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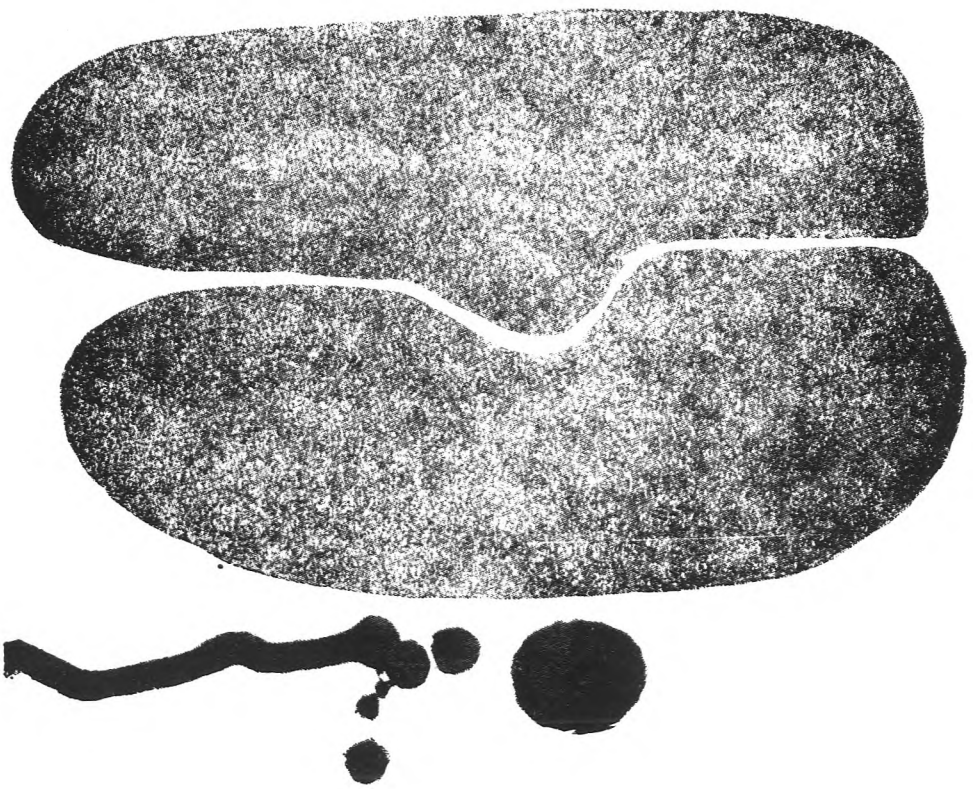

Vol. 15

# JOURNAL OF THE BALINT SOCIETY

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*Contents* *Page*



**Editor:** Philip Hopkins

*Photograph by Dr Edward H. Stein*

DR MICHAEL BALINT
(1896 - 1970)

# Editorial

Exactly thirty years ago, in 1957, Michael Balint's widely acclaimed book, *The Doctor, his Patient and the Illness* was published simultaneously in Germany and in the United States of America, as well as here in Britain.[1]

Although his ideas and his work with general practitioners, together with their sweeping implications, are well enough known and accepted by many doctors here as well as all over the world, there has been relatively little interest shown by the large majority of the 30,000 principals in general practice in our National Health Service.

They have not rushed to form and work in Balint-groups, as doctors have done in other countries.

In a discussion with me just before his death at the end of 1970,[2] Michael told me that he thought a lot could be done to improve the training of medical students. 'But,' he explained, '. . . this would be very difficult because it means reorganising medical training, which (then, as now) rests on the basis of a mosaic structure.'

'Medicine,' he said, '. . . consists of a mosaic: there are large and important pieces, and small and unimportant pieces; and the student is a nomad who runs from piece to piece, spending two weeks, three months or so with each piece according to its importance. What we want is that he should stay put with a few patients, but this is against the whole structure. It won't be easy to integrate our sort of training, with its very intense and ongoing relationships like in family practice, with a few patients, with the very extended and highly important training so that he should have a good view and gain good knowledge about all branches of medicine.'

Michael went on, 'The right place to start is to create a few university trainers who can do this, because otherwise anything you can organise will be nonsense . . . But this is very difficult, because the people who are selected for university posts, the best people, go through the university brainwashing, teaching hospital atmosphere, and we cannot have the people who are needed . . .'

Fortunately, there has been a change, a remarkable change. There are now 16 units in 30 teaching hospitals where undergraduate medical students are taught about general practice by Balint-trained doctors, ten of them Professors of General Practice, one a Reader, four are Senior Lecturers and one a Director of Medical Studies in General Practice.

The extent to which Michael's work with general practitioners, and the importance and use of the doctor/patient relationship, are discussed, varies enormously, but the survey described in the Michael Balint Memorial Lecture shows that it is far less in those other departments where the teachers have not had personal experience of Balint-work. (See page 9)

In his book, Michael put on record, in the chapter containing the *Summary and Outlook for the Future*, that, '. . . in 1955, at one of the meetings of the Medical Section of the British Psychological Society, a consultant of a big London teaching hospital proudly stated that all medical students at his hospital received adequate training in the psychiatric and psychotherapeutic skills needed in general practice. This adequate training consists of two short courses, followed by *a six-week attachment in the psychiatric department*. Compare, with the psychiatrist's pride, the indignation of a professor of anatomy, or of an obstetrician, if anybody dared suggest that six weeks' training in anatomy or obstetrics was sufficient for future general practitioners. Moreover, we know that many general practitioners, after qualifying, will never attend a confinement, whereas all of them will have to cope with their patients' psychological problems as an inevitable part of their daily work'[1] (p. 283).

In further discussion about the need general practitioners have for developing the special skills required in this area of their work, he stated frankly that he could not see how facilities can be provided in an academic curriculum for all students to acquire such skills, nor did he know '. . . whether it is desirable, or even feasible, to demand this of every student. On the other hand, every doctor possessing these skills is a better doctor than he would be without them'(p. 288).

Nor, it seems, have any others made such progress in this matter in the past seventeen years, except the one ray of light which has come from University College Hospital, where Balint held a student-group until the resistance from other specialists resulted in his having to stop.[3]

Heinz Wolff has described his experience of supervising over many years, students' psychotherapeutic sessions with patients, in student-groups, and can be highly recommended to all who have anything to do with training students,[4] or who are themselves concerned with treating patients whose need includes the application of those psychotherapeutic skills which Michael and Enid Balint have described so well elsewhere.[5]

Michael diagnosed that, '. . . general practice is seriously ill, but the illness is benign and, provided the right therapy is applied, the prognosis is good' (p. 292).

The problem now is to find a suitable method to provide the right therapy. Perhaps we in the Balint Society should be looking for ways to influence those working in general practice teaching units to extend their application of the Balint-method to their students. They could then go on to work with other specialist departments to increase their understanding of the need for students to widen their outlook beyond the physical diagnosis.

The good prognosis predicted by Michael will then be within our reach.

**P.H.**

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# Michael Balint: Training and Research

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*The Seventh Michael Balint Memorial Lecture, given on 19th May 1987.*

I am more delighted than I can possibly say, to have the honour to give this, the seventh Michael Balint Memorial Lecture. But as I feel that I am representing them tonight, I want to share the honour with all the members of those first two groups* referred to in the preface to his book, *The Doctor, his Patient and the Illness.* Michael Balint wrote, 'The book represents part of the results of a 'research project' by a team of fourteen general practitioners (in two groups) and a psychiatrist'.[1]

Michael later came to refer to us as his 'Old Guard', and it was our patients and our problems which provided the material for that initial research project which, in turn, was the basis for the training scheme which Michael and Enid Balint, who I am very happy and pleased to see here this evening, later developed jointly.[2]

Tonight, it is also appropriate to commemorate the publication of *The Doctor, his Patient and the Illness,* which appeared simultaneously in Germany and the United States of America, as well as here in Britain in 1957, exactly thirty years ago. Since then, it has been internationally acclaimed for its profound effect on the practice of medicine all over the world.[3]

Although most of us here will be remembering Michael Balint for his outstanding work in connection with doctors in general practice, it is not out of place to recall that he and Enid Balint also had an enormous influence on the training of social workers at first in the Family Discussion Bureau, now the Institute for Marital Studies; on doctors concerned with the Family Planning Service, who now have their own Institute of Psychosexual Medicine; as well as on the organization and practice of the probation services, and on the development of brief psychotherapy in Britain.

Michael's place in the world of psychoanalysis was recognised by his election to the presidency of the British Psychoanalytical Society. He was in his third year of office at the time of his death on the last day of 1970. During his fifty years as a psychoanalyst, Michael published seven books and well over one hundred papers.[4]

Shortly after I returned from my national service, at first to continue my surgical career, one of my hospital chiefs invited me to share his consulting room with him at Number 3 Park Square West. A little later I replied to an announcement inviting doctors to attend a "Discussion Group Seminar on Psychological Problems in General Practice." I met my near neighbours of Number 7 Park Square West, Michael and Enid Balint. My experience of training-cum-research was about to begin.

Michael Balint described the beginnings of his researches into the doctor/patient relationship, in an interview I recorded with him on 27 November 1970, just five weeks before his death on the last day of 1970.[5, 6]

**Dr. Michael Balint:** At the end of the war, in 1945, I got a job in London as Director of a Child Guidance Clinic and started my practice here. A few years later the Tavistock Clinic invited me to help train social workers . . . and that was how we worked out, Enid and I, the technique, but of course not yet for medicine, for social workers.

**P.H.** The main point of course, is that it was training and research?

**M.B.:** Yes, right from the start. And training and research came in two directions: training and research of the general practitioners to understand psychological problems; and of the psychiatrists to understand general practice, and again extend their points of view far beyond the narrow field of the one-to-one relationship in the analytic consulting room.

In that same interview, Michael described something of the scientific basis of his earlier training:

**M.B.** When I qualified, I had to stand in for my father and developed some understanding of what general practice was. But all this was, let's say, not really known by me consciously, it was there. Because my training, real training which was consciously accepted and really interested in, was almost entirely scientific: my main interests were chemistry, physics and mathematics, exactly as befits a . .

