone suggested ways in which he could be prevented from 'manipulating' the ward team. He should be 'confronted and challenged'. Other services should be set up for him. He must be made to see that he does not have a mental illness and be more self-reliant. The doctor was reassured that she was doing really well with this very trying and devious patient. That was level one.

A second phase was prompted by my interventions: how did he get to be like this? What sort of person used he to be? The doctor described the patient's history: he couldn't do 'A' levels because father wanted him to leave school. He wanted to do engineering; he had a furniture

stall in the market for 10 years. He had been married for seven years but had no children; he still talks to his ex-wife by phone once a week. He has no other friends. In this phase of the discussion the patient becomes more alive. The group begin to treat him more like a human being and less like a problem to be solved. Why couldn't he just be allowed to stay in the ward if that's what makes him feel better? The team and the patients are the only family he has. That was level two.

The third level was just touched on. I managed to get a word in to ask: how does he make us feel? The answers were: angry, sad, frustrated. Might he be feeling some of these things too? The group considered this possibility briefly. They began to talk about the frustration and the sadness. But before long the discussion dived back hurriedly for the safety of practical solutions. I was disappointed, but not discouraged.

What sort of leader, leadership skills, attitudes do you need for a group like this?

Michael Balint emphasised that the most important thing was for the leader to be a good listener. The experience of being listened to helps the group members to listen to their patients with a similar degree of attention. He also said it was important for the group members to do the work and not expect the leader to give them all the answers.[2]

In both these areas I think GPs make excellent leaders. GPs who are interested in Balint are naturally good listeners. Psychotherapist leaders, especially those who have not had any previous Balint experience, will sometimes talk too much. They will succumb to the temptation of telling the group exactly what is going on. The group listen with open mouths. Whether this is due to admiration or disbelief may be hard to tell.

GP leaders don't do this because they don't know anything about psychodynamic theory. When they do say something, it is usually to make one of a limited number of interventions. These are designed to redirect attention to the patient as a person with feelings and to the doctor-patient relationship.

Who taught us this style of leadership? As far as I can tell we were taught to do this by Enid Balint who demonstrated her skills to us many times and also supervised the GP group leaders' workshop in London in its early days. This is the kind of leadership technique which GP leaders are passing on to their successors.

## EXAMPLES OF BASIC INTERVENTIONS

What do you think the patient might be feeling?
What sort of person do we think she is?
Do we know anything about her background?
What about her family?
How does this patient make us feel?
What could it be that makes her behave in that way?
How does he feel about this doctor?
What sort of doctor does he want her to be?

*And, of course:*
Let's get back to what is going on between doctor and patient
But – when you think about it –
Even these basic questions are informed by the ideas of psycho-analysis:

## SEVEN THINGS THE ROMANS TAUGHT US

I. Some mental processes are **unconscious**: hidden but influential. This is the most important principle and is the reason for all the others.
II. **Ambivalence.** Opposing ideas may be present in the mind at the same time
III. **Forgetting** is important. Michael Balint taught us to present without notes and to treasure the things about the patient which one had forgotten.
IV. **Childhood** is an important influence on adult life. GP Registrars in the early stages of their training don't often go into patient's early life. But the infant self is present in adult life, demanding attention; needing a mother and father.
V. Doctors are figures of overwhelming importance in patient's life. This is called **transference.** You don't need to interpret it or even mention it but you had better be aware of it.
VI. Patients affect and disturb **doctor's feelings.** This is called Counter-transference. Neglect that at your peril as well. Feelings may be those of the patient but they may also be your own which are vibrating in sympathy. Our book *What are you feeling doctor*[7], which I know you are all going to read, has something to say about the importance of the doctor's own emotional history.

The last one (Number VII) is a bit more difficult. This is where perhaps you do need a bit of Latin.

VII. This is the idea that symptoms are like words that may have more than one meaning. Or different layers of meaning. Patients' discourse may include dreams, puns, images, symbols and metaphors, whose meaning is not immediately obvious. For example, when a patient talks about caring for a stray kitten she may be talking about herself being cared for by the doctor as well. You need a bit of Latin to understand that. Not total fluency but, as the language guides for tourists put it, enough to get by.

## ARE THESE IDEAS THE EXCLUSIVE PROPERTY OF ANALYSTS?

No they are not and they never were. Even Freud said that the poets and philosophers discovered the unconscious long before he did. Nowadays there are lots of therapists, counsellors, psychologists, social workers, nurses, health visitors, managers, writers and broadcasters who are familiar with them too.

But do you need to have had a training in therapy or at least a period of personal therapy in order really to understand and use them? Can we access this way of thinking and feeling in other

ways? Do we need lectures? Should we do lots of reading? I can't help thinking that reading *Anna Karenina*[8] would provide more insight into human relationships than a textbook on psychotherapy. I feel sure that talking and thinking about the consultations which make us feel uncomfortable must be helpful. Even if it can only be in a weekend group once or twice a year. We do need to cultivate our own awareness of emotions if we going to help other people to be better at it. Whether we need personal therapy as well I am not sure. I don't think it can do any harm. But unless you feel that you need it - it may not do any good.

## CONCLUSION

The Romans have gone and I don't think they are coming back.

We are on our own. We think our method is a good one and we believe that we have something very valuable to pass on to young GPs which will help to sustain them, throughout their careers.

What should we be teaching our group leaders?

Do they need a degree course in Latin?

My view is that if we can pass on to them what the Balints taught us, we will get by with just a little Latin.

## WHAT DID **OUR** ROMANS DO **FOR US?**

This is a kind of paraphrase of my seven principles. This is the way it appears when you work in a Balint group. It is not in Latin.

Michael Balint and Enid Balint taught us

1) That what we did was often worthwhile – especially when we thought we were doing nothing. They showed us that, very often, when we thought we were doing nothing, we were actually listening to our patients and staying with them.

2) That we are tremendously important to our patients: even when they are giving us a hard time.

3) They kept reminding us that patients are human beings like ourselves.

4) Patients have powerful emotions and so do we.

There will be interaction between their feelings and ours – whether we like it or not. Some of those feelings will be hidden or disguised. They may be presented to us in the form of metaphors: stories, symptoms.

We may not understand those feelings and we may not like them. But at least we can acknowledge their presence and recognise that they are important. This may need a greater awareness of feelings that are at first hidden – or if you prefer – unconscious.

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**After the lecture: (from left) Paul Sackin, Katrin Fjeldsted, Professor Dame Lesley Southgate and John Salinsky.**

# Balint and Emotional Intelligence

by Michael Courtenay

*Keynote paper given at the Oxford Balint Weekend in Exeter College on Friday 15 September 2000*

Dear friends, I shall begin with a story, as stories are the kernel of Balint-work. Last Christmastide my wife and I had four grandchildren staying. Their parents went out to the pub so I found myself baby-sitting on the sofa watching an unsuitable Arnold Schwarzenegger film: "The Last Great Action Man". The youngest was pressed to my left side, the only girl to my right. Their respective sibs were on alternate flanks. When their parents got back from the pub, my daughter-in-law said: "There's a picture." My realisation that I was basking in the affection of the small fry produced a warm glow of pleasure – one of those magic moments when one becomes aware that being a grandfather can be supremely emotionally rewarding. Then, almost immediately, came the thought that if each grandchild has 25% of my genes, then the four on the sofa with me might possibly contain all my genes! Did that mean, I wondered, whether my pleasure was no more than narcissistic self-love? But emotional intelligence also spoke to me of being in receipt of the love of the children, never mind the underlying genetics, however much that might appeal to my reason.

Since the Age of Enlightenment a consensus seems to have developed in the West that Reason should reign supreme in the world of humankind. And reason is seen as something that is based on thinking alone. Feeling has been denigrated into a second class mental activity; to be mastered by thinking clearly. The character of Spock in the TV series 'Star Trek' personifies this idea. We have come to realise in the late twentieth century that to suppose humankind was created to rule Nature is a travesty of the truth. The fact is that we, too, are part of evolving Nature and must seek to find our proper function in a worldwide ecosystem. Of recent years the neuroscientists have been educating us into an appreciation that our emotional minds, though older than our frontal cortical systems in evolutionary terms, are closely connected to them in functional terms. It is the working together of the pre-frontal cortex and the limbic system that truly represents the functioning of the human brain. From the point of view of our brain neurons firing away in the course of producing our stream of consciousness there is no distinction between the production of thought and feeling. They are two sides of the same coin. To despise our emotional life is tantamount to inflicting self-harm. On the threshold of the twenty-first century it is exhilarating to find that reductionist science has caught up with the experience of the Balints to confirm that our endeavours to combine thinking and feeling in the practice of medicine have not been a wasted journey.

The neuroscientist Antonio Damasio[1] has studied patients with damage to the prefrontal-amygdala neural circuits and found their decision-making is terribly flawed while showing no deterioration at all in terms of IQ or any cognitive ability. Despite their intact intelligence, they make disastrous choices in business and their personal lives. Damasio argues that their decisions are so bad because they have poor access to their *emotional* learning. He goes on to postulate that feelings are indispensable for *rational* decisions; they point us in the proper direction, where dry logic can then be of better use. Emotions matter for rationality. In the dance of feeling and thought the emotional faculty guides our moment-to-moment decisions, working hand in hand with the rational mind, enabling or disabling thought itself. Likewise, the thinking brain plays an executive role in our emotions; except in those moments when emotions surge out of control and the emotional brain runs rampant. Goleman[1] comes up with a statement calculated to produce laughter among this gathering: "Many patients can benefit measurably when their psychological needs are attended to along with their purely medical ones."

