THE BALINT GROUP IN GENERAL PRACTICE

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Summary

The development of a psychotherapeutic apporach to general practice since the 1920's by Michael Balint is described. The importance of getting in touch with patient's feelings and conflicts is emphasised. The aim of the approach is to help the patient understand the meaning of the problems they present to the doctor to listen to the hidden reasons for the patient's visits to him. A Balint group is described.

The Balint Group In General Practice

There has been considerable interest and effort in the development of a technique for psychotherapeutically influencing the patient, which is germane to General Practice since 1920s[1-12]. The issue remains important because epidemiological studies that have surveyed General Practice, show that this approach picks up far more psychiatric cases than a search of hospital records and General Practitioners refer only about 5% of their adult psychiatric patients to hospitals[13]. It has also been shown in the UK that GPs fail to detect about one third of their patients' psychiatric disorders[14]. For each disturbed child referred to a Child Guidance Clinic, there are 5 equally disturbed children not referred[15]. In addition GPs who practice the Balint approach have taken a special interest in patients with psychosomatic problems. Balint was always interested in emotional and relationship problems of General Practice and commenced Seminars for GPs in Budapest in the late 1920s. He restarted this work in the late 1950's, in London, when many GPs were anxious about their future role within the order of medicine, and it was widely recognised that medical teaching and medical practice had been neglecting the emotional aspects of General Practice. In addition Balint[15] as well as Mallan[16] had a major impact on psychiatry with the development of short term psychoanalytic psychotherapy in the context of post World War II Britain. Balint in particular

The Renaissance in General Practice, a phenomenon in the 1960's owed a great deal to the recognition of the enormous therapeutic potential in the doctor/patient relationship, a factor of which Balint[1] had opened the eyes of the profession and which he had begun to examine. It became clear to Balint that the most common "drug" prescribed in General Practice was the doctor himself and the chief aim of Balint's[1] initial work was to describe certain processes in the doctor/patient relationship - the undesirable and unwanted side effect of the "drug" doctor, which caused the patient and his doctor unnecessary suffering, irritation and fruitless effort. Balint[1] was trying to describe the diagnostic signs to enable G.P.'s to recognise those pathological processes or side effects in himself in good time; in short a kind of pharmacology of the doctor. He realised very quickly the disquieting revelation that very little was known about the timing and dosage needed for this oldest of all "drugs", the doctor himself. Balint[1] felt it was very important for each doctor to know what kind of patient he was unsuccessful with or what his blind spots were. Stein[12] felt that coming to terms with the feelings that the patients stirred up in doctors was a significant part of a doctor's maturity.

At the time Balint commenced his group, General Practitioners had no established methods for training them in psycho-diagnosis and psychotherapy. He felt that the research he wanted to do could only be conducted by G.P.'s while doing their every day work undisturbed and unhampered, sovereign masters of their own surgeries. He organised G.P.'s into groups with himself as leader. He resisted a teacher/pupil relations with the G.P.'s but aimed at developing a free give and take atmosphere in which everyone could bring up his problems in the hope of getting some light on them from the experience of others in the group. G.P.'s were requested not to bring detailed written case histories, as it was felt that this would involve a good deal of secondary elaboration of the clinical material which was exactly what Balint wished to avoid. From the beginning Balint's intention was that a G.P.'s report should include as full an account as possible of his emotional responses to his patient or even his emotional involvement in his patient's problems. A frank account of this, the emotional aspect of the doctor/patient relationship could only be obtained if the atmosphere of the discussion was free enough to enable the

G.P.'s to speak spontaneously. The problem with a carefully pruned written report was that there was a weeding out of most of the remnants of the emotional processes in the mind of the reporter, or of his critics, thereby giving disproportionate emphasis to intellectual processes. Balint wanted to avoid the ending up with a detailed written clinical report with a kind of detached scientific assessment of the patient with all the emotional feelings extracted.