**P.H.:** . . a proper doctor . .

**M.B.** . . a proper doctor . . and I have almost become an electrical engineer, and it was really touch and go. But anyhow at the end I decided to become a doctor and started my medical training . . in my later years I became assistant first in the department of physical chemistry, then in the department of hygiene and biochemistry. When I graduated as an M.D. I decided to study biochemistry. At the same time — just the opposite — I got interested in psychoanalysis . . . that was about the turning point in my career, because I then began to think how to utilize all this knowledge that I had got together, and skills and so on, I decided to study what is called now the psychosomatic illnesses. Really I am one of the pioneers — I started it in about 1922 and published a few papers about it . . "[7,8,9,10] Then I came back to Budapest.

Haynall describes how after Michael obtained

*Dorothy Arning, George Barasi, Norman Chisholm, Max Clyne, A. J. Hawes, Berthold Hermann, Philip Hopkins, John Horder, Leo Hornung, Aaron Lask, Philip Savill, George Szabo, Greta Tintner, Anne Zweig.

his Ph.D. in biochemistry he started treating psychosomatic cases at Berlin's Charité Hospital, and so was the first man in history to analyse such cases.[11] This was clearly the beginning of his life-long interest in applying psychoanalytic concepts to clinical medicine, which led to his truly great legacy to medicine, his thesis that the essential basis of general medicine is, and must lie in the doctor/patient relationship, and it is for this that he will always be remembered.

I think that Michael would also have liked to be remembered for being the doctor who tried not to teach. In an earlier paper on training general practitioners in psychotherapy, he reported that a new approach had been tried, '. . namely, to shift the emphasis from 'teaching' to 'training', using group-methods . .' and he stressed 'the limited value of 'teaching' psychotherapy . .'[12] He later expressed his views about this even more strongly in his paper on the structure of the training-cum-research seminars, which was how he liked to describe his groups.[13]

This, I think is the main feature which distinguishes Michael's method from all other methods of training. He wrote in *A Study of doctors* '. . without the pressure of constant and on-going therapeutic responsibility, our method proved, as a rule, unsuccessful.'[14] So it was that he always insisted that we should learn from our feelings when we were with our patients, when we described our case histories to the group, and during all that followed in the ensuing discussions.

This is an appropriate point to digress to report that at this very moment, another very important Balint event is taking place. A meeting is taking place during the whole of this week in Yugoslavia, at the Dubrovnik Inter-University Centre. They are discussing the progress of Balint-groups all over the world, as well as planning for the further development of Michael's ideas and work, and there will be an inaugural ceremony to celebrate the opening of A School of Balint-Method.

It is very encouraging to see this progress in yet another country, which in my view, points to the growing need for an up-to-date assessment of the effects of applying Balint's ideas in general practice. All the more so since John Horder, a previous Michael Balint Memorial Lecturer[15], a member of the 'Old Guard', and a past-president of the Royal College of General Practitioners, and two colleagues, have recently reported the negative results of their preliminary exploration of six accepted methods aimed at influencing the behaviour of general practitioners, whether in their work with patients, or in the organisation of a practice.[16]

They also quoted from the extensive work of Freeman and Byrne[17], and concluded that 'Most people assume that education changes behaviour, but it is not easy to find convincing evidence that vocational or continuing training changes the behaviour of future general practitioners or those in post.[16]

As Horder and his colleagues did not include Balint-training in their study, it occurred to me that the time has come for a review of the literature to see what evidence might be found about the effectiveness of Balint-training. In addition, I conducted a survey among Balint-trained doctors. (Appendix A.)

Predictably, I found that Michael Balint, together with some of his colleagues at the Tavistock Clinic in 1966, was first to describe in great detail an analysis of the outcome of the first fourteen years of Balint-groups. Rating scales based on the doctors' performance in the group discussions were devised. Their use and the results, good and bad, were frankly tabulated and reported in full.[14] Specific criteria, later to be called 'Balint signs', were recognised and listed; newly developed methods for selecting doctors for Balint-training were described, and the changes in outcome recorded.

Sadly, Michael was not to live long enough to follow up the implications of these findings, but others have continued to develop further the work Michael had started, and they have recorded the results of their efforts. Happily, Michael's insistance that training should always be accompanied by research, has been assiduously followed.

In the United States of America, Greco and Pittenger reported their findings with regard the effects of the developing insights into the doctor/patient relationship.[18] In Holland, in 1970, Boer and his colleagues reported on the same subject.[19,20,21] Here, in 1971, Howard Bacal published the results of his pilot study to assess the results of Balint-training at the Tavistock Clinic.[22]

In the following year, over 350 doctors from many countries attended the First International Balint Conference. Many of them described their experience in Balint-groups, and some presented the results of their assessment of Balint-training.[23] The references to all this, and other work are contained in the published reports of four of the International Balint Conferences,[23,24,25,26] especially in the extensive bibliography listed in the Proceedings of the Fourth International Balint Conference.[25]

The interesting and encouraging results reported from the use of questionnaires for doctors participating in Balint-groups in Belgium[26] and Hungary,[27] impressed me very much, so I decided to follow their example.

I sent out 112 questionnaires in December last year. 20 were lost to the survey (Table 1): 1 woman doctor had died: 5 questionnaires were returned by the Post Office marked 'gone away'; 7 of the 92 questionnaires which were completed and returned, (82.23%) had to be discarded because the respondents stated they were not general practitioners; 13 men and

**TABLE 1**
QUESTIONNAIRES COMPLETED BY 85 BALINT-TRAINED GENERAL PRACTITIONERS

| | Male: | Female: | TOTAL: |
|---|---|---|---|
| Questionnaires sent to: | 83 | 22 | 105 |
| Died: | — | 1 | 1 |
| Returned, 'gone away': | 5 | — | 5 |
| No response: | 13 | 1 | 14 |
| Questionnaires completed: | 65 | 20 | 85 |
| | | | (80.95%) |

1 woman did not return the questionnaires, leaving 85 (80.95%) questionnaires for analysis. (See Appendix I)

One doctor stated that she thought it was '. .a rather silly questionnaire', but she was kind enough to complete it! Doctor O.S., who has had extensive experience as a Balint-group leader, and has done a considerable amount of work on the assessment of the effects of vocational training on trainees,[29,30,31,32,33] supported her view and did not complete the questionnaire as he 'disliked the way it was constructed.' He also objected to the 'sloppy phraseology' of my questions, which 'would make it impossible to get consistent answers.'

The rest of his otherwise splendidly constructive letter expressed his views, thereby answering my 'non-questions'. He also referred me to his recently published article in *London Medicine,* in which he wrote: 'My formal training had not prepared me for the stress and unpredictability of general practice and I benefitted a great deal from the group. It helped me through the difficult readjustment from being a junior hospital doctor in a large hospital to becoming a principal in a single-handed practice . . . To this day I still work in a way that is profoundly influenced by what I learned in that first group. I have no doubt that it was a valuable experience; one that any doctor thinking of entering general practice ought to try.'[32] Because I have been convinced that Michael's aphorism, 'if you ask questions, you get answers — and hardly anything else', is right, I deliberately avoided direct questions in my survey, which require a 'Yes/No/Don't Know' answer like, 'Do you feel more at ease with your patients now?' or 'Have you observed any change in your attitude towards specialists?'[27] As indeed I avoid asking a patient direct questions when I need to understand his feelings rather than know how many times a day he empties his rectum or bladder.

I therefore followed the current trend of studying 'attitudes', which is now so popular in papers published in the academic medical journals, as well as in some of our 'comics'; and recently used by Greg Wilkinson in his fascinating paper on general practitioners' attitudes to psychotropic drugs and psychotherapy, which he read at the last meeting of the Balint Society,[28] I decided to use the wording of Horder's conclusion about education and his 'difficulty in finding convincing evidence that vocational or continuous training changes the behaviour of future general practitioners or those in practice.'[16]

I asked two main open 'non-questions' about possible changes in behaviour and performance following medical education and training (Appendix A: Questions 3 and 4). The response was wonderful — I actually received one more completed questionnaire yesterday, bringing the total response to exactly 81% — and I am most grateful to all those who afforded me the most remarkable and enjoyable experience of gaining so much insight into their personal reactions and attitudes to their Balint-training.

There is a close similarity between the numbers of respondents' answers to questions number 3 (Table 2) and 4 (Table 3).

63 (74.2%) of the 85 agreed that education had changed their behaviour, and most of them made it clear that it was their Balint-training which they held responsible for such change. In the same way most of the 68 (80.2%) who agreed that continuing training did change their behaviour, it was their Balint-training rather than the vocational training which had changed it.

**TABLE 2**
**Q.3. Did education change your behaviour?**

| | Female: | Male: | TOTAL: |
|---|---|---|---|
| Agree: | 14 | 49 | 63 |
| Disagree: | 3 | 5 | 8 |
| Do not know: | 3 | 11 | 14 |
| | 20 | 65 | 85 |

**TABLE 3**
**Q.4. Did vocational or continuing training change your behaviour?**

| | Female: | Male: | TOTAL: |
|---|---|---|---|
| Agree: | 15 | 53 | 68 |
| Disagree: | 3 | 4 | 7 |
| Do not know: | 2 | 8 | 10 |
| | 20 | 65 | 85 |

There was extraordinary similarity in the reactions and views expressed, albeit in different ways, and I could not begin to choose which to quote, so here are some of the comments taken at random:

'. .true for me, education changes behaviour. '

'. . sure education changes behaviour . ' and 'It seems obvious, it must have done . . it encouraged me to listen . ' these three examples represent 10% of the replies. The rest specifically mentioned Michael, or other Balint-group leaders by name.