But what about us? How are we to cultivate emotional intelligence in our work? It is a classical Balint aphorism that if the doctor feels something during the course of a consultation the emotion may be being transferred from the patient. I cannot help feeling this one-sided view of the emotions experienced by the doctor was a product of Balint's anxiety that the seminars might become therapeutic rather than a training process. The book *A Study of Doctors*[2], untypically of Balint writings, kept discussion of cases at arm's length. But in spite of trying to separate treatment from training the Balints were clear about the core process of the consultation. The doctor's task was to get close to the patient initially and then withdraw and reflect on what could be observed in the doctor-patient relationship. In other words the first phase is empathic, understanding not only the symptoms but also the patient's emotional world; while the second phase was a rational appraisal of the emotional position of both doctor and patient in relation to the meaning of the symptoms. The term 'emotional intelligence' had not yet been coined, but its reality was clearly recognized. Which path, then, is our way forward? I believe it to be a deliberate decision to use both what we think and what we feel as an integrated instrument of diagnosis. Indeed, many years ago Tom Main remarked to me at a day conference at the Tavistock Clinic that the combining of feeling and thinking should be a goal for all doctors.

In the Epilogue to the proceedings of the fourth International Balint Congress in 1978[3],

Tom took the Balint movement to task for not listening to what each national movement was saying, suggesting that everyone thought *their* approach was right and all the others wrong: 'let *me* tell you how to do it – I know and you do not'. He ruminated on the narcissistic ignorance and uncertainty that lay behind this evangelistic development.

Then it occurred to him that he could use no better model than Freud himself. He was reminded that Freud was not a popular doctor when he began his work in Vienna and he did not have many patients. "Because he could afford to give patients a lot of time he gave each of them a whole hour, six days a week; but because he liked writing notes, he allowed ten minutes for this in the hour, so the patients were with him fifty minutes. He did not do these things because they were right, but simply because he was having a go, doing what he could. Freud's method has since become worshipped and the fifty minutes has become holy, but he did not set out to be holy, just to try to do the best he could under his circumstances. He did not have impressive electrical apparatus, just ordinary domestic furniture so he had the patients sit on the couch near his chair. At first he hypnotised them, and then put his hands on their heads and urged them to remember, but he got fed up because these attempts were not always useful, so he tried not putting his hands on the patients, nor urging them to remember but simply asked them to say what came into their minds. Thus he *stumbled* on the technique of free association. He did not like being looked at a lot, so he had the patients look away from him and thus he *stumbled* on the observation that they had fantasies about him which were not justified by fact, until he *stumbled* upon the transference. His setting was decided by what he could and could not do, but he was a wonderful observer, not a passionate healer, and because he was a genius doing his best in the circumstances, he discovered some amazing facts about the human mind."

In the research group whose work was published in *Six Minutes for the Patient*,[3] after more than a year's work Michael Balint got so angry that the group were not addressing the task to see what happened in an 'ordinary' consultation that he lashed out at the group following a case presentation which had involved a long interview. The following week Jack Norell presented a throw-away case of a girl with acne which suddenly opened the door to understanding the routine short consultation. This insight was developed at a weekend meeting in Aberdeen with the effect that the group *stumbled* on the 'flash'. So we must learn to observe in our own settings what we can and cannot do. I have travelled back with Tom's help to Freud, because I want you to see that what are often thought as bold experiments in the work of Balint groups are really rediscoveries. German Balint doctors who lie on the floor in order to get a new perspective on the case are only trailing Freud in the development of a working method.

Now to return to emotional intelligence. The concept of the flash has been somewhat discredited over time and I think this is because it was originally understood in 'thinking' terms. It was thought that when the doctor felt stuck in the course of treating a patient the response should be that one twiddled the dial of the receiving apparatus to try and reach the patient's wavelength and so establish a meaningful connection with the patient's distress. But what was missing from this description was the fact that when a flash occurred it was always preceded by an acute *feeling* of dissatisfaction on the part of the doctor. I think the idea of emotional intelligence is well illustrated in a case presented by a dear friend and colleague, Cyril Gill (whose early death I still mourn), at the first Balint International Congress.[5] He set out the case under three headings: Traditional medical interview, Traditional personal interview and Personal interview with 'flash'. He recounted the case of Miss P, a 56-year-old single woman, who complained of feeling tired and ill. The doctor got her to enlarge on this, and learned that she had felt sluggish and cold lately. He took a full history and examined her, bearing in mind such possibilities as myxoedema and anaemia, which occurred to him early in the interview. He found nothing physically abnormal on examination, but referred her for various tests. The results of the tests were all normal, but the patient still felt ill, so he asked her to come for a longer interview.

When they met again the doctor asked various questions about her life, and learned that a recent change in the office had upset her. She was not easy to talk with, but he obtained a past history of a dominating mother, who had rather isolated her; made her feel she should take pride in her work; but also 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 summarised this picture for her, as far as it went, and she agreed it was all 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 along these lines would meet resistance. He could never change her, or her life situation. So he prescribed anti-depressant tablets, and asked her to return in a fortnight.

So ended the first two traditional medical enquiries, governed by reason and ending in impasse. Now for the un-traditional phase. She returned even more depressed, and the doctor said apologetically, 'Oh dear, we must try again,' at which she burst into tears. She bent her head forwards, bringing her hat more into view, and it was shaking as she cried. The doctor felt irritated by this, since it looked ridiculous. This thought shocked him, as he liked to think of himself being sympathetic to his patients. He realised at once that she might be making other people unsympa-

thetic to her in a similar way. She started apologising for her tears, and was surprised when the doctor apologised 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 he meant when he suggested that she might be keeping other people at arm's length by a rather stern manner. He referred to the hat, which was a formidable affair, and she took the point with interest and good humour. Finally she was able to agree that her initial complaint of feeling cold might be because there was nobody to warm her up, but her stern manner was hiding this from other people.

Surely, looking back, the flash represents a change of feeling which is understood at the same time in terms of thinking. This is not a high-falutin concept, but a down-to-earth recognition that our feelings, those of our patients and ourselves, are as valid and important as our intellectual reasoning. The 'qualia' of thinking and feeling are both based on signals passing along the myriad neurones in our brains. They may be different in detail, but essentially the same kind of phenomenon. Cyril, as he surveyed the shaking, over-the-top hat of his sobbing patient, recognized the expression of her feelings of desperation because of his own *unsympathetic feelings* at time. But *his* feelings meshed with his reasoning powers so that he could conjure the necessary insight to achieve a breakthrough in the doctor-patient communication.

If you wish to accuse me of teaching my grandmother to suck eggs, so be it. But remember this, if I have had to hark back to Freud and two International Balint Congresses in the 1970s to illustrate the theme of our Millennial Conference, why are we all stuck in the mud? Do we take the insights of Balint-work for granted or do we just lay them to one side in our daily struggle at work? In the work that led to the recently published book: *What are you feeling, Doctor?*[6] my colleagues, in my opinion, broke new ground because of their courage and honesty. Nevertheless, when it came to writing the book I think I was unable to persuade them that we had stumbled on truths far wider than the purely medical ambit. For me, their work informs the whole concept of professional conduct, where personal experience is welcomed as an aid to fuller understanding, rather than excluded for fear it might interfere with professional competence. I think the lessons we learned might be just as useful in the police force as they appear to be in medicine. And as Marie Campkin has remarked, Tom's lecture might also generate research into February vs July consultations and the meaning of professional love.

If we seek to deny ourselves as persons, maybe because our circumstances in general practice, in nursing, and other allied professions are so constrained by a diet of diktats and inadequate resources then trouble lies ahead. If we come to believe that there is no time to deal with the emotions of our patients and ourselves then what is left of medical practice – biological plumbing? Dear friends and colleagues, if we have no time for emotions we are dead. Let us embrace our emotional intelligence and burst the bonds that ignorant people seek to impose on us. Humankind is the slave of rationalization, but let us, while recognizing our vulnerability, endeavour be bold. Let us seek to resist this slavery in the twenty first century!

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# Teaching the Doctor-Patient Relationship through Balint Groups:

## The Possibility of a Time for Reflection during Medical Training

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(This paper was presented at the Oxford Balint Weekend in Exeter College, September 2000)

First of all, I would like to thank you for giving me the opportunity of being here and showing our experience in teaching the doctor-patient relationship using Balint groups. It is really a great pleasure for me to talk about this work whose main purpose is helping to change the current medical paradigm.