Balint[1] emphasised the importance of listening as distinct from traditional medical history taking. He emphasised the importance of intervention at the early "unorganised" phase of the patient's illness. It became clear that a doctor's feelings for his patient often interfered with the treatment which lead to a poor outcome. Nevertheless, if the doctor could be trained to understand the meaning of his emotional reactions to the patient, then the treatment was often enhanced. Balint[1] pointed out the danger of complying automatically in diagnostic work witht he rules of "elimination" by appropriate physical examination" as a protection against missing a possible organic illness, and the fact that this rule was achieved only as a price of establishing a "ranking order of illnesses and of patients attached to them." He also emphasised the danger involved of "elimination by appropriate physical examination" on finding an irrelevant physical sign and helping the patient to "organise" his illness around it sometimes with calamitous consequences. It was clear that missing a psychological problem, could have equally serious effects to missing a physical one.

The importance of not trying to reassure a patient before it was clear what the patient's visit was about, was something that came up in these early Balint Groups.

The initial approach that Balint[1] used was to bring patients back for long interviews at the end of surgery, but this was felt to interfere with the normal flow of general practice. This led to the development of the flash type of interview that could be used in the normal 5 to 15 minutes available for a general practice consultation[8]. The Flash consists of a spontaneous mutual awareness of something important in the patient. For the doctor to experience a flash of insight, he has to allow himself the discomfort of abandoning his own ideas of what should be happening and tune into the patient's distress.

Often a flash concerned the relationship between the doctor and the patient, but even if it does not, the relationship is changed by the flash. The main characteristics of the flash technique are the intensity of contact between the patient and the doctor; the freedom the technique gives to the patient to use the doctor in his own way, the freedom the technique gives to the patient to use the doctor to make his own observations and to escape from theory and interrogation; the freedom it gives the doctor to be used i.e. to give himself without anxiety that the patient will abuse his time; the discipline it imposes on to the doctor during the brief interviews to observe both the patient and his thoughts and feelings. The doctor gives the patient one ear, but the other is listening to his own emotional reactions to the patient. The doctor's task is to observe how the patient talks, acts, thinks and behaves, and why this causes him pain, what he is like, what he seems, in an obscure and confused way, to share with his doctor; what really makes him want his doctor's attention. The Flash technique allows the doctor to cut across the massive amount of data that he has about the patient.

Aims of the Balint approach

It is hoped that the changes that occur in the doctor/patient relationship in the Consulting Room will generalise to other relationships outside it. A reduction is aimed for in the patient's symptoms, e.g. depression or anxiety. This approach also aims at reducing emotional tensions between the patient and people in his family and at work.

In addition the Balint Group for G.P.'s has the following functions:

(A) Support.

(B) The development of new strategies in a context of general practice and the development of a science of practice.

(C) To allow the G.P. to reassess his practice techniques.

(D) It has an educational element, particularly in relation to psychosocial problems and can be a useful element in a G.P.'s continuing medical education.

Petroni[11] has suggested an additional aim of personal care where each G.P. brings to the group any personal concerns relating to his own life and explores any issues relating to any member of the group including the leader or his practice.

The relevance of psychotherapeutic approach to general practice developed by Balint was studied in an Irish context so that the appropriateness of such an application could be ascertained.

An Irish example

The Balint Group met for approximately two years at two weekly intervals and the meeting lasted 1½ to 2 hours each. Each G.P. told the story of his patient in his own way. The ensuing presentation was acceptable because something of value emerged which probably would not have been achieved in any other way. It is possible, with exhaustive detail and the rigid presentation format, to squeeze the life and feeling out of a presentation. This technique departed from the traditional beside teaching, but it did so in a secure knowledge that the absence of the patient himself was no loss - the central subject of this study, the doctor/patient relationship, was present and mirrored in the group/doctor interaction. Free from the constraints of a formal and logical presentation, the reporting doctor was able to represent and almost impersonate his patient. The following is an example of a typical case and a discussion and understanding that ensued.