'Of course Balint-groups have changed my behaviour. '

'. .the Balint-group made me more patient and understanding of behaviour problems. '

'My experience in a Balint-group did change my behaviour not only in my relationship with patients but also in general relationships . '

'. .experience in a Balint-group was an important factor. .one of the factors which influenced my decision to leave psychiatry and enter general practice.'

On the other hand, Dr. R. P. who completed one of the discarded questionnaires, wrote: 'We all know perfectly well, both from our own experience and from observation of others, what happens to the doctor in general practice, changes his behaviour . . ' He described his Balint-training as a 'failure', because it led him to leave general practice to become a psychiatrist. His book on basic psychotherapy is very readable.[34]

Dr. E. J. demonstrated her change of behaviour: 'I would have left general practice if I had not met Michael Balint. '

Dr. A. H. wrote: 'The seminar was the most important aspect of my education (and introduction

to research) next to qualifying in Medicine . .' He, like so many others, expressed his views in response to the invitation *'to agree or disagree',* which I think is less likely to occur with a 'Yes/No' questionnaire. He added it was the 'Balint-group which changed my behaviour, NOT medical education.'

Dr. H. S. wrote in a letter: 'In this context the work of the Balint Society is very important. The in-depth study of the doctor/patient relationship is a powerful learning experience and one which has a long-term effect on one's work, behaviour and overall enjoyment of life . . I was in a group with Enid Balint for two years and I remember the experience with gratitude, as I felt that I learned to be a more skilful and caring doctor. This must have affected my behaviour.'

Dr. J. H. wrote: 'I joined a Balint group run by Michael and Enid in 1963 and was profoundly changed by it . .'

Dr. J. P.: 'The conviction that this approach to patients was more fruitful than my old medical school illness-orientated one has remained unaltered. In Michael's favourite phrase, 'it makes sense''.

Dr. N. D.: 'I think that the conventional medical training which I and those of my era suffered, really was the opposite pole to what is amusingly called 'holistic medicine.' I sometimes wonder how any sensitive doctor could practice any other type of medicine, and there is little doubt in my mind that Michael Balint sowed the seed of this in those early years, for which the medical profession and the public should forever be grateful.'

Those who disagreed, 8 for question number 3 (8.2%), and 7 for question number 4 (9.5%), or did not know, (16.3%-11.6%) were mostly the same people for each question, but many expressed their reasons for so doing, and at the same time ended up by agreeing in part that their experience in Balint-groups had helped change their behaviour.

Among those who did not agreed that education or training changes behaviour was Dr. H. S., who quoted Michael Balint's statement in the Conclusions in *A Study of Doctors:* (p. 128) 'In this way, he (a 'born' or 'gifted' practitioner who has been fully trained and reached the top 8% who have made it) may be able to give up without too much pain, some of his accustomed ways of behaving towards his patients and to achieve the often mentioned 'considerable though limited change of her personality'[14] *Personality,* mark you, not *behaviour* which is what John Horder wrote about . . Think back on the behaviour and even personality of John Horder, Cyril Gill, Jim Carne, me, yourself, all of whom you have known for many years. Have they or we changed in personality or behaviour in the last 30 years . . .? I believe we are very much the same as we were. Our *attitudes* have changed enormously, but not I think, our personality or behaviour.'

Dr. R. S.: 'Put me down as 'don't know' — for statistical purposes. I know of no trial where half general practitioners at random are put into a Balint-group, the other half given experience which would be a placebo. (ie. a group discussion without the Balint philosophy) that would demonstrate that Balint-training has scientific alteration in patients' behaviour . . . but I know very little that has been done that would satisfy an educational behavioural scientist . . Having said that, I am quite sure that the Balint experience profoundly affects people just as psychoanalysis does, but what is as equally difficult to prove scientifically'.

Jack Norell agrees that it is difficult to find convincing evidence that the behaviour of general practitioners is changed by vocational training or by continuing education: 'No systematic study has yet been performed into the connection between educational input and the subsequent professional performance of general practitioners . .' and he continued with, 'At present Balint-groups represent the only potential source of valid experience about influence on a general practitioner's everyday behaviour. My own subjective judgement is that such experience gradually led me to become more generalist and more patient-orientated, in addition to widening the scope of general practice towards emotional problems.'

This is entirely in keeping with Michael's initial aim to help us to become more aware, which is needed today for an ever increasing proportion of our patients, even more than when Michael said this to me in November 1970: (TAPE RECORDING):

**Dr. Michael Balint:** The other great branch of medicine started with the recognition that when a patient comes to a doctor, and especially the family doctor, complaining, then it is not certain that he will have an indentifiable illness. In fact, only in a certain percentage of cases do they have one. And there are not proper reliable statistics, but you have written about this,[35,36] but it looks as if at least 20%, 30%, or even much higher percentage of the patients consulting the family doctor, not the hospital, but the family doctor, are suffering from what we call Class 2 conditions, that is where there is no diagnosable illness.

**P.H.:** That's in traditional medical terms?

**M.B.:** Absolutely none. However hard you try, you can't find any identifiable illness. And now the great problem starts — what to do? And what usually is being done when the patient is forced into some sort of category, doctor and patient then agree what is the trouble about and this agreement is treated. And we have learned what is the price of it, an enormous price is paid; and the drug bill for the National Health Service, and the enormously wasted time and so on. It's not worthwhile going into it, everybody knows it, but nobody really wants to take it seriously. We did the study of the repeat prescription which is one class of this non-illness, or 'fake-illness', 'organised-illness' situation.[37] There are many more and if I live long enough, that will be the next ten years of research . . .'

I wonder what Michael would have thought about one of the main current selling points used by the computer-for-general-practice salesman — 'It makes your repeat perscriptions so much easier, doctor!'

He would certainly have wondered at the ever-increasing numbers of patients we are seeing who need his approach for their multiple symptoms.

It is worth remembering that at the time when we first started attending Michael's early seminars, the

climate of opinion about emotionally disturbed, or neurotic patients was very biased against them. Stephen (later Lord) Taylor had just published his widely acclaimed book, *Good General Practice,*[38] in which he had written: 'There is a substantial element of truth in the hypothesis that the better the clinician, the less often does he diagnose neurosis.' (p.416) You can imagine how that made us feel!

Among the many benefits reported by the Balint-trained doctors who participated in my survey, one very important effect which was mentioned by several of them, is that of improvement in what is commonly called 'job-satisfaction'.

Dr. M. S. wrote how he 'floundered in general practice, like so many of us, then attended a seminar and it changed my whole professional life . . and I regained vocational satisfaction.'

Dr. H. S. wrote: 'The work in the Balint-group has given me a deeper understanding of the relationship between the doctor and patient and therefore of human nature itself. This led to a great satisfaction in my work. I do not think that anyone questions the concept that job satisfaction improves the quality of an individual's work.'

Having recently seen a number of patients suffering from work-related depressive illness, as well as unemployment-related depressive illness, it did not surprise me to see a main feature on the topic of *Work — Pleasure or Pain?* in a recent issue of the Sunday Times.[39]

I have been distressed, however, in recent months, not only to see colleagues as patients suffering from work-related reactive depressive illness, but also an increasing number of articles in the medical press about doctors wanting to change jobs before they are forty[40]; others who are depressed and suffering from 'burn-out',[41] and yet others who write about 'throwing off the shackles' before they are 60![42]

I cannot help but wonder how this could come about, and whether it is in any way related to two of the most striking findings in my survey? One is the disappointment, resentment, and sometimes anger, expressed in various ways by almost every doctor in the survey, and stated so succinctly by Dr. A. H.: 'My formal training did little to equip me for the ill-defined and often only partly voiced needs of patients in general practice . . .'

The other equally striking finding is the consistent relief expressed by all these doctors, when they found that their Balint-training helped them to understand their own feelings of inadequacy and frustration as well as those of the patients, so that they coped better with what previously had been overwhelming problems.

Could it be that this unrelieved sense of inadequacy and frustration, together with the continuing pressures from unsatisfied patients and shortage of time, (although this is now said to be 8¼ minutes per patient) all becomes too much for the doctor whose scientific knowledge and skills learned in the hospital setting seem to be of value for so relatively few of the patients he sees in general practice.

In turn, he finds himself delegating more and more of his possible functions as a family doctor to the Practice Nurse, the Health Visitor, the Social Worker, the Psychologist, the Community Psychiatric Nurse, the Counsellor attached to the practice, and all the others. If, as was reported recently, the 'personal list' is less frequently maintained, and patients do not mind which of the doctors in the group sees them,[43] this is a sad reflection on the standard of the 'personal' medical care which is held to be a basic part of family medicine. Hence the implied changed emphasis in the announced title of a recent medical conference on *The doctor, THE patient and the illness.*

What happens to the 'job satisfaction' which normally follows the happy results of a good and well-established doctor/patient relationship? Are we now seeing the effect on doctors of what we read in a medical magazine that, 'Many women prefer to see nurse practitioners', 'because', boasts one, 'I give them my time instead of prescriptions for nitrazepam . . .'[44] and '. . . patients talk more to trainees.'[45]

The Social Services Committee report on Primary Health Care,[46] states that with the increasing number of general practitioners, now over 30,000, patients might expect a better service in the future. Reference is made to the shortage of consultation time, a major criticism expressed by patients' organisations about the failure of 'doctors to listen'; and we '. . should share patients' feelings'[47] and that '. . GPs fail to spot psychiatric illness . .'[48] and heaven knows, there's an awful lot of that about!

What does all this mean? In discussing these problems with doctors now in need of help, it is quite clear that they are experiencing and suffering exactly what all of us in the Balint Society have experienced and suffered in the past.

It seems that the way to improve matters does not rest only on encouraging practising doctors to form and meet regularly in Balint-groups. There is also a pressing need to plan for more appropriate training for our future medical students. I can claim no originality for saying this — read what Michael had to say about this in 1970 when I asked him what he felt about the need for further psychological understanding by doctors of their patients' problems:

(TAPE RECORDING)

**P.H.:** . . how important do you feel this is?

**M.B.:** Enormously important. If you would realize that for about 30% of your patients your training wasn't . .

**P.H.:** . . was useless . .

**M.B.:** . . was useless . . . I mean it would be a scandal, both in the medical profession and in the universities and the public . .