Medicine was born along with man's history. Its beginning was predominantly mystical. The physician was a kind of sorcerer[1] who had power over life and death.[17] Throughout the ages, medicine became a scientific discipline and the doctor became a real scientific professional accordingly. The acquisition of such a great amount of knowledge has been paralleled by an increasing distance from the patient. Medicine, nowadays, is the **science of the illness, not the science of the ill man.** A patient generally goes to see the doctor as if he was dumb. The doctor just sees a disorder, and does not see the patient as a real human being. He does not listen to him! A change in this paradigm is necessary.[2,5,8,9] Medical students need a time for reflection during their medical training in order to study the doctor-patient relationship.[3,7,13] We, in Goiás Federal University, think this time must be during anamnesis training in the third year. (Anamnesis is the process of meeting the patient, talking to him and learning about his history and background in detail) Our medical students attend two years in which they study exclusively basic subjects such as Anatomy, Pharmacology, Physiology and others. They only begin to go to the University hospital in the third year. This is the first time that they meet patients: when they learn how to do an anamnesis and also when we teach the doctor-patient relationship.

We have a ten year experience of teaching the doctor-patient relationship using Balint groups[15] in our medical school. Balint himself didn't believe in Balint groups for students, but he did it during his life![2] Other authors, most of whom are here among us, believe that this is a possibility and, nowadays, we know this can be a very important tool during medical education.[10,11,12,16]

This is our experience. We have 120 students in the third school year, so we have 8 groups with about 15 students in each. There is a medical professor for each group. The students must go to the University hospital and do anamnesis for their classwork. They must discuss their anamnesis with their professors. But I am responsible for teaching doctor-patient relationship for all of the groups. I meet each group four times an year, when we perform a Balint group. The students, after going to the hospital for the anamnesis with the patients, must come to the groups with me. We usually discuss both the student's and the patient's emotions when they meet one another and their relationship, naturally. I use the Balint method with an emphasis on psychology in medical care and the doctor-patient relationship.

In my personal experience, I noticed that all students feel afraid of the first meeting with a patient and they talk to me about this in the Balint group. They usually talk about their discomfort when going through the experience of seeing themselves as 'doctors', using white coats, entering the patient's room to ask many questions about his life. They also report becoming anxious because they don't know anything about medical therapy yet. I explain to them that the most important thing in the doctor-patient encounter is the understanding of the patient as a real person, with his own life experience, his happiness and his pain. I explain to them the importance of the eidetic attitude for listening to the person without pre-conceptions.[4,14] That is basic in human medicine.

The medical students experience a considerable development in their personal relationships, humanity, subjectivity, and their reflective and phenomenological attitude toward patients in general. They become able to understand the patient's behaviour and standing in the world, and their illness process as well.

Some students fail to attend these groups and this is considerably important; but we know this kind of learning situation is very hard for them, because they must face themselves and their attitudes in order to change them. All the students that participate, need self-reflection and, as we know, it is difficult to try, to do and to get! So, as their professor, I must be tolerant with this

difficulty. Now, I am starting a Balint group with 10 fourth-year medical students in order to continue the third year experience.

Our experience has shown that the Balint group is an incontestably useful tool for helping medical students in discussing and understanding the doctor-patient relationship.

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# Balint and virtue

address by Dr Peter Toon at the Annual Dinner June 2000

The medical profession in the UK is facing a crisis:

- There has been a flood of widely publicised disasters – heart operations on children in Bristol carried out in defiance of poor results,[1] the storage of body parts after death in Liverpool without relatives' consent,[2] the mass murders of Harold Shipman,[3] smear misdiagnoses in Canterbury[4] and many others. Much of this is media hyped, and most patients continue to trust their own doctor and doctors they come across, but we cannot ignore its impact.
- there is widespread low morale amongst doctors in general and general practitioners in particular; many feel they are overworked, undervalued and under excessive stress. Problems of recruitment and retention follow from these feelings.

Strangely this situation has arisen when probably more can and is being done in terms of scientific medicine than ever before, and we have evidence based practice, audit and shortly revalidation in an attempt to ensure that standards are higher than ever. Why is this?

Part of the problem no doubt is chronic under-funding of the NHS, and international travel and communications which make people aware that our health service is not so good as others. The under-funding is being addressed through the NHS plan, though staff shortages take longer to address, and whether throwing money around will solve the infrastructure problems is not clear. The LIZEI programme demonstrated that cash is not always the rate limiting step; it is hearts and minds that have to be changed, and it those I want to address.

Dissatisfaction with medical attitudes is not new; this was a major reason for the introduction of ethics teaching into the medical curriculum around 20 years ago. There was a hope, which now appears naive, that doctors who were better informed about the rational arguments concerning their actions would be better doctors.[5] There is little evidence that this rational, Enlightenment view is correct. Interestingly, whilst medical schools have been hoping to make their students better doctors by teaching them about ethical codes and ethical analysis, the academic discipline that underlies this teaching has been having doubts about this approach. Prompted by several thoughtful philosophers,[6,7] the duet of deontological and consequentialist ethical systems which has dominated moral philosophy since the Enlightenment has been joined by a third partner as old as either but recently neglected; the ethics of virtue.

Virtue ethics asks not what is right or what maximises the good, but what does it mean to be a good person? This question Aristotle addressed in his Ethics.[8] Although Christian thinking tends to relapse into a rule based approach to ethics, its better moments too have emphasised the importance of virtue rather than moral rules. "Love God and do what you like" as St. Augustine put it. A millennium and a half after Aristotle, Aquinas too looked at ethics in terms of virtue in his great synthesis of Christian and Aristotelian thought, the *Summa Theologiae*,[9] and produced a definition of virtue still worth thinking about – "the habit of acting rightly according to reason".

Virtue ethics rather fell into abeyance with the Enlightenment's emphasis on reason and the replacement of the holistic models of human nature of earlier ages by Cartesian dualism.[10] One important figure in the modern – or perhaps post-modern – revival of virtue ethics is the Scot Alisdair Macintyre, whose analysis of the bankruptcy of the Enlightenment vision and philosophical framework for a virtue ethic in *After Virtue*[10] has been very influential. Another is a less well known philosopher, Marta Nussbaum[9], who points out that the virtues are the qualities needed to overcome the challenges of life.

It is Nussbaum's vision of virtue that brings us to Balint. It was the awareness that they lacked the qualities they needed to overcome the challenges of general practice in the 1950's that led the pioneers to their famous meetings with Michael and Enid Balint.[11] Since then a number of research groups (most recently one on the doctor's defences[12]) have explored these qualities, and many doctors have experienced the value of this method in enhancing our abilities to cope with the problems of clinical practice. The traditional, once a week for two years closed Balint group is not the only way in which one can acquire these abilities, and perhaps the fact that few people now want to follow that route represents not the failure of the Balint movement but its success. Much of the message of the original Balint approach has become normalised in the culture of UK general practice or is addressed in different ways – for example in Roger Neighbour's approach to the consultation,[13] and the currently fashionable narrative medicine.

What is the shared ground between virtue ethics and Balint? Firstly, a shared vision of what it is to be human. Emotions as well as reason influences what we do and how we behave. The rationalist model of the Enlightenment (and of evidence based medicine) is not sufficient alone to provide a framework for all we have to understand.

Secondly, both Balint and virtue ethics are teleological. We are not aimlessly wandering through life picking up what pleasure we may and avoiding what pain we can, as the consequentialist, atheist ethics which underlies much

thinking in modern society suggests. We are seeking for meaning – not necessarily religious meaning, and indeed the great teleologist Socrates was executed for atheism and impiety – but meaning within the context of our life. Balint sees patients as not merely looking for relief from suffering but also taking part in this quest for meaning.

Thirdly, and perhaps most importantly, one way of looking at what goes on in Balint groups is that we are concerned with the characterisation and the development of the virtues. Through the discussion of individual cases which challenge us, we work towards a better understanding of what it means to be loving, courageous, hopeful or prudent as doctors. There are general features of these virtues relevant to all of us – famously "the courage of our own stupidity," and the "flash" when the previously unlovable ugly duckling of a patient reveals his or her innate beauty. But since virtues are personal qualities, they will be exercised differently by each person. The contemplative introvert's way of being courageous will be different from that of the hearty extrovert.

But understanding what it is to be virtuous is only half the battle. In the painstaking, and sometime painful listening and attention of the Balint group the habit of acting rightly according to reason is cultivated, and we emerge as more virtuous doctors. Since however carefully we draw boundaries around our professional life these boundaries are semipermeable we also become more virtuous people.

Here I must emphasise the double benefit of both Balint work and a virtue approach to ethics. Doctors who do Balint work do so not only because it makes them better doctors, to their patients' good, but also because it makes them happier doctors. We are used to thinking of ethics as being about what we must do for others,[15] in obedience to the "stern daughter of the voice of God",[16] something which no doubts contributes to the widespread feeling of being overburdened discussed above. Looking at ethics in virtue terms replaces this burden of duty with the search for the "good life". Like the quality of mercy this is twice blessed – good for the person living it as well as well as for those around her. Rather than putting doctor and patient into a conflict where one must gain and the other lose, this is in managerial parlance "a win-win solution".

These issue concerns the virtue of the individual, and this is vital.. But Macintyre makes it clear that the virtues are not cultivated in isolation, but in groups engaged in what he refers to as practices – socially organised activities though which social goods are generated whilst at the same time the virtues of those involved in them are enhanced and developed. Medicine is one such practice, but like any practice it can become distorted by an incorrect understanding of its values. This I would suggest has happened in two main ways to medicine.