The doctor described how he was called out late at night to see a child who had had an asthmatic attack. The doctor examined the child, but felt the child did not need antibiotics, which the father was insisting on the doctor prescribing. The doctor explained to the father that they were not required in this instance. The G.P. became aware of some irritation and anger at the father's persistence. The Balint group were then able to point out to the G.P. that the feelings that were welling up within him gave him an understanding of how it felt for this child to live with this father and the kind of feelings that this father stirred up in the child. This understanding had the effect of reducing the doctors sense of irritation.

Another G.P. had seen a patient for a number of years with tiredness, headaches and pains in her neck. No physical abnormalities were found. Initially, she was slow to trust him and had a fear of intimacy. The group suggested that something

traumatic might have happened earlier in her life. Gradually, she began to trust the G.P. over a number of sessions and was able to tell him of a secret of her trauma that she had withheld for fifteen years. The relationship with the G.P. was changed by this disclosure and further discussions could take place on the basis of exploring her real psychological conflicts.

The Group helped a G.P. cope with a young mother, who presented over a long period with complaints that she could not stop her baby crying, could not give him enough to eat and could not keep him happy. The group focused on the mother's uncertainty about her ability to be a mother and helped the G.P. to give the mother space to express her anxieties about herself in the first instance and then to support the mother in her mothering role. The meaning of the early losses that the mother experienced in her childhood were explored and understood. This helped to make the doctor/patient relationship more effective and the increased understanding that the Group was able to give the G.P. helped him.

Some G.P.s described the Group as time consuming but useful personally, the fact that some G.P.s were at different stages in their careers was a source of some conflict. There seemed to be a need for groups for trainees and groups for senior G.P.s. Another point of stress was that feelings of participants stirred up in a Balint Group are much more intense than a G.P. would normally expect in a teaching/learning situation and attention needed to be directed to these feelings by the leader. A re-evaluation of old styles of practice arouses very considerable anger.

The Group was a learning experience and it is usually not possible to learn from such an experience and the rethinking of their practice without some pain being involved. The Group challenged some idealised fantasies the G.P.s had about themselves and the notion that their old style of general practice was the only way. The switch over from the old to the new style of general practice involved the G.P.s tolerating some uncertainty about their styles of practice and their identity as practitioners during the change over period. It is important for the leader to attend to these as well as rivalries between participants. It would be probably be preferable if the Group be led by a psychotherapeutically oriented G.P. This leader would be easier for G.P.s

to identify with. In practice this is often not possible as it is one of the core psychotherapeutic professionals who takes the role of Group leader. A decision was taken by the leader to apply very few group dynamic principles but to focus on the doctor/patient relationship in the consulting room and the reactions of individual doctors in the group to history of the patient presented. Some G.P. training groups focus more on group process and this had the advantage of giving the G.P.s some further personal understanding of themselves. The disadvantage might be that it would take the focus off the doctor/patient relationship and make the group more group therapy experience. Likewise, the personal care and personal concerns of the G.P.s were not dealt with. There would appear to be a need for separate groups to be set up to focus on these issues, and of course these groups would also have secondarily a beneficial effect on the doctor/patient relationships.

It is also became clear that G.P.'s were more successful when they got involved with patients, hesitated in the prescription of psychotrophic medication, and coped with the tensions and countertransference feeling without rejecting the patients by referring them onto someone else. The countertransference feelings were seen as giving the doctor information about the patient. The possibility of a mismatch between doctors and patients was also discussed. Sometimes a Balint Group can help a G.P. to resolve these mismatch issues. At other times it became clear that referral was appropriate, and that patients resolved these mismatch issues by transferring to another doctor.

One G.P. summarised the effect of the Balint Group on him as follows: "The Group discussions made me a better 'talking doctor' and the patients appreciated this. We thus had a more effective relationship". This was what was set out to be achieved.

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