**P.H.:** Do you feel there's a place for a better training of this sort for medical students?

**M.B.:** Of course. I experimented with it at University College Hospital and a lot can be done.

**P.H.:** And why haven't other medical schools taken it up?

**M.B.:** Sorry, no medical school has taken it up.

**P.H.:** How would you regard the future — how can we best interest other doctors in your attitudes in Britain?

**M.B.:** Very difficult, because we are considered as quacks.

**P.H.:** There's no doubt about it, yes . . .

**M.B.:** It's very difficult for a peculiar group to attract general support.

**P.H.:** We hope, through our new Society, to bring in more people and interest people and spread this sort of knowledge . . . Can you see any ways of doing this?

**M.B.:** Very uphill work, but this is what has to be done. But it will be very uphill work because of the lack of trainers — very few trainers, and I don't know how to further the training of trainers.

**P.H.:** Do you feel there are sufficient psychiatrists in the country sufficiently well trained to do this work, or do you think that general practitioners with experience of this work could themselves do it? Or do you think that other general practitioners wouldn't take notice of them?

**M.B.:** Heaven knows. It is a very interesting topic . . .:

When preparing this lecture, I listened again to the recorded interview with Michael, and I thought it would be appropriate to extend my survey in order to find out what progress has taken place in our medical schools with regard Michael's ideas. It so happens that I carried out a similar survey in about 1960, as a member of the Undergraduate Education Committee of the then College of General Practitioners. Dick Scott in Edinburgh was the only British professor of general practice at that time. I sent questionnaires to 30 medical schools with general practice teaching units — 22 have Departments of General Practice, while the others use names like Community, Family or Social Medicine, Primary Care or Epidemiology. My gratitude goes to all those who returned them. (Table 4)

**TABLE 4**

HEADS OF 30 UNDERGRADUATE UNITS TEACHING GENERAL PRACTICE

| | |
|---|---|
| Professors | 21 |
| Readers | 1 |
| Senior Lecturers | 6 |
| Director of Studies in General Practice | 1 |
| Assistant in G.P. in Dept. Soc. Med. | 1 |

Of the 16 who have had Balint-training, 9 are professors; 11 of the other 14 are professors; 11 have not had Balint-training.

All 16 of the Balint-trained Heads of Department reported that reference is made to Balint in their students' course; 8 of the other 14 made reference to Balint, and the remaining 3 'did not know'. (Table 5)

**TABLE 5**

**Q.(i) Is any reference made to Balint's work during your students' study of general practice?**

| | Yes: | No: | Don't Know: |
|---|---|---|---|
| Respondent had Balint training: | 16 | — | — |
| Respondent did not have Balint training: | 8 | 3 | 3 |

Balint-groups were arranged by 6 of the Balint-trained general praactice teachers, 2 not, and 8 'did not know'. Of the other departments, 1 arranged Balint-groups for students, 11 did not, and 2 'did not know'.

Question number 6 asked if it was thought to be useful for students to learn about Balint's ideas at this stage of their training. 15 of the Balint-trained general practice teachers thought yes; 1 thought No. 13 of the 14 non-Balint-trained teachers thought Yes, and 1, no.

Michael stated that he had to stop his student groups, but Heinz Wolff has reported his experience of successfully running student groups at University College Hospital in an excellent book, *First Steps in Psychotherapy,* written jointly with co-authors who have been running a similar scheme at the Psychosomatic Clinic of Heidelberg University since 1977.[48]

Interestingly, four of the respondents to my questionnaire to Balint-trained general practitioners were members of Michael's student-groups, and each said how much this experience has helped them.

This is only a preliminary report, and will warrant further analysis, and points to the need for further study and action.

The Shorter Oxford English Dictionary defines 'evidence' as 'ground of belief' or 'that which tends to prove or disprove any conclusion'. For those who are willing to listen to doctors who have experienced Balint-training, in the way in which we have learned to listen to the 'evidence' which our patients give us when they come for our attention, there is considerable evidence to help them to conclude that here is a method of training which really can get to those parts that our more traditional treatments cannot reach!

This, in no way detracts from the wonderful benefits which modern medical science brings to some of our patients, but it certainly does add enormously

**TABLE 6**

**Q.(iii) Do students have the opportunity of having patients allocated to them for supervised psychotherapy during the General Practice course?**

| | Yes: | No: | Don't Know: |
|---|---|---|---|
| Respondent has had Balint training: | 1 | 15 | — |
| Respondent has not had Balint Training: | 1 | 1 | 12 |

to the benefits which not only we in Britain, but doctors all over the world, can bring to many more of our patients whose symptoms and suffering cannot be related to pathological processes alone.

It is largely for this that we remember Michael Balint with admiration and gratitude. As Dr. Endre Schnell, Organiser of the International Balint Commemorative Congress, in Budapest said: 'Although Michael Balint was born in Hungary, his fatherland was the world.'[50]

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## APPENDIX A

### QUESTIONNAIRE COMPLETED BY 85 BALINT-TRAINED GENERAL PRACTITIONERS

1. How long did you attend a Balint Group(s)?:.....years .....months

2. Name(s) of Group Leader(s):

3. Did education change your behaviour? Agree/Disagree/Do not know*

   Do you have any comments?: Yes/No*

4. Did vocational or continuing training change your behaviour? Agree/Disagree/Do not know*

   Do you have any comments?: Yes/No*

5. Please give references to any relevant work you have published:

6. Any other comments (quotable!):

Date ..... Signed: .....

*Delete as required.

Continue overleaf, if necessary.

## APPENDIX B

### QUESTIONNAIRE COMPLETED BY 30 HEADS OF GENERAL PRACTICE TEACHING UNITS

(i) Is any reference made to Michael Balint's work during your students' study of general practice? Yes/No/Don't know.

(ii) Or in the Psychiatric Department? Yes/No/Don't know.

(iii) Do students have the opportunity of having patients allocated to them for supervised psychotherapy during the General Practice course? Yes/No/Don't know.

(iv) Or in the Psychiatric course, as at University College Hospital? Yes/No/Don't know.

(v) Do students have the opportunity of attending Balint-type Groups? Yes/No/Don't know.

(vi) Any comments you might like to make, however brief, about the possible usefulness of medical students learning about Balint's ideas at this stage of their training?

(vii) Have you had any personal experience of attending a Balint Group? Yes/No.

# A Matter of Interest*

Kenneth Sanders
Psychoanalyst in General Practice

When I started in general practice, in 1954, in a London suburb, I was bewildered — like so many — by the many psychological and psychosomatic cases, for which I was untrained. I turned with relief to the Tavistock clinic and enjoyed working in seminars, first with Dr. Pierre Turquet, and then Dr. Michael Balint.

Perhaps I seemed too enthusiastic, for Dr Turquet divined, somewhat to my surprise, that I had an interest in training as a psychoanalyst. There was an unexpected result. I began to enjoy general practice so much that I could not think of giving it up. Over a period of years, I gradually evolved a way of working that has enabled me to work separately in both fields, and now I am often asked how this combination has affected my work in general practice.

I have attempted to provide an answer in my book, *A Matter of Interest*. When I looked at the clinical notes of conversations with patients that I had kept over twenty years, I discerned a common thread running through them. That thread is — the containment of anxiety.[1]

My theoretical orientation is that line of psychoanalytic thought represented by the names of Freud, Melanie Klein and Bion. Freud finally related the concept of anxiety to the child's feelings of tension in the absence of the mother. Melanie Klein, working directly with young children, not only confirmed this but presented the evidence that this anxiety was experienced in relation to two worlds — external reality, and the inner world of the imagination. Anxiety throughout the life cycle, she suggested, can be linked to these infantile experiences. I will refer to Bion, at the end of this article.

I have drawn examples from some of the chapters of the book, which are in chronological order, hoping to demonstrate that the thread of anxiety can be usefully looked for in general practice from infancy to old age, 'when old men fear death as children fear to go in the dark' (Bacon).

**Infantile asthma: containing the anxiety**

An unmarried West Indian girl brought her baby, her first, to the surgery. She was apologetic, but explained that she was feeling frightened of the infant, now five months old. She placed him on the couch rather than hold him, and stood well away. When the baby gave a small cry, she jumped — just as a baby startles on hearing a sudden noise. She could not explain more about it, she was breast-feeding and caring for the baby well, but felt frightened of him.

She agreed her constant anxiety was that something might go dangerously wrong. She herself was the eldest of four children, brought up by her mother until the age of five. Then her mother left for England, leaving her in the care of her grandmother. At the age of twelve she rejoined her mother in England. After a few years, however, her mother returned to the West Indies, once more leaving her behind.

The patient then added that she was not living with the father of the baby and felt very isolated in her flat in a tower block. She felt very unsupported and, holding this little life in her hands, she was frightened that she might fail to sustain him — a re-awakening of her own experiences of being left by her own mother.

Increasingly frequent and severe attacks of coughing and wheezing in Billy G., at nine months old brought about a rapid crescendo of anxiety in his mother. She had managed her first child's occasional attacks of broncho-spasm reasonably well. This little girl, five years older than Billy, often came with her mother and brother to the surgery, a silent witness to the family crisis. The father did not participate until much later.

In Billy's case the asthma was only part of a crisis that escalated around the problem of separation anxiety. His terror of being on his own, was only gradually culled out from an enveloping confusion, when an attempt was made to contain the panic.

At first the problem was tackled in a straightforward way, but the response to medication was disappointing. He was referred to a paediatrician, but Mrs G. meanwhile responded with interest to my request for details. The first few months of his life, when he was bottle-fed were without incident. However, prior to the onset of his first attack of asthma, plans were being made for a family holiday in Scotland.