The first is emphasis on the means rather than the ends – a fascination with disease and its understanding, on exploration and control for its own end, rather than seeing these as means to the end of healing patients. We are all familiar with this trap – the interesting case, studied as an exercise in natural history without empathy for the person whose life is blighted by the condition.

The second is emphasis on the treatment and cure of disease, to the exclusion of the equally important function of helping people understand and cope with their illnesses. This does not imply that cure and alleviation are unimportant, but just that they are only one side of the coin. Traditionally obsession with cure has been a feature of the high tech hospital practice, but as we rightly pay more attention to the effectiveness and the evidence base of what we do in primary care and on measuring our preventative and anticipatory care, we risk the same distortion.

Balint work, focussing on the interpersonal relationship between the one who is, or fears himself to be ill and the doctor he consults for help in understanding his situation is one method in which we can try to deal with these challenges virtuously, to the benefit of both parties.

A third distortion has faced medical practice through the ages – the focus on the power and the money which it generates rather than on the well being of patients.[18] This is an ever present danger, but my impression is that this is actually less important to our present crisis than the other problems I have mentioned.

Although rigorous measures on revalidation, on clinical governance and on quality assurance in relation to the biomedical aspect of medicine are important, these alone will not extricate us from the present crisis. Neither virtue ethics nor Balint groups offer ready-made answers to our problems. The solution will probably not come from one source alone – narrative medicine, the growing interest in medical humanities, and even a germinating seed of interest in the empirical application virtue ethics in medical education will probably also play a role. But the tradition which we celebrate tonight has a key role to play in this task. It is in the hope that we will rise to this challenge that I give you the toast – the Balints and the Balint Society.

**Postscript**

Later this year I plan to run a series of groups, the aim of which will be to characterise the virtues needed to flourish in general practice in the twenty first century and discover how we can cultivate them. They will not be Balint groups, but will draw on Balint methodology as well as other qualitative research techniques. If anyone is interested in taking part in such a research group, please contact me.

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# Balint in the Balkans

Address by Dr. Heather Suckling, President of the Balint Society.

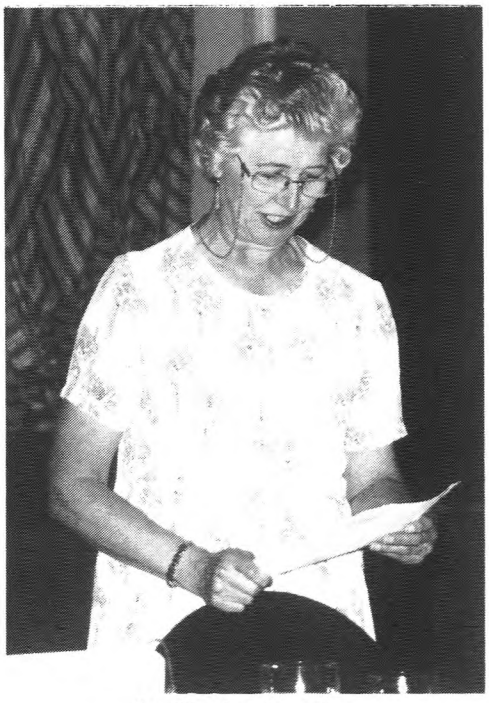
*Given at the Society's Annual Dinner 25 June 2001.*

**Introduction**

When David reminded me that it was my duty as President to address the Society after dinner I decided to speak of my experience with Balint work in Macedonia. However in order to have a more snappy title I thought I would take advantage of the alliteration and call it "Balint in the Balkans". Therefore I felt obliged to start with a definition and immediately I was facing a problem, what constitutes the Balkans?

I am told that "Balkan" originally referred to mountains in Bulgaria, but various definitions are available and it seems that the most common one is that part of the world which was occupied by the Ottoman Empire, namely: Greece, Albania, Macedonia, Bulgaria, Serbia (south of the Danube), Montenegro, Kosovo, Bosnia-Herzegovina and Croatia. Croatia tends to exclude itselt from this list and as that is the only country other than Macedonia where I know of Balint work taking place, I am left to speak about Macedonia.

Macedonia is a small independent republic which was part of former Yugoslavia. It is a landlocked, mountainous plateau divided by the Vardar valley which over centuries has provided a route from Central Europe to Greece and the coast. The capital, Skopje, sits astride the river Vardar. Many of you will remember that it was mostly destroyed by an earthquake in 1963 and as a Japanese architect was in charge of much of the rebuilding it has a somewhat incongruous appearance. The Greeks still consider Macedonia to be part of Greece and the name has caused a serious rift between the two countries.



**Dr. Heather Suckling**

The population of Macedonia is 2.2 million divided roughly between the majority (60%) Macedonian Slavs who are mainly of the Orthodox religion, but with a few Methodists, somewhere between 25-30% Albanians mainly Muslim but with a few Roman Catholics, and about 10% Roma. These figures are estimates and there are other smaller groups including Turks, Slav Muslims from Bosnia and Macedonia and the Vlachs and there is an enormous amount of intermarriages with citizens from neighbouring countries, especially with Serbians and Croatians. Therefore it is not surprising that the Macedonians often refer to themselves as Balkan, for example when complimented on their hospitality will say "that is our Balkan way" and they drink "Balkan" coffee and the women will frequently say, in a derogatory way, "he is a typical Balkan man". When discussing politics with my Macedonian friends, if I mentioned the word "negotiation" they would smile and say "come on Heather, this is the Balkans". Yes, "Balkan" has come to be synonymous with "extreme", everything is either done immediately or not at all, things are black or white, there are no grey areas.

How would Balint work fit in here? As we all know Balint groups are all about *understanding* relationships, toleration, uncertainty, the unknown, grey areas ... what would they make of Balint work?

**Ohrid**

On my first visit in May 1999 I was working with the CME group in Ohrid, a beautiful city on a large lake in the south west of the country. It was here that the first Slav University was founded and the monks, Cyril and Methodius who invented the Cyrillic alphabet lived. My remit was to help the teachers ("Educators") with communication skills. Peter Toon had asked me to run as many Balint groups as I could. On arrival, I asked to see a practice so that I could have some idea of their consultations. I discovered that, far from having close doctor/patient relationships, patients did not even see their doctors alone; there may be several other patients coming in to the room in the middle of a consultation, demanding immediate attention from the doctor! There was no concept of confidentiality; informed consent is a rarity and relatives are informed when a patient is dying and *they* decide what the patient is told, often threatening the doctor if they think he is going to be honest with the patient. These are sometimes

threats of physical violence and stabbings and shootings do occur.

I was wondering how on earth I could introduce Balint into such a setting, when an unexpected opportunity arose.

The local Educators, whom we were teaching, put on their first CME course for Macedonian doctors working in primary care. These were doctors from Prilep, a town in central Macedonia where there is a marble quarry and cigarette factory. The Macedonians from Skopje, Bitola, Ohrid, Strumica and elsewhere tend to look down on those from Prilep, so they were particularly pleased to be invited to the first course. As a foreign guest I was invited to introduce myself and mentioned in this brief introduction my interest in Balint work. To my surprise a small group of participants came to me at coffee time and asked me to tell them more about it. As the timetable was very full we agreed that I would come to their hotel one evening and explain more to anyone who was interested. To my surprise the whole group were there and, after my talk, they invited me to go to Prilep the next week, after the course and run a demonstration group.

Fortunately, one of the Educators, Saso, a respected Psychiatrist, himself from Prilep, was also very interested and made the arrangements. In spite of his strict instructions about a group setting and the need for informality, we arrived to find that the Medical Director and his entourage were there to meet us. They led us to the board room which was full of doctors and sat us down round an enormous table! In spite of my reputation for always rearranging furniture before any educational activity, this time I felt that it would have been extremely discourteous to do so. After the welcome speech the Director left and I led the group with Saso interpreting.

There were 16 round the table which formed the group and I ran it as a goldfish bowl, or "aquarium" as it is now known in Macedonian. To my amazement the group ran well, like a reasonably respectable Balint group. We had one case of a woman in the town who was well known to the doctor, who liked her, but was fed up with her frequent attendances. She was wondering how to handle this when the patient presented with a breast lump which was malignant. Needless to say, the relatives did not want her to know the true diagnosis. The dilemmas of frequently attending patients, the rights of patients and relatives and the difficulty in dealing with serious conditions were explored at some length. No solutions were obvious, but the doctor thanked us and said she felt better for sharing her anxieties. (She later sent me a photograph of herself, taken at the dinner at the end of the course.)

After that I ran a few groups for the Educators (there were 10 of them) and four of them showed enthusiasm, but alas the psychiatrist is now Mayor of Prilep, a full-time job and 2 of the others are working with me on a different project.

**Stip**

On my next visit, Spring 2000, I was invited to Stip, another town where a group of doctors who had been on the CME course had started a Balint group of their own. I am afraid some of our members may not regard this as a *pukka* group, but it is a start and in a culture where doctors publicly criticise each other, to find a group where there is mutual trust and confidentiality is, in my view, very worthwhile.

**Veles**

Last October I went back to work with a new group of 24 Educators in the central town of Veles. They were divided into 3 groups and this time I ran a group every day so that each doctor experienced 6 Balint groups. I started by giving them a short introduction about Balint work and also the Aims and Objectives of a Balint Group.

The Educators were very enthusiastic and very anxious to learn leadership skills, so I took the bull by the horns and taught them! Depending on my mood I look back on this as either a brave attempt or a terrible mistake, but on balance I do not regret it. My philosophy is that something is better than nothing and if we wait for perfection we will wait forever. They have been introduced to the following ideas:

- both the patient and the doctor deserve respect and trust
- their own feelings and emotions matter and may reflect those of the patient
- the consultation itself is important
- the concept of the "drug doctor"
- that professionals can share their anxieties and mistakes without losing respect
- they have the ability to provide their own support systems.

From my point of view I learnt a great deal about healthcare in Macedonia, about the relationship between the doctors themselves, as well as between doctors and patients. The cases gave me an insight into the management of common conditions, the dilemmas of the doctors, the role of the Directors, the role of nurses, the difficulties the Educators have in applying their new knowledge, of health beliefs of patients and doctors and, of course, insight into the personalities of the educators themselves.

**Primary Care Specialist Training**

My present role in Macedonia is to help them design a programme of specialisation for primary care doctors (in other words Vocational Training). Naturally we are recommending that the Day Release programme, which will be obligatory throughout the three years, includes a Balint Group. My Macedonian colleagues are even more enthusiastic about this than I am! Although it has been difficult to negotiate some of our ideas with the professors at the Faculty of medicine (there are 258 of them, 60 professors of Internal

medicine alone) none has protested about Balint and one of the professors of psychiatry actually complained that we had not included Balint, by name, in the Framework of Competencies. It was a great pleasure to be able to reassure him that it would be included in the training programme!

**Strumica**
Two weeks ago I had the chance to visit a brand new Education Centre in Strumica, in the south east of the country, where a CME course was being run and I was delighted to see that the Balint session had been highly acclaimed by the participants who were asking how to go about arranging an on-going group.

**"Macedonian Balint Society"**
I had hoped that by now the local enthusiasts would have formed a Balint Society. I have given them a copy of our constitution and offered advice and support. Unfortunately, the political situation over the last year has become steadily worse and has not been conducive to starting new ventures. Many of the Educators have sent their families abroad and both the Macedonian and Albanian educators are fearful for the future. However, I am still hopeful that they will make the effort and that on my next (and last) visit in August, a Society will be formed.

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# Programme of Meetings of the Balint Society for the Thirty-second Session, 2001-2002

**Annual Dinner of the Balint Society** — **26 June 2002**
Royal Society of Medicine
1 Wimpole Street, London W1

**Lecture series 2001-2002**
Lectures are held at the Royal College of General Practitioners
14 Princes Gate, London SW1 1PU
Time: 8:30 p.m. (with coffee from 8.00 p.m.)

Dr Nick Temple, Consultant psychiatrist in psychotherapy, Adult Department, Tavistock Adult department, Tavistock Clinic. — **23 October 2001**
**Title to be announced**

Dr John Horder, Retired GP, past president of the RCGP. — **20 November 2001**
**"Michael and Enid Balint: My experience of their contribution"**

Dr David Bell, Psychoanalyst, Adult Department, Tavistock Clinic. — **19 February 2002**
**Title to be announced**

Dr Linden West, Psychotherapist, Principal Lecturer in Education, Canterbury Christchurch University College. — **19 March 2002**
**"Doctors on the edge"**

Gillie Bolton, Research Fellow in Medical Humanities, Sheffield University Institute of General Practice. — **14 May 2002**
**"The power of expressive, reflective writing"**

All meetings are PGEA approved
Further information from the Hon. Sec. Dr. David Watt

# Auntie Rozi

By Beatrix Udvarhelyi
Fourth year medical student at Semmelweis University, Budapest.

An extract from her Ascona Prize Essay (2000)

I am always deeply moved by the bathing of elderly patients at the section of chronic medicine in a hospital. Together with a few university and sixth form college students I usually visit these elderly men and women to give them a bath. First I was worried because I had no idea how I would be able to cope with other people's suffering.

Serious patients are lying here. Almost all of them are bedridden and incontinent. The bodies of most of them are covered with pressure sores. Many of them are hardly able to talk. Yet, suffering is not the central theme any more.

There are some that wait for the inevitable with quiet resignation. There are some that have not got over the revolt of 'the whole world is against me.' Each of them is an enigma: all you have to do is to find the key to them. There are some that expect gentleness and tenderness of us and some that require a firm, determined attitude.

But they are all alike when it comes to expressing their gratitude for even the tiniest little things. With eyes wide open, they are scanning our movements to know how they can help a bit. Many have got rid of their distrust and fear of our accidentally dropping them after the first occasion. They have incredible strength in those of their limbs that they can still use – some of them can grasp really hard the armrest of the bathing trolley or the bedside. I feel it is a special honour for me that it is I who can wash these frail and feeble bodies.

It is good to know that we are expected.

At times like this, it is always the same image that hovers in my mind: the body is the temple of the soul. How true is this saying. As if the naked body undressed the soul as well ... There is someone lying before me in her naked truth, in her absolute reality. One who no longer wants to look any better – a person reveals herself to me truly and truthfully, pure and unmasked. What confidence is placed in me with this full and complete exposure. I am always moved when I am granted the treasure of trust.

Can I give as much to provide something in return ...?

Auntie Rozi lies by the window in bed number four of ward eight. Every Tuesday evening she waits for her turn lying on her back all the way covered up to her chin. Her skinny, frail body is lost beneath the big blanket; her head is sunk deeply in the pillow. She never speaks a word. She waits with endless patience. She opens her mouth to speak only when asked, but her voice is barely audible. Her eyes tell, however, everything. She radiates confidence. She never shows any signs of dissatisfaction. She is one that relies on us without the slightest reservation. I can never feel any tension, nervousness or fear with her. She takes everything peacefully from us. This earthly misery makes her body entirely exposed. One would believe that no one could take it with a sound mind. Yet auntie Rozi is beyond that. One would think initially that her body had completely slipped from under her control since her members can hardly move; she has got catheters and a guest opening. But as soon as I look at her face, I feel immense internal power emanating from her.

I know nothing of auntie Rozi's life, and we cannot engage in a conversation – in the traditional meaning of the word. This may not be needed, after all. I feel our relation to be very intimate – as if we were old friends who understand each other without words. Her face speaks to me more sincerely than a word can. Her features do not hide anything – pure emotions from deep inside can only give her such a fine lineament.

We have now come to auntie Rozi's bed. I remove the blanket off her and undo her diaper. The boys hold her with firm hands and put her over to the bathing chair. I cover her front side with a clean sheet. We put a washing sponge, the soap and her clean nightdress in her lap. While doing it, all of us speak to her in a kind, cheerful tone. We do this for all of our patients. The ward slowly fills with life – everybody has found her tongue. There are some who reach out for their 'bridegroom' (local name of the gauze twine tied to the bed) to help them pull upward and be positioned to see us better.

What follows then is the 'ride' through the hallway to the bathroom, where 'splashing' commences. Usually two of the woman nurses give the bath. First we remove the things packed in auntie Rozi's lap, then the sheet and finally we help her to take off her nightdress. The wheelchair is rolled next to the shower stall. We'll ask her if she likes the temperature of the water.

And now comes the fun of splashing!

First quick shower with water; then we thoroughly soap her all over her body carefully watching her catheters and the guest opening. The big hole in the seat of the chair makes it possible to wash her from below. But we have to be careful with the sponge because a big pressure sore has developed there.

When washing her back, I stand in front of the chair and stop it with my foot to prevent it from rolling away. It is as if I embraced auntie Rozi, reaching under her armpit and pull her a bit towards me – in the meantime my companion can

shower her backside. We will quickly get over the hair washing too.

Meanwhile we keep talking to her. We incessantly keep asking whether she likes the way we are doing it. She whispers barely audibly: that's right, all confirmed by the gratitude and warmth radiating from her eyes.

Auntie Rozi cannot wash even her face alone. We are helping her with that. My fellow nurse lifts the shower rose quite close to her face. Auntie Rozi looks at me with her eyes wide open. From this moment on, it is like only the two of us existed in the world. It is rare that I feel so close to another human being ... how beautiful such a face is ... how much love it shows ...

I stroke her carefully – I feel a delicate, soft, wrinkled face in my hand. She slowly raises her head a little higher, closes her eyes not to let the water get in them. Her eyes are full of gum! They probably must not have been washed for over a week. I have got to wipe them a number of times to completely clear it away. By caressing, I try to pass the water to all the little niches of her wrinkles.

Well, we are done!

We have not realized that we had been drenched with water up to our waist. This makes us laugh ... It does not matter – when we have given a bath to everyone, we will change our clothes anyway.

We dry auntie Rozi gently – making sure not to scrub her skin anywhere. We'll put her clean nightdress on her and off we roll her back to bed. In the meantime the boys and nurses have changed the bed sheets and prepared the new diaper. The strong hands are already lifting her back to her bed. When the nurses have finished dressing her wound, I tie back the diaper.