This history suggested that disturbance of Billy's anticipated routine, or any frustration caused a storm of psychosomatic disturbance. I discussed with Mrs G., now in a continuous torment of worry, the idea that he felt in some way an indescribable terror when he was not held either bodily or by her attention, when he could not see her, hear her, or feel her presence supporting him. She was interested and responsive and I undertook to monitor with her future developments in short weekly meetings, at the end of morning surgery, but recommended that she endeavoured to restore the sleeping arrangements to normal. The sister was still sleeping in the double bed with father, and mother with Billy. Whenever possible, I suggested, she could talk to Billy, now two years three months old, and try to convey to him that she understood that he was frightened of being alone and became cross when she turned her attention away from him.

When we met the following week she began to speak to me about the sleeping arrangements and the separation problem. To her surprise, despite failure on numerous other occasions, this time she successfully persuaded Billy to take to his own bed at night, and she returned to her husband's.

But she added that whenever she went out and left Billy at home he would sit by the door and cry

*This article is based on a talk given to the Balint Society on 23 October 1986.

and scream until she reappeared. According to Mr G., it was 'murder'!

At each of Mrs G's weekly visits the intention was to contain the panic and to observe any connection between Billy's tantrums, the asthma attacks and his feeling of being 'murdered' by separation. While his mother and I talked, Billy was invited to play with the toys in the drawer of the desk, which included some little figures of men and women, houses, chairs and other oddments — torch batteries, a small hammer and envelopes.

Billy, now a fair-haired, impish toddler, was wilful but cooperative, and accepted the routine of these meetings well. An extract from my notes made at some of these sessions follows:

*9 January:* (aged two years and three months)
Mother remarked that he cannot wait for a drink when he wants one. Since she has been talking to him, he is repeating the word 'afraid'. Billy took a small torch battery from the drawer, placed it on a toy chair, then removed it and hit it hard with the small hammer. My suggestion was that he is demonstrating what it feels like to him when he has to wait for his mother, or when he is taken off her knee.

*16 January*
Billy had a bad night before the appointed day at the surgery. He walked in with a toy gun, picked up a telephone directory from the floor, put them on mother's lap and hit them with the small hammer. Mother remarked that he now turns to his father for attention. If he sees him walking off, he says 'wait for me'. She mentioned that he is not toilet trained, and cannot wait to go to the toilet.

Billy's activities suggest an attack on the mother and on any other baby who might be taking his place on her knee, or in her mind. He is perhaps feeling identified with his father, and reflecting his experience as a witness of the parental intercourse, when he shared their bedroom.

*13 February*
Billy put a telephone directory on his mother's knee, left it there, and stayed by the drawer playing with a pen and paper. Mother said he had been playing with a drawer at home, and had also been playing at being a policeman. She went out for the evening one night, and Billy coughed and was restless as a result.

I think he is becoming concerned about his incontinent behaviour, and thinks the answer is connected with having a 'policeman daddy', to help in the control of his violence and to protect his mother.

(The sessions continued at weekly intervals)

*10 April*
Billy has been well without the need for any tablets. He took the little hammer and tapped gently at the fireplace. He looked round the room and found a rubber suction cup used for unblocking the sink, murmuring 'big boy'. Mother reported that he is always hammering, and banging his bike into the wall. There has been a lot of hammering going on in neighbouring flats. He is less worried about being separated from her, and is starting the nursery next week. He is still incontinent, but his play is more constructive, putting toys together and carefully taking them apart. He slept in a room on his own while his sister was away on holiday.

It was decided, that as Billy was starting the nursery, and the attacks of asthma as well as the temper tantrums, were more controlled, and the level of anxiety in the family diminished, the sessions would continue at fortnightly intervals.

*4 June*
As Billy had not been well, his mother brought him within a week. Billy showed me some money, and his mother told me that he had now started using the toilet — for 'penny and tuppence'. He also plays at going shopping, and came in today carrying a little basket. He is clearly making progress in containing his emotional outbursts and feels that he now has a place — the sessions — where both bad and good things may be discussed.

*12 June*
Billy came in announcing 'my new shirt'. Mother reported a good week: they had been to the swimming pool. Billy said 'I have got a policeman's hat'. Mother said that three months before he had started playing with a tea-cosy as a policeman's hat: now his father had bought him one.

Billy now discovered some money that he had left in the drawer the previous week. He showed it to me and said 'I did tuppence in pants'. He puts the directories on mother's knee and hammers very gently and lovingly. Mrs G. then said that he was learning to become more independent and clearly was much relieved at the improvement in the situation, but she said 'we can't always keep coming here'. We then had some discussion about a break for the approaching summer holiday.

*13 November*
Billy had been fairly well but with a little nocturnal wheeziness and swelling of the eyes. He took the toys out of the drawer, balanced a cow on the desk, knocked it off and said 'Ow! It's fallen in the water'. He then played with the little toys, set up the toy church as a playschool, speaking of doors and windows and counted 'one, two, ten, twelve'. Mother said that his sister played at schools with him and tried to teach him to count. When he goes to play-school he got upset if he thought she was going home and not just shopping nearby. Billy took the hammer out of the room to show another little boy, and then returned to play at 'falling in the water'.

My impression was that he was trying to understand leaving and coming back, counting the passage of time so that he can wait more calmly without disaster threatening, falling in the water meaning an asthma attack, perhaps.

Billy's state of mind went through a gradual evolution during this year of regular 20-30 minute sessions. The aggressive hammering of the first few weeks was replaced by more gentle movements, suggesting a movement away from sadism and towards an appreciation of rapport between two people. His time in the parental bedroom may have contributed

to his misconception of the relationship between his parents, but his growing interest in the 'policeman daddy' suggests a growing awareness of the protective role of a man in a woman's life. No doubt he felt that I was motivated by a desire to protect his mother, as well as himself, from his outbursts of fury.

The partial transfer of his separation-anxiety to the sessions, and its containment there, was also evident, and I think he was grateful for the opportunity. The family stayed with the practice for a further year after these sessions ended, and the crisis had passed over: they then moved back to their home town and I did not see them again.

**A five-year-old child and her grandmother**

A five-year-old girl's mother died, but her father and grandmother were unable to make contact with the child's deep distress. When she refused to go to bed at night, or to school, or let her grandmother out of her sight, she was brought to the surgery by the grandmother who asked me to provide a sedative. But then, at my request the child produced a series of drawings (colour plates in the book) which we discussed together at weekly intervals over a period of five weeks.


Drawing 1

Grandmother sat in the chair again at the side of the desk, the drawing was produced, and Sally stood between us as we inspected it together. Grandmother reported that the last two days had been better, but Sally was still reluctant to go to school on Monday morning. As we looked at the drawing, grandmother explained that Sally had made a mistake with a word and had crossed it out, and put Nanny, that is, grandmother, and that she was going to draw a chair but had altered that to a kite.

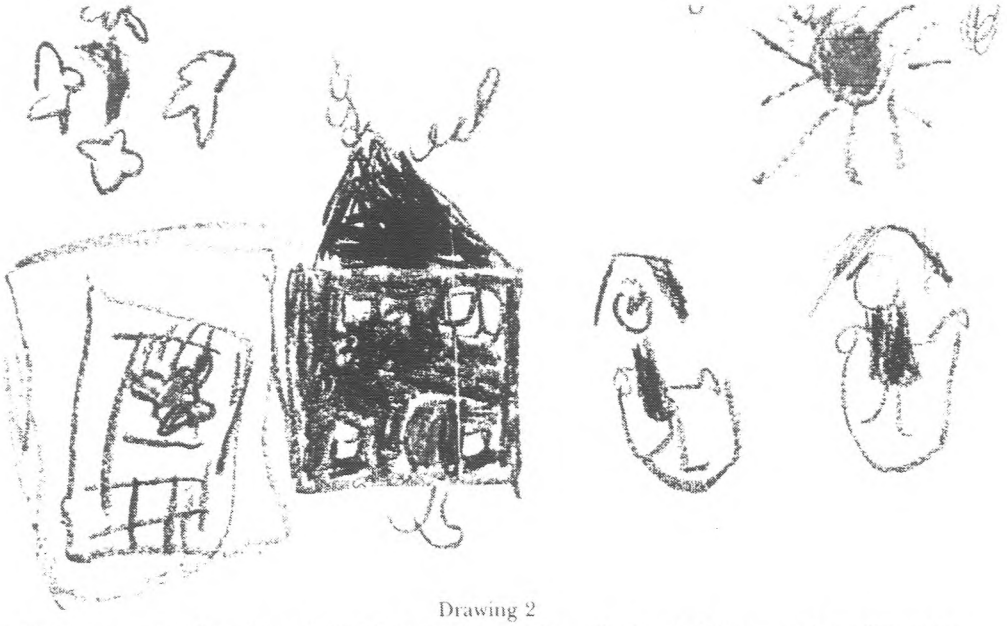
This led me to remark, as I considered grandmother sitting there in the patient's chair, Sally now leaning against her and watching me, in the positions usually occupied by mother and child consulting the doctor, that perhaps Sally felt that it was her Mummy who was now crossed out, and Nanny was in her place, providing a lap for her to lean on, and that the chair that Mummy used to sit on, was now changed to a kite, and that it was as if Mummy had flown up to heaven, and that she was frightened that if she went off to bed, or to school, Nanny might go away too.

Sally nodded agreement, as if all that was clear and must be obvious to anyone. Grandmother, however, looked a little anxious and explained that there was no need for Sally to feel frightened or lonely, because she and Sally slept in the same room. She now went on to say that there was only one bedroom, with twin beds. Sally was occupying one of them, and her husband was sleeping in the sitting room on a convertible sofa. As they were planning to adopt Sally, they were intending to move out of London, so that they would be able to afford a two-bedroomed flat.

I now asked about the sand and the boat, and Sally said it was the seaside, where she had been for an outing with grandfather.

This interview which took place during the evening surgery occupied about fifteen minutes, and I suggested that we meet again in a week, with another drawing, to which they agreed.