I ask her if she is lying comfortably. She just looks at me peacefully. She likes everything the way it is. But I keep asking her if we should not pull her a bit further up. She indicates with her eyes that that would be nice. Finally I straighten out the blanket. I caress her face one more time.

And then a little smile appears on auntie Rozi's wrinkled face. It is the greatest thank you I can get from her – it is addressed only to me right there, right then...

At times like this I am deeply moved. What a big thanks and gratitude to get for such a trivial thing. It gives me strength – for the entire week. It helps me to overcome those difficult moments.

I do not really know for whom this brief encounter means more. Auntie Rozi does not ask anything about me; she accepts me the way I am – completely exposing herself to me, entirely unbeknownst to her. I get the unconditional trust from her that all of us wish for so much.

# Book Reviews

**Doctors on the Edge: general practitioners, health and learning in the inner-city** by Linden West (2000), paperback pp230. £16.95. ISBN 1 853435 24 4. Free Association Books, London.

This book is based on detailed interviews and discussions that the author carried out over several years with 25 GPs from inner London and Medway. The result is a moving portrayal of the realities of life for doctors 'on the edge' of survival in a harsh environment. But the messages are by no means all pessimistic. 'On the edge can be read differently; as a cutting edge ... where GPs are experimenting ... with diverse ways of working and learning about their role'. Indeed, the project described in the book arose because the author, as an academic educationalist, was asked to evaluate the impact of a self-directed learning group of GPs, many of whom went on to be subjects of the main project.

As well as being an educationalist, the author is also training as a psychotherapist. He gives a very honest account of the strengths and dilemmas of an interviewer cum psychotherapist. All interviews were transcribed and fed back to the subjects, forming the starting point for the next discussion. This method gave the GPs a powerful opportunity for reflection and it was a very valuable learning experience for most of them. West made it clear to the participants that his relationship with them was not a therapeutic one and yet, 'I grew close to certain doctors ... and worried about them and the impact of the research on their condition'. These close relationships were essential to the success of the project though I couldn't help worrying just a little at the intensity of the relationship between West and 'David Levine' described in detail in a chapter appropriately called 'Man to man'.

Clearly there are parallels with West's approach and a Balint group, particularly the importance of reflection on the transcript of the previous discussion. Of course Balint groups focus on the doctor-patient relationship and usually mostly on the 'patient' end of that continuum. But experience of the recent 'defences' group (Salinsky and Sackin, 2000) has shown that relevant personal issues can be safely and profitably discussed in a Balint group. And there is a particular link with that group and West's book as one of West's subjects was also a member of the 'defences' group. In *Doctors on the Edge* this GP discusses a patient also described in *What are you Feeling, Doctor?* I found it fascinating to hear further reflections from this doctor, placed in the context of characteristically honest and moving revelations about his personal life.

*Doctors on the Edge* describes doctors who are in almost as much turmoil as their patients. West enables them to look at themselves and, in many cases, to grow and to learn to cope better with the forces from within and without that have made their lives so difficult. The dilemma of women doctors trying to balance work and home is a familiar one but presented here we see many different angles to it. Many issues are equally problematic for men and many of the men interviewed here are prepared to bare their souls in an appropriately 'feminine' way. Some of these men are single handed GPs from ethnic minorities who deserve gold medals for their hard work and dedication but instead are heartbreakingly rewarded with discrimination from some patients and 'the system' alike.

Once I'd got through the introductory pages and such jargon phrases as 'a gendered cultural psychology in transitional times' I couldn't put the book down, though I needed the tissues by me. It had me reflecting on my own situation and motivations for being a GP (albeit one who was defended enough to leave the inner city at an early point in his career) and I don't doubt it will do the same for you.

It's one thing reading about the inner life of these GPs and the complete mismatch of their aspirations to the prevailing culture. As a GP I yearn for some solutions, solutions to the folly of GP vocational training being based mainly in hospitals, undergraduate education that generally ignores the humanities and represses the emotions and a system of medical care that rewards the measurable rather than the important. West's book could do a lot to bring about the solutions I crave but I fear that those with the power simply won't be able to understand it.

**Paul Sackin**

**Reference**

Salinsky J and Sackin P (2000) *What are you Feeling, Doctor: identifying and avoiding defensive patterns in the consultation.* Radcliffe Medical Press, Oxford.

**General Practice: Demanding Work: Understanding patterns of work in primary care.** John Waller and Paul Hodgkin (2000) soft back pp177 ISBN 1 85775 447 6 Radcliffe Medical Press Ltd, Abingdon.

General practitioners see a million patients every day. No, not each one of us, although it sometimes feels like that. A million is the grand total seen each day by all 30 000 general practitioners in the NHS. The cost of our services (in1999) was a cool £3 billion on top of which you should add £4 billion (now it's £5 billion) for the cost of the prescriptions. These are just a few of the fascinating and revealing statistics which the authors of this book have collected. They studied 30 practices in Sheffield over a six year period in the late 1990s. Some of their findings are predictable but most are quite surprising. Many of the chapters ask a question; the first one is 'Are GP consultation rates rising? The surprise answer to this one is no, they are not. So why do we all feel so overworked and stressed out? The next chapter tries to answer that one and comes to the conclusion that consultations are

much more complex than they used to be for a number of reasons; these include higher patient expectations, more delegation from secondary care and the fact that the practice nurse is now seeing more of the patients. Wait a minute, shouldn't having a nurse makes things easier? Well, yes and no. She sees quite a lot of patients and her average consultation time is no longer than a doctor's. But the doctor is now seeing a higher proportion of the really sick and difficult-to-manage patients.

Another intriguing chapter deals with the effect of deprivation. Does a deprived area generate more consultations and more hospital referrals? Not necessarily, it seems. The idiosyncratic nature of the individual practice and its doctors may be more important. You can see what I mean about the surprises. I feel that I don't want to reveal too many more for fear of spoiling the excitement for you. But I must just tell you about frequent attenders as those are the people we get to know best and who tend to be presented at Balint groups. Frequent attenders (those who appear in your surgery at least 20 times in a year) comprise 1.3% of the patients but they account for 8.3% of the consultations. Frequent attenders are more likely to have a chronic illness and this may well be a psychological 'illness'. My final statistic with which to stun you is that 42% of frequent attenders were on antidepressants.

Are these facts about Sheffield generalisable to the rest of the country? It seems to me that the authors make a good case for believing that they are. One of them is (or was) a general practitioner and the other a practice manager, so they are more than mere collectors of data. Their reflections on their findings are also worth listening to. Towards the end there is a rather poignant chapter (written, I suspect, by the GP) in which the changes in the nature and culture of general practice are spread before us. We are asked to face the facts and stop kidding ourselves. We have given away many of our core roles such as delivering babies and watching over our patients at night. We are moving away from continuing personal care by the same doctor to 'a fast, efficient, courteous service' delivered by a multidisciplinary team of clinicians. We need to think about ways of improving our information technology and getting a bigger flow of capital investment into our practices. And yet ... this bright vision of the future does nothing to fill 'the void that is growing at the heart of practice'. How can we and our patients find meaning in our lives? How can we come to terms with questions such as why me? Why now? Why this disease? When am I going to die? The chapter ends on an ambiguous note. Balint doctors might be tempted to answer that the void can only be filled by the preservation of the individual doctor-patient relationship. Or is that being totally out of touch with reality? Read *General Practice: Demanding Work* and see if you agree with the conclusions as well as the title.

**John Salinsky**

**Post-Kleinian Psychoanalysis: The Biella Seminars** by Kenneth Sanders (2001) paperback pp.130. £19.50 ISBN 1 85575 249 2. Karnac Books, London and New York.

This collection of essays originated from a series of occasional informal talks given by the author to students at the Biella School of Psychoanalytic Psychotherapy in Italy. They do not therefore attempt to constitute a systematic course of instruction, rather a series of reflections arising from the authorís current clinical work, in which he relates the case material both to analytic theory and its historical development, and also to a wider perspective of philosophical and literary considerations. Each chapter also includes some questions and discussion which arose in the seminar.

The students were at different stages of their training, but presumably shared a basic familiarity with, and understanding and acceptance of the analytic concepts of Freud, Klein, Bion and Meltzer which would greatly exceed that of the average non-psychoanalyst reader. In his introduction the author acknowledges the problem in the seminars of 'presenting material that was familiar and elementary to some, and complicated and obscure to others'. This 'problem' must loom even larger as the book is offered to a readership not only of psychotherapy students and practitioners but also to 'educationalists, social scientists, doctors and all those who value the endeavour to enrich their work with imagination', and it is from somewhere within the latter category that I myself approached this book.

To do justice to the author required from me a certain initial 'suspension of disbelief' – a willingness to accept at face value the statements which underpin the argument so as to follow its thread, rather than be repeatedly held up by apparent knots in it. Proceeding through the book I felt my comprehension of some of the concepts was improving, and that there were indeed many ideas and reflections which were enriching and thought-provoking. Inevitably the questions raised by the students in the discussion did not address my personal doubts and difficulties with some of the 'elementary' assumptions of Kleinian theory, since they were entering the argument at a different level, and had their own problems with the material.

Some chapter headings give a flavour of the range of the seminars: 'Dreams: who writes the scripts?' 'Identification and the toileting of the mind', 'The mermaid and the sirens' (with an interesting interpretation of the differences between these two mythological creatures and their psychological counterparts).

A recurring theme, expanded in the penultimate chapter called 'Psychosomatic and somapsychotic' was the concept of 'maternal reverie' which I understand to be the means whereby the mother 'contains' the infant's earliest attempts at thought, and feeds them back to him so that some kind of understanding begins to develop. If this aspect of mothering is

inadequate, or later trauma intervenes, there ensues a relatively 'mindless' state in which the infant can not learn to distinguish between physical discomfort like colic and the pain of the mother's absence. (The parallel with the adult somatiser is obvious.) The role of the analyst in acting as a container and processor for the client's distress and its development into insight is clearly a continuation of this maternal function.

I was struck by the thought that as GPs we play a somewhat similar role with many patients who will never be in a formal psychotherapeutic relationship, but who need to have their distress heard and reflected on, and somehow returned to them in an ameliorated and more bearable form. To be able to do this the doctor has had to learn to think symbolically and to recognise the interplay between the physical and psychological, and then to be able to pass on this understanding to the patient. For some doctors, and patients, the initial impact of trying to do this is like my problem with some of the material in this book – it can almost seem like a foreign language, or like discussing a religion one does not share. Perhaps there is merit in exposing oneself to such a challenge occasionally, by reading a book which makes such demands, both in order to learn something new, and to remind ourselves of what we require of our patients when we try to convince them to share our way of understanding their illness.

**Marie Campkin**

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## Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to the Editor, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG, UK. Email: JVSalinsky@cs.com

**Style**

Articles should be typed on one side of paper only and double-spaced. Abbreviations must be explained. Research papers will be peer reviewed to assess their suitability for publication.

**References**

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

We welcome the submission of articles on 3.5 inch computer disk. Authors should supply the name of the file on each disk and send a hard copy in addition. Better still, you could send them by email to **JVSalinsky@cs.com**

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# Obituary

## Irene Bloomfield (née Herzberg)

Born 9 September 1910 in Berlin – died 23 July in London

She was the senior psychotherapist at University College Hospital in London at the time of Michael Balint's death and, with Dorothea Ball, took over the leadership of the Wednesday afternoon group of which I was a member, for about 9 months. She was a very lively and active leader who was both intellectual and intuitive. Her main contribution to psychotherapy was in dealing with the psychological scars inflicted by the Nazis on those they persecuted and the survivors of the death camps and their children.

She was born Irene Herzberg to a psychiatrist father and journalist mother in Berlin. Her family experience watching the growth of Nazism as a teenager gave her a passionate lifelong concern for people's suffering. To begin with this found expression in Zionism. At about the age of 20 she obtained a permit to escape to England as a domestic servant, but within a few years she went to Palestine, where she served in the Jewish Brigade. After the war she demonstrated against the British mandate's refusal to allow death camp survivors to enter Palestine, which led to a term in prison. Subsequently she began to feel that she could serve humanity best by helping individuals rather than by political action.

After returning to Britain, she studied psychology at night at Birkbeck College. Her first post was in Exeter in child guidance. Later, in 1957, she transferred to UCH where she was influenced by Michael Balint, S. H. Foulkes and Robin Skynner. She pioneered the professional training in counselling of clergymen of all denominations including Anglican and Roman Catholic priests, Salvation Army captains and rabbis at the progressive Leo Baeck college. She visited Poland and East Germany while both were under Communist rule.

I remember one random case in a long surgery where I had difficulty remembering the details of a consultation with a man in a long grey raincoat when she asked "do you really care about this man?" That made me sit up and take notice of her. Another case where a patient had tried to kiss me, drew a dismissive retort that every therapist has to face this situation sooner or later and learn to deal with it.

Her efforts enabled the entire UCH multidisciplinary team to work harmoniously. She taught medical students to think about the doctor-patient relationship and was a popular supervisor of their psychotherapy training. Officially she retired in 1983 but she carried on unpaid, running group-therapy programmes and seeing patients well into her seventies. She found that patients with religious beliefs, once their immediate psychological block had been removed, made more rapid progress than non-believers. This intrigued her, though she herself was not a believer. With her Anglican and Roman Catholic colleagues she founded the Association for Pastoral Care and Counselling.

With the late Rabbi Hugo Gryn as an ally, she set up the Raphael Centre to provide counselling for survivors. There, she began to realise that the children of the survivors had inherited some of the burdens of their parents. Her last conference, organised by the Tolerance Foundation in Prague concerned the training of groups to work with the remaining survivors and their children.

The one unresolved problem in her own life was her ambivalence about religion. Her intellectual parents did not practice Judaism and left her to make her own choices, but without the necessary tools. She summed up her plight by saying she could never believe, but neither could she reject belief. That personal paradox did not prevent her imparting great strength to several generations of those who led the religious life at parish and congregational level. In 1966 she married Richard Bloomfield but they had no children and the marriage was dissolved in 1971.

**Peter Graham**

# Secretary's Report 2000-2001

The academic year 2000-2001 began for the Society with an unusual enterprise. We had been asked to give a demonstration of Balint work to Newham General Hospital, a District General Hospital in the East End of London, on Wednesday, September 13th. They have a monthly educational half-day when all elective and clinic work is suspended for a hospital-wide educational session. The Society's link with the hospital is that it is the local hospital for Peter Graham's practice and my own, and the wife of the educational director is on the Balint Council. We decided to give a group experience to as many doctors as came, arriving with 10 leaders, and setting up groups after a short introduction. There were 51 group members in 5 groups, mixed by speciality and job grade, having let the participants assign themselves to the groups. Group participation was good though varied between groups, and feedback sufficiently positive to schedule another day next year, despite a few people who seemed to want a more didactic approach to the doctor patient relationship.

At the end of that week we were off to Exeter College, Oxford, for the annual weekend. 39 people attended so we had 4 groups, including 2 medical students and one practice nurse. The novelty this year was no fishbowl and the introduction of a short paper session on Saturday afternoon. The latter was very successful, with a packed lecture theatre hearing 3 papers: "The girl with misty eyes", given by Dr Sotiris Zalidis; "Teaching the doctor-patient relationship through Balint groups: the possibility of a time for reflection during medical training", given by Dr Rita Francis Gonzales y Roderigues Branco, Faculty of Medicine, Federal University of Goias, Brazil; "What are you feeling, Doctor?: the story of a Balint research group", given by Dr John Salinsky. The weekend ended with the AGM of the Society at which 4 new members joined the Society, keeping us stable at around 150 members.

The RCGP lecture series began on 24th of October 2000 with Jeff Roberts talking on "Snakes and ladders: some experiences of the psychosomatic interface". Ten people signed the attendance register but not everyone does so. For most lectures attendance is between 15 and 20. The 28th of November brought the well known medical anthropologist Cecil Helman to speak from his speciality on "Body and self: are they the same thing?" In the New Year, on March 6th, 2001, Heather Suckling and Chris Donovan spoke of their work at the RCGP on "Adolescent Consultations". This seemed likely to make an interesting research group topic.

The final lecture, the Balint Memorial Lecture 2001 on April 24th, was combined with a reception to launch the new Balint book, *What are you feeling, Doctor?* The evening was introduced by Dame Lesley Southgate, current President of the RCGP, who had written the book's Foreword. She spoke very warmly of the power of Balint work in general practice, and of the interest the book may have for many primary care workers. We continued with one of the principal authors, John Salinsky, giving the Memorial Lecture, entitled "Psychoanalysis and general practice: What have the Romans done for us?" This was a stimulating discussion of our, and particularly Balint work's, ongoing relationship to psychoanalysis, using a clip from the Monty Python film *The Life of Brian*. Special visitors on the occasion, attended by over 60 people, were Dr Marie-Ann Puel, President of the Société Médicale Balint (France), and Dr Heide Otten, President of the German Balint Society.

On the weekend of May 11th-13th Dr Caroline Palmer, GP in Colne, Lancs and a Balint Council member, organised a Balint weekend in Chester. It turned out to be a unique event. The venue, Gladstone Conference Centre, just outside the city walls was excellent. We had just nine participants, including Heather Suckling and myself, so there was one group. Something made the chemistry work extremely well both in and out of the Balint group, probably the presence of a practice counsellor and a social worker, who is working in a Primary Care Mental Health Team. There was a lot of fruitful discussion on how to provide counselling and psychological services through Primary Care Trusts, as two participants were responsible for their respective PCTs in mental health. We hope to run another May weekend here next year.

The Group Leaders Workshop is continuing under the firm organisational hand of Dr Peter Graham. It now meets at the Tavistock Clinic by invitation, but anyone wishing to attend can get in touch with me to go onto the mailing list. Groups may now be presented in the form of process notes rather than formal audio transcripts (as this has proved logistically and financially impossible recently). The Workshop is an important part of the ongoing leadership accreditation system, which has been put into place over the last two years.

The finale of the year was another gracious and delicious Annual Dinner at the Royal Society of Medicine on June 25th. The President, Heather Suckling, addressed the 21 diners after dinner on her experience of medical education work in Macedonia "Balint in the Balkans".