Sally produced the drawing, and stood by me, a little closer than before, to consider it; grandmother sitting facing as before. Sally explained that there were two pictures of her skipping, one in a blue dress and one in red. There on the other side of the house, was



Drawing 2

a bird in a cage in a box. I was doubtful about the wisdom of coming too directly to the point, when grandmother clearly favoured caution, but I said eventually, 'You know that I am wondering if all the trouble about going to bed and to school is because Mummy isn't here any more, now that she has gone up to heaven on the kite that you drew last time, and that I think you only feel safe when Nanny is near?'

Sally, listening attentively, nodded. 'Now, I am wondering if the bird in the cage in the box isn't somehow like the lady on the kite, and that perhaps you are thinking that your Mummy was put in a box?' This felt a very tense and perhaps dangerous moment, but Sally abruptly changed her attitude from that of a thoughtful listener, and, as if a spring of constraint had been released, she flushed with emotion, and began to talk with animation, expressing in her rapid urgent words, choked with tears, a mixture of grief, horror and indignation.

'Aunt Mary told my cousin Helen that my Mummy was in a box, and Helen told me, and we started to cry, and I said to her, THAT MAKES ME FEEL VERY UPSET!'

Grandmother and I were both a little alarmed by this outburst, and exchanged glances, and then when she had calmed, I asked about other things in the drawing. She told me that there was another bird in the sky, and the sun and some clouds. I suggested that was Mummy now in heaven, and that because Sally was so upset about it, she had put some clouds round the sun, and was wearing a blue dress, in the drawing. She assented to all this with a nod or two. Grandmother had listened showing some anxiety as before, but sympathetically, and I suggested another meeting next week with another drawing.

These extracts from the chapter on a five-year-old and her grandmother, demonstrate how the child was enabled to verbalise her pain and her acute symptoms of anxiety, relieved.

**Depression in adult life — working & weeping**

A despondent single man, a factory hand approaching thirty, who lived with his parents, came to complain of his moody and irritable temper, his anxiety attacks in trains, his inexplicable guilt feelings and self-consciousness, his disinclination for work.

He mentioned his brother, eight years his junior, who had developed acute diabetes a year earlier and had recently married. They used to share a bedroom and the patient would lie awake at night frightened that his brother might die in a coma. At the wedding he had been the 'best man' but had felt very conspicuous, convinced that everyone saw him sweating.

He had very little previous ill-health, but had been treated for enuresis as a boy. His podgy build, slow manner and helpless demeanour, combined to give an impression of doleful immaturity. In the year that followed he was frequently off work, sometimes too depressed to leave the house. He now drifted from job to job where previously he had worked regularly. His mother was worried and asked him to see a psychiatrist. But he could not face waiting in the out-patient department, and was averse to tablets.

He came to talk again, told me that he wept for five to ten minutes at a time and quite frequently, particularly at the thought that his mother might die and he would be alone — she understood him, but his father did not.

He repeated that his troubles started with his brother's illness and marriage, but no further progress was made. He toyed with the idea of admission to hospital, but when he eventually consulted a psychiatrist, this was not offered. He tried to find work again but gave up the jobs after three or four days. Finally, after many months, there was a talk that helped. A week before Christmas he reported a return of his depression. It came on suddenly while he was waiting for the bus, reluctant to go to work, to meet or talk with other people. He had been irritable with his

mother — he wondered, he said, whether it could all be connected with the approaching Christmas holiday.

I agreed. Experience in psychoanalysis amply documents the emotional impact of public holidays on the 'infant' part of the personality — anxiety about the closing down of shops and transport, the break with routine. The Christmas pre-occupation with the birth of a new baby, commonly stirs a variety of emotions.

He was keen to follow this train of thought. When the family gathers for a party, he explained, he doesn't want to take part. I commented that it might be that when he was little, there was a family celebration to mark the birth of his younger brother. Perhaps he felt neglected when everyone attended to the new baby? He replied that his sister-in-law's mother had a nervous breakdown after the birth of her daughter's baby. She refused to enter the room because she feared that she might attack the baby, and has since been admitted to a mental hospital.

He looked at me directly for the first time, and spoke now with unusual animation. He asked if it could be something like that in his case? I replied that it was possible that when his younger brother was born he felt overlooked and displaced, perhaps he hoped he would die. The approaching Christmas celebrations might revive these emotions. He then said that his brother and sister-in-law, and their baby were in fact coming to the house at Christmas.

This interview was different — his interest kindled and intelligence sparkled in his eyes. He discussed the matter with his mother and surprised her with his conviction that it was his jealousy of his brother that had been upsetting him. He began to recover his capacity to work.

**On the brink**

The present generation of men and women, whose lives are running out of time with this century — in their seventies and eighties — have lived through two World Wars as soldiers or as their wives and sweethearts. In the living rooms, photographs of a youth in uniform, although faded and stereotyped, recall the times when death in the wars was a constant threat.

Courageous octogenerians, not cheated of time, find it possible to joke about their approaching end. Mr Street had a store of minor witticisms with which he greeted me in the last year of his life — 'I have a strong weakness, doctor', or referring to his tablets that needed replenishing, 'I am running out of amunition'. Living alone, struggling with his periods of depression, one day I noticed he had a small cut on his cheek. 'I stood too close to the razor — don't think I tried to commit suicide!'

The dividing line between cheerfulness and denial may be unclear but compare that old soldier's resignation with a childless married lady in her mid-seventies. Her character was hypomanic, even in health she was excitable, garrulous, with rouge and lipstick lavishly applied. Her timid husband on the other side of the surgery desk, tried to suppress his embarrassment as she adhesively extended the consultation with a neverending stream of confused chatter. When he finally took her arm to leave, they floated out of the consulting room on the flood of her rhetoric.

When she had a coronary thrombosis and her heart failed, I visited them at home. She lay in bed, swollen with fluid, breathing with difficulty, with the same over-rouged cheeks and lips, elaborately curled and blonded hair, still protesting her youth within hailing distance of death, insisting that no-one would believe that she was not under seventy.

Within six months of her death her husband reported blood in his urine. He effaced himself to the extent of getting overlooked on the waiting list for surgery for his cancer of the bladder, and died himself soon after.

The first part of the book which traces the thread of anxiety through the successive stages of the life cycle, is followed by chapters discussing respectively, resistance to the offer of discussion, the problems presented by psychosis, the counter-transference and its psychological meaning, and psychosomatic illness.

**Bion's contribution on psychosomatic illness**

But to conclude, I wish to refer again to the contribution made by Bion, whose psychoanalytic model of the mind is of a container — the feeding breast, and its mental counterpart, maternal reverie — and the contained, the infant's anxieties. In this model the infant communicates with the mother by evacuating into her mind, in fantasy and fact anxieties it is unable to tolerate, for her to receive, contain, modulate and finally return to the infant in a form that is: bearable. This is a model of the development of the capacity to think about frustration and mental pain, the container-contained structure and function, then being available for internalisation by the infant, so that it can learn from the experience to think for itself. If this does not occur, then, Bion suggests 'protomental' phenomena are seen, where physical and psychological are undifferentiated, and emotional experiences is likely to manifest itself just as well in physical form as psychological.

Emotions imply depth of character, in contrast to shallowness. The personality able to experience and contain anxiety has a three-dimensional quality. If the parents lack this, their child's anxiety is liable to manifest itself in psychosomatic illness, or spill out of the family context, and involve outside agencies, doctors, social workers and school.

I first met a vivacious continental lady about 15 years ago in a panic about her 18-month-old boy. The records showed that the child had seen a doctor nearly every week of his life, with screaming attacks, colds, constipation, vomiting, teething, not sleeping, not eating, etc.

On one occasion when he was four, I found him sitting up in bed wheezing and coughing. His mother sat by him, and with a flannel dabbed at his mouth, as he dribbled thin fluid. I asked for a basin, and when this was put before him, he vomited into it copiously, then leaned back, with wheezing and anxiety relieved.

I felt I had witnessed the realization of the psychological difficulty. In place of a three-dimensional maternal basin, there was a two-dimensional flannel. Soon after, the mother had her own psychosomatic difficulties with digestion. I invited her to come for a talk. She arrived carrying a plant, and handed it to me with the caution that it needed a larger

container for healthy growth! She had asthma as a child herself. Her mother died from cancer when she was 15 and she is scared of it. She was brought up on a small farm and is unable to read or write. Her husband serves in a restaurant. On the first anniversary of his mother's death, his hands began to shake rattling the cups and spilling the coffee over the customers. The problems of containment, following the loss of his mother, were now affecting him.

These parents I concluded were deficient in their capacity to contain their child's anxieties and the 'two-dimensionality' of their characters affected a psychosomatic response in their child.

Psychoanalysis has developed rapidly in recent years and is of great interest to family doctors in their struggles to comprehend the kaleidoscope of human distress that awaits them in their daily work.

**Reference:**

1. Sanders K. *A Matter of Interest: Clinical Notes of a Psychoanalyst in General Practice.* (ISBN 902 965 22 0. Paperback: 109pp.) 1986. Strathtay Perthshire, Clunie Press. (£6.50p.)

# Ascona Balint Meeting, 1987

The 15th Annual International Balint Meeting, held in Ascona at the beginning of April, proved to be another very successful event. Its theme was 'dependence and autonomy'. While it was primarily designed to give continental medical students (drawn from no fewer than 38 different universities) a taste of Balint-group activity, the official programme began with a talk by Professor Paul Watzlawick, and it concluded with one by Sir John Eccles, FRS.

Also included was a ceremony at which prize-winners of an essay competition were presented with their awards. The first prize went to Karen Borgards, a female medical student from a private university in West Germany, for a paper on the inter-relationship between students, patients and medical staff.

However, the majority of the time during those three days was devoted to a series of group case-discussions held in neighbouring hotels. The group-leaders were drawn from several different countries and the sessions were conducted in German, French, Italian or English.

The English-speaking group, which I was privileged to lead, was in fact mainly composed of Dutch medical students. They had originally been introduced to the Balint approach by Dr. Tilenus, a psychiatrist from Einthoven University, who accompanied me as co-leader of the group. The other participants were actually GP-colleagues of mine, members of our Balint Society who were attending the meeting of the International Balint Federation being held in Ascona that weekend.

As I had discovered at previous Ascona meetings, the essential Balint-group atmosphere was very rapidly achieved, even though many of the participants were strangers to each other. A ready understanding emerged of the difficulties facing each presenting doctor, despite the fact that there was little in common between well-established general practitioners from England, and newly-qualified hospital doctors, and students still receiving their undergraduate education at medical schools in Holland. But the openness, and the relevance of the comments, and the close identification with the presenting doctors, was truly remarkable and created a very good feeling among everyone in the group.

This does not mean that the prevailing mood was necessarily optimistic and cheerful. On the contrary, there was a degree of sadness arising from the reported experiences of many of the students. Time and again they related how frustrated they felt at the lack of continuity with patients whom they had interviewed only once or twice; and being prevented from behaving in a totally open way with them; and having to be answerable to their medical superiors, physicians and surgeons who were perhaps not tuned in to patient-centred medicine and unaware of how the doctor/patient relationship might be used to help patients to cope with their troubled feelings.

However, this sadness did not degenerate into depression and defeat. A spirit of encouragement was created in the group, a feeling of challenge, which helped the students to look forward to the time when they themselves would become independent and fully responsible doctors. My British colleagues felt that these Dutch medical students would make splendid general practitioners.

Professor Boris Luban-Plozza is once more to be congratulated for the inspiration and the organisation of such a meeting, which has again provided important new ideas at so many levels.

J. S. NORELL

# General Practitioners' Attitudes To Psychotropic Drug Therapy and Psychotherapy*

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## Introduction

Doctors' attitudes to treatment are a potential source of bias in the assessment of both medical and psychiatric interventions. But little attention has been paid to the questions of whether and to what degree doctors attitudes to treatment may affect clinical outcome. This is true in psychiatry, where much attention has centred on the problems of diagnostic reliability; and in general practice, where there are wide differences among doctors in their recognition, treatment, and referral practices for patients with psychiatric disorders.

So far as psychiatry is concerned, attempts to study these variations require account to be taken not only of doctors' professional characteristics, but also of their personal characteristics, and in particular, their attitudes to psychiatry.

The most important practical aspect of psychiatry concerns patient management, and there is a need for an instrument to measure doctors' treatment attitudes in this domain.

## Background

Two visual-analogue scales for measuring doctors' attitudes to psychotropic drug therapy and psychotherapy were modified, shortened, and combined in a 21-item questionnaire (Treatment Attitudes in Psychiatry Scales (TAPS)), which proved to be brief and easy to use.[1] A form of concurrent validation of the scales, using two groups of consultant psychiatrists who were either members of the Biological Psychiatry Section or of the Psychotherapy Section of the Royal College of Psychiatrists showed significant differences between the groups in the expected directions, and also the extent to which these attitudes overlapped — polarisation of therapeutic attitudes was more evident in the results from the Biological Psychiatry Section.[1]

*Purpose of study*

The purposes of this study are to assess the reliability and validity of the scales when used by general practitioners.

## Method

### Samples

The TAPS was sent by post to three samples of general practitioners.

(i) *A psychotropic drug therapy criterion group:* a convenience sample of about half of the GP members of the Psychopharmacology Research Group (PRG) (chosen by their organiser Dr. Wheatley);

(ii) *A psychotherapy criterion group:* all general practitioner members of the Balint Society (BS) resident in the UK whose names appeared on the then current (1985) membership list; and,

(iii) General practitioner principals in the 48 practices taking part in the Third National Morbidity Survey from General Practice (MSGP).

*TAPS questionnaire*

The 21 TAPS items are reproduced in the Appendix.

The TAPS psychotropic drug therapy scale scores were calculated by: (i) rescaling the 10 psychotropic drug visual analogue scale item scores; (ii) multiplying each re-scaled item score by the value of the unstandardised regression coefficient previously obtained with the criterion groups of psychiatrists; and (iii) summing the total.[1]

A similar procedure was followed for the psychotherapy scale scores. The instrument is usually completed in about five minutes.

## Results

Fifty-one general practitioner members of the PRG, 99 general practitioner members of the BS, and 100 principals in the MSGP responded to the questionnaire. Their characteristics and response rates are shown in Table 1.

**TABLE 1**
**Characteristics of GP Criterion Groups**

| Characteristic | PRG | BS | MSGP |
|---|---|---|---|
| Sample size | 60 | 128 | 107 |
| Sex | | | |
| Male | 48 | 86 | 86 |
| Female | 4 | 34 | 15 |
| Unknown | 8 | 8 | 6 |
| Age (mean years) | 53 | 55 | 49 |
| Response rate | 85% | 78% | 95% |

*Description of scale scores*

The percentages of BS and PRG members agreeing with the individual TAPS items are shown in the Appendix. The psychotropic drug therapy scores and

**TABLE 2**
**Mean psychotropic drug therapy and psychotherapy scores**

| Scale | PRG | BS | MSGP | Psychiatrists |
|---|---|---|---|---|
| | | | | **Biological** |
| Psychotropic drug therapy | 22.5 | 17.8 | 18.5 | 26.6 |
| (SE) | (0.9) | (1.3) | (0.9) | (0.6) |
| | | | | **Psychotherapists** |
| Psychotherapy | 13.7 | 17.1 | 12.2 | 21.8 |
| (SE) | (1.0) | (0.9) | (0.8) | (0.7) |

*Paper presented to meeting of the Balint Society on 28 April 1987.

psychotherapy scores for the three samples of GPs and the two samples of psychiatrists are shown in Table 2 and 3.

The mean psychotropic drug therapy score for biological psychiatrists (mean = 26.6; SE = 0.6) was significantly greater than that for either the PRG, the BS, or MSGP principals (Welch's d = 4.16; 13.14; and 7.5, respectively; $P \leq 0.001$ in all cases).

Similarly, the mean psychotherapy score for psychotherapists (mean = 21.8; SE = 0.7) was significantly greater than that for either the PRG, the BS, or MSGP principals (Welch's d = 6.63; 4.37; and 9.06, respectively; $P \leq 0.001$ in all cases).

The mean psychotropic drug therapy scores for the PRG were, as expected, significantly higher than the mean scores for the BS and MSGP principals (Welch's d = 2.72, $P \leq 0.001$; and Welch's d = 3.15, $P \leq 0.001$); but the mean psychotherapy scores for the BS were only significantly greater than the mean scores for the MSGP principals (Welch's d = 2.87, $P \leq 0.001$).

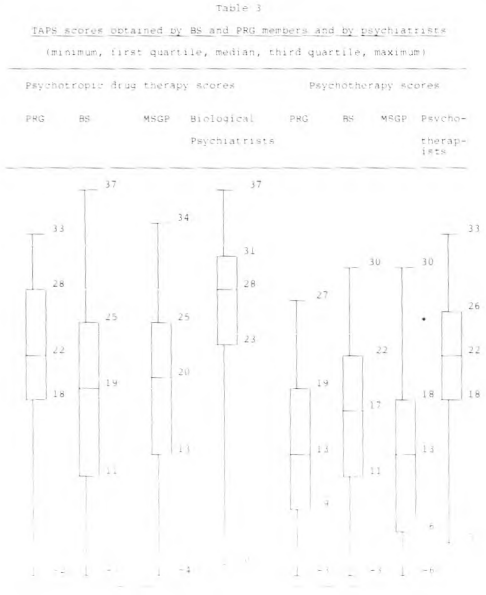


Table 3 shows, in diagramatic form, the spread of scale scores and the extent of overlap between the different groups involved.

*Reliability*

Internal consistency (homogeneity of the items comprising the scales) was assessed by measuring Cronbach's alpha coefficient. The values for alpha are shown in Table 4: the median values for the psychotropic drug and psychotherapy scales as used by general practitioners were 0.46 and 0.41, respectively.

*Validity*

Content validity was assessed with reference to the findings noted above i.e. the percentages of BS and PRG members agreeing with the individual TAPS items and the criterion groups' observed scale scores were in the expected directions.

**TABLE 4**
**Cronbach's alpha coefficients**

| Scale | PRG | BS | MSGP | Biological psychiatrists | Psychotherapists |
|---|---|---|---|---|---|
| Psychotropic drug therapy | 0.49 | 0.66 | 0.46 | 0.09 | 0.47 |
| Psychotherapy | 0.41 | 0.66 | 0.55 | 0.41 | 0.18 |

Moreover, Pearson product moment correlation coefficients were calculated between psychotropic drug therapy and psychotherapy scores for the PRG, BS, and MSGP groups, and these were 0.44 ($P \leq 0.001$); 0.41 ($P \leq 0.002$; and 0.34 ($P \leq 0.001$), respectively, indicating, that less than 20% of the variance in psychotropic drug score could be explained by the psychotherapy score, and that the scales were measuring different attitudes.

Concurrent validity (the extent to which the scale scores correlate with other variables that can be regarded as suitable criteria) was assessed by correlating psychotropic drug and psychotherapy scale scores with variables from the Third National Morbidity Survey; i.e. (i) standardised prescription rate (all scripts); (ii) standardised prescription rate (nervous system); (iii) standardised prescription cost (all scripts); (iv) standardised prescription cost (nervous system); (v) standardised male patient consulting rate (mental disorders); and (vii) standardised female consulting rate (mental disorders).

Complete data were obtained for 24 of the 48 practices taking part in the Third National Morbidity Survey. A significant negative correlation was found between psychotherapy scale scores and total prescribing costs (r = 0.52, $P \leq 0.05$).

## Discussion

General practitioners from the Psychopharmacology Research Group and the Balint Society had significantly lower mean psychotropic drug therapy and psychotherapy scores than criterion groups of biologically or psychotherapeutically oriented psychiatrists. There were similar differences in scale scores, in the expected directions, between the two general practice criterion groups. However, unlike criterion groups of psychiatrists, criterion groups of general practitioners did not show polarisation of attitudes with respect to psychotropic drug therapy and psychotherapy scores.