**David Watt**

# Report on the First Balint Spring Chester Weekend Workshop

On May 11th, this year, a small group of G.Ps., and associated professional workers met together in Chester and spent the weekend making and experiencing magic! It wasn't just the comfortable country house atmosphere of the Gladstone Centre, its delightful grounds, good food or the time spent exploring the ancient city and its attractions, but the magic of attentive, intuitive and compassionate listening which made the week-end so special.

They each had brought with them in their minds, troubling clients or awkward situations with their patients, which had rendered them professionally ineffective, and disheartened. By the end of the weekend, despite hours of attentive listening to often harrowing and complex stories, each participant left feeling refreshed and invigorated, and eager to return to the situations which had previously caused them such grief, equipped with new understanding, compassion and insights.

The group met in an intimate little attic room, almost as if in an ivory tower, withdrawn from the world and enabling some higher functioning to occur and perspective to be brought into play. The situations and problems discussed and experienced, were however very down to earth and grounded in reality. The first case, presented on the Friday night, was riveting, painful and shocking, and the group took off straight away helping tease out the different strands of the story and helped share the concerns and empathised with the presenting doctor.

The theme that recurred so often during the case presentations and discussions during the weekend was ambivalence. It was sometimes our ambivalent feelings towards our patients or clients, such as feeling that we may not actually like them enough to want to know or understand them better, or that their situation and illness is so horrific that to function we may block it out. In other presentations, the theme was of a more existential ambivalence, about our role as doctors etc, as agents of social control, the public health / personal care split, or our sense of relief, but also guilt at times to be the ones not suffering the patient's pain, and sometimes embarrassment / gratitude about our position of power or good fortune. The fact that the group included people from allied disciplines helped demonstrate and materialise these feelings within the group, and the group worked very effectively as a result, with head and heart.

It is also interesting to ask why the group explored this theme so much, and the leaders wondered whether the groups' ambivalence about their field of work mirrored the feelings and mood of the public and press, in which the medical profession are either hailed as saintly heroes or demonised as heartless monsters.

Everyone who came said it had been a really positive and enjoyable experience, and the evaluation forms were glowing about the usefulness of the Balint technique! All who came are keen to come again, and so the Gladstone short course centre has already been booked for the weekend of May 10th 2002! We hope that more of you can come and make it even more of a success this time.

**Caroline Palmer**

# The International Balint Federation 2001

by John Salinsky

I have been writing this column now for several years and the existence of the International Federation should be well known to everybody. However, for the benefit of new readers let me say that the Federation has existed since 1974 and its role is to help Balint enthusiasts all over the world to keep in touch with each other, exchange ideas and find opportunities to travel to each others' countries. There are at present 16 affiliated Balint Societies from different countries and individual members in another 12 countries. The council of the Federation meets twice a year to discuss current issues and plan International Congresses (see below for this year's Congress). The council meetings are held in different European countries in no particular order but we try to achieve a balance between East and West.

In October 2000, the council met in Paris as guests of the Société Medicale Balint. Among other things we discussed the training and accreditation of group leaders in different countries (always an important subject). Dr Anita Häggmark gave us a very interesting account of a new leader training programme which has recently started in Sweden. This meeting was preceded by a special gathering organised by the SMB and entitled 'Vieille Garde and Nouvelle Vague'. The idea was to bring together some of the surviving 'Old Guard' Balintians who knew Michael Balint personally – and to invite the authors of some new books about Balint to come and discuss their work. Michelle Moreau-Ricaud introduced her biography *Michael Balint: le renouveau de l'École de Budapest* and Messrs Courtenay, Sackin and Salinsky waved copies of *What are you Feeling, Doctor?* After some discussion about the books, the old timers got down to their reminiscences. The oldest guest was Dr Armand Steinberg (aged 90) the first president of the SNB, who reproached us for not sitting in a circle in true Balint style. He and a number of colleagues had vivid memories of what it was like to be in one of Michael's groups. Some found him rather challenging, even frightening! But Paul Sackin remembered him from a student group in London in the sixties as being very warm and supportive and not at all scary.

Then, in March 2001 the council members gathered in the ancient town of Zadar on the Adriatic coast of Croatia. To our surprise, the actual meeting took place at sea, on the good ship 'Angelina' which took us on a cruise (accompanied by a substantial buffet) to one of the offshore islands for which Croatia is famous. The waves were a little frisky and papers tended to slide around the table but we managed to get some work done, including a discussion of the plans for the next International Congress which will be hosted by Croatia's neigbouring country, Slovenia. If you have not already booked your place at the Congress you can read about it below:

**The International Federation going aboard the 'Angelina'.**

# INTERNATIONAL BALINT FEDERATION

## THE 12th INTERNATIONAL BALINT CONGRESS IN PORTOROŽ, SLOVENIA

## *'BALINT AFTER BALINT'*

The International Balint Federation (of which the UK Balint Society is a founder member) will be holding the 12th International Congress from **Wednesday 3rd to Sunday 7th October 2001**. The host country is **Slovenia** and the venue is the seaside resort of **Portorož**, on the Adriatic coast.

If you have not already booked your place there is still time to do so! If you have happy memories of the Oxford International Congress (1998) and would like to repeat the experience, this is your opportunity. As far as Balint is concerned, Portorož is the place to be this year and many of the friends you met at Oxford will be there. On the other hand, if you have never been to an International Balint Congress, maybe it's time you did. Bring the family and and combine it with a few days holiday in one of Europe's most attractive and varied countries.

*But what goes on at these Congresses? Will it be in English?*

OK, here is the information you need:

The idea is to get together with people from all over the world who are looking after patients (just like yours) and getting perplexed by the intricacies of the doctor-patient relationship (just like you do). You can listen to original papers by Balint enthusiasts with different ideas and points of view. Most of these will be in ENGLISH. Some will be in Slovenian or maybe Italian but there will be simultaneous translation. There will also be lots of Balint groups running every day. They will be in different languages and you can join one in English. However, you will still enjoy the experience of working closely with people from different countries who can speak English nearly as well as you do. There will be doctors and psychotherapists from countries such as Sweden, Finland, Germany, Israel, Brazil, Hungary and Romania who are quite happy to work in English. And very interested to learn how we do things in England which is, after all, the place where Balint groups began.

There will also be plenty of time for meeting your friends socially, eating, drinking, relaxing and sight-seeing.

*How do I get there?*

There are daily flights to Ljubljana, the Slovenian capital via British Airways or Adria, the Slovenian national airline. From the airport there will be a special bus service to take you to Portorož. You can also fly very cheaply with Ryanair to Trieste ( Northern Italy) which is only 70Km from Portorož (transport can be booked for you).

*Where will I stay?*

The Congress will take place in the Metropol Conference Centre which includes a number of hotels with different price ranges varying from economy to luxury. The details are all in the Final Announcement brochure which you can obtain from the Secretary of the Balint Society (David Watt) or the Secretary of the International Federation (John Salinsky). You can also contact the chief organiser Dr Zlata Kralj. Her email address is Zlata.Kralj@guest.arnes.si And there is a Congress website at www.balint-si.com.

*How much will it cost?*

The registration fee is E400(Euros) which is about £250 sterling before July 16 rising to E500 (£300) afterwards. There are big reductions for students. Meals are not included but there are plenty of cafes and restaurants within and around the conference centre. Hotel prices range from E40 - 76 (£25-50) per night for a single room.

**Social programs:**

Excursions will be arranged to other parts of the country including the ancient town of Piran with its well-preserved Venetian Renaissance architecture and the spectacular caves of Postojna and Škocjan. You can also visit some beatiful tranquil lakes surrounded by snowy Alps. And don't miss the ruritanian charm of Slovenia's capital city, Ljubljana. There will be a conference dinner and farewell party on Saturday evening.

I look forward to seeing you in Portorož!

**John Salinsky**
**General Secretary,**
**International Balint Federation.**

# The Balint Society Prize Essay, 2002

The Council of the Balint Society will award a prize of £500 for the best essay on the Balint group and the doctor-patient relationship.

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2002** and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

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# International Balint Award 2002 for Medical Students

For more than 30 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verità' (the mountain of the truth) in Ascona. Owing to their influence on medical training in medical schools these seminars are acknowledged as the "ASCONA MODEL" (WHO), and their main purpose consists in Balint teamwork, examination of the doctor/patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. An award of **SFR 10'000.** will be made to the author of the best description.

The criteria by which the reports will be judged are as follows:

1. **Exposition:** the presentation of a truly personal experience of a student-patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. **Reflexion:** a description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. **Action:** the student's perception of the demands he (or she) felt exposed to, and an illustration of how he then actually responded.
4. **Progression:** a discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st of March, 2002** to the following representative:

Dir. Dr. med M. Tomamichel, Via Simen 10, 6900 Lugano.

**The presentation of prizes will take place at the Monte Verità Centre, in Ascona, Switzerland on the 15th of June 2002.**

Information can be obtained from: Prof. Dr. med. Dr. h.c. B. Luban-Plozza,
Foundation of Psychosomatic and Social Medicine,
Via Monescia 2,
6612 Ascona.

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The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.
Produced by Haverstock Publications, 249 Haverstock Hill, London, for the Balint Society

Printed by The Galloway Gazette Ltd., 71 Victoria Street, Newton Stewart, DG8 6PS