*Reliability*

Previously, the test-retest reliability of the psychotropic drug therapy and psychotherapy scales was measured using Pearson's product-moment correlation coefficient. This refers to the *stability* of the subjects' scores, the extent to which they may be expected to achieve the same score, at least relative to each other, on two different testing occasions. These reliability coefficients ranged between 0.54 and 0.74 for the criterion groups of psychiatrists, indicating stability over a period of six months. In view of this finding, and because of lack of time and resources, stability was not assessed for the general practice groups.

A different aspect of reliability, internal consistency, was assessed here. A range of values were obtained, but overall there was evidence of internal consistency, which was highest for the BS on the psychotropic drug scale, and lowest for biological psychiatrists on the same scale.

In fact, stability is probably the more important type of reliability, since without it the scale may have no validity, unless the scale aims to measure *change* in attitude, when high stability might indicate no change. Evidence of internal consistency, on the other hand, though desirable, is not an essential characteristic of a scale, since a high internal consistency may indicate that items in the scale are redundant.

*Validity*

The psychotropic drug and psychotherapy scales appear to have content validity i.e. the item selection represents a fair sample of the domain that the test is supposed to measure, and the scales seem 'on the face of it' to produce measurements of these attitudes which fit in with expectations. Other aspects of validity are more difficult to assess, because it is not clear what might constitute a criterion for either of the therapeutic attitudes in question. On statistical grounds, the isolated finding of a negative correlation between attitudes to psychotherapy and total prescribing costs in the MSGP group may be spurious. A further study of this is being undertaken with the BS, but the results are not yet available.

*Conclusion*

The TAPS appears to have reliability and validity and may be recommended for use in general practice studies where there is interest in doctors' bias in relation to their attitudes to psychiatric treatment e.g. in clinical trials. Scores obtained by groups or individual doctors can readily be related to those of the reference groups described.

Further details about the reliability and validity of the TAPS and the method of scoring are available from the author.

**Summary**

The Treatment Attitudes in Psychiatry Scales (TAPS), a 21-item questionnaire dealing with: (i) attitudes to psychotropic drug therapy and (ii) psychotherapy was developed for use in general practice studies. The instrument was administered to two criterion groups of general practitioners from: (i) the Psychopharmacology Research Group and (ii) the Balint Society; and to a group of general practitioners taking part in the Third National Morbidity Survey. The results provide evidence for the reliability and validity of the two scales in general practice.

**Acknowledgements**

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## Appendix

# PSYCHOTHERAPY SCORE

| ITEM | BALINT Agree (%) | BALINT D/K (%) | PRG Agree (%) | PRG D/K (%) |
|---|---|---|---|---|
| A WELL CONTROLLED STUDY OF THE RESULTS OF PSYCHOTHERAPY OVER A FIVE-YEAR PERIOD IS NEEDED | 75 | 14 | 94 | 4 |
| PSYCHOTHERAPY IS NEITHER AS VALUABLE AS ITS ADHERENTS CLAIM NOR AS DANGEROUS AS ITS OPPONENTS BELIEVE IT TO BE | 56 | 18 | 53 | 28 |
| ENOUGH IS NOW KNOWN ABOUT PSYCHOTHERAPY TO GUARANTEE THAT WE ARE ON THE RIGHT TRACK | 48 | 28 | 25 | 26 |
| PSYCHOTHERAPY IS THE ONLY TREATMENT OF EMOTIONAL PROBLEMS WHICH OFFERS ANY HOPE OF SUCCESS | 46 | 26 | 45 | 14 |
| THE PURPORTED CURES ACHIEVED THROUGH PSYCHOTHERAPY REALLY TELL US MORE ABOUT THE THERAPIST THAN ABOUT THE PATIENT | 28 | 23 | 33 | 28 |
| RESEARCH INTO THE PSYCHOTHERAPEUTIC PROCESS HAS MADE MONUMENTAL STRIDES IN THE LAST DECADE | 25 | 30 | 67 | 20 |
| THE GROUNDS UPON WHICH THE EDIFICE OF PSYCHOTHERAPY RESTS ARE AT LEAST 50% THE FANTASY OF ITS CREATORS | 25 | 21 | 35 | 28 |
| PSYCHOTHERAPY IS AN UNKNOWN QUANTITY AMONG MEDICAL TREATMENT METHODS | 24 | 19 | 39 | 16 |
| THAT PSYCHOTHERAPY IS CONSIDERED AN EFFECTIVE MEANS OF CURING MENTAL ILLNESS IS EVIDENCE OF THE POWER OF A MASS DELUSION | 16 | 14 | 29 | 18 |
| PSYCHOTHERAPY IS THE TREATMENT OF CHOICE IN ALL PSYCHIATRIC DISORDERS | 7 | 7 | 14 | 8 |
| PSYCHOTHERAPHY IS MORE LIKELY TO BE DETRIMENTAL THAN BENEFICIAL | 4 | 9 | 10 | 8 |

## Appendix

# PSYCHOTROPIC DRUG SCORE

| ITEM | BALINT Agree (%) | BALINT D/K (%) | PRG Agree (%) | PRG D/K (%) |
|---|---|---|---|---|
| PSYCHOTROPIC DRUGS HAVE THEIR PLACE IN PSYCHIATRY | 100 | 0 | 98 | 0 |
| PSYCHOTROPIC DRUGS CONSTITUTE A MAJOR BREAKTHROUGH IN OUR ATTEMPTS TO HELP THE MENTALLY ILL | 84 | 12 | 92 | 6 |
| PSYCHOTROPIC DRUGS ARE BEING USED TOO FREQUENTLY AND WITH LITTLE THOUGHT TO THE INDIVIDUAL PATIENT | 77 | 12 | 77 | 8 |
| THE USE OF PSYCHOTROPIC DRUGS HAS FACILITATED THE MANAGEMENT OF THE HOSPITALISED MENTALLY ILL AND AIDS IN CREATING A STATE MORE FAVOURABLE FOR PSYCHOTHERAPY | 71 | 12 | 37 | 28 |
| USE OF PSYCHOTROPIC DRUGS MAY OR MAY NOT BE HELPFUL TO PATIENTS WITH EMOTIONAL ILLNESS | 69 | 21 | 78 | 16 |
| PSYCHOTROPIC DRUGS LEAD TO MIRACULOUS RECOVERIES IN MENTALLY ILL PERSONS | 32 | 26 | 25 | 29 |
| PSYCHOTROPIC DRUGS CURE NOTHING AND CAN OFTEN CONFUSE THE TREATMENT | 23 | 13 | 6 | 12 |
| THE USE OF PSYCHOTROPIC DRUGS OFFERS VERY LITTLE TO PSYCHIATRIC TREATMENT WHILE PRESENTING MANY RISKS, PROBLEMS AND OBSTACLES TO MORE EFFECTIVE TREATMENT | 19 | 11 | 6 | 12 |
| THE USE OF PSYCHOTROPIC DRUGS HAS BROUGHT MAN'S CONTROL OF MENTAL ILLNESS TO A POINT SIMILAR TO MAN'S CONTROL OF PAIN | 19 | 14 | 31 | 12 |
| THE USE OF PSYCHOTROPIC DRUGS SHOULD BE DEFINITELY DISCOURAGED IN PSYCHIATRIC TREATMENT BECAUSE OF THEIR DOUBTFUL VALUE AND THE DANGER TO THE PATIENT | 9 | 16 | 6 | 14 |

# Aims and Objectives and Balint-Training

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Many useful ideas about teaching have been brought into postgraduate education following the introduction of structured vocational training for general practice. The organisers of training courses have had to learn about curriculum planning and how to write formal descriptions of their teaching objectives. This involves writing specifications of what is expected to be achieved by the learner and how he will be expected to behave after training.

Case discussion groups have been shown to be valuable in general practice training[1] even though such groups differ from the traditional Balint-group in having none of their stability of membership or consistent attendance. I believe that those of us who are enthusiastic about the educational advantages of Balint-group training have a duty to explain what they are all about and to demonstrate how effective they are. As a first step it is useful to try to define the aims and learning objectives of group-training. This is to help those who are considering whether to get involved in Balint-training to know what they have to offer. Course organisers, potential group members, and those who have to authorise paying for running groups all need to know as much as possible about them.

The idea is to clear up misconceptions by showing all concerned exactly what is being aimed at, even though there still is really no way of appreciating what it is like to be in a group without actually experiencing one. I propose to define the aims and objectives as behavioural descriptions as these are commonly used in educational program planning. This is therefore an attempt to redefine the learning expected of Balint-group members in educational terms rather than in the jargon more usually appreciated by those familiar with psychodynamics.

When the first Balint-groups were formed in the 1950s, their purpose was not clearly agreed. They were advertised as research-cum-training groups designed to study psychological problems in general practice. Michael Balint's interest was to see how appropriate it was to attempt to offer some training in psychotherapy to those general practitioners who were interested. From his point of view, it was an experimental exploration of the nature of general practice to see if psychotherapeutic skills might have a useful place. From the viewpoint of many of the doctors who joined the early groups however, it seems that their expectation was to be taught how to look after their patients for whom ordinary medicine did not seem to be relevant. They came, for the most part, expecting to be given answers to their problems by someone who was expert in psychiatry and therefore able to teach them how to treat their difficult emotionally disturbed patients.

In his book, 'The Doctor, his Patient and the Illness',[2] Michael Balint explained that his concern was to equip with appropriate skills those doctors who found that they were untrained to deal with psychological problems. He explained that psychotherapy was above all not theoretical knowledge, but a personal skill that could be learned by discussing cases in a small group led by a psychoanalyst. He reported how he had set out to create conditions in which doctors would, from the outset, be able to practice psychotherapy under supervision and would be helped to review their own methods and responses to patients. In a dictum that has become famous he observed that the acquisition of psychotherapeutic skill did not consist only of learning something new, but inevitably also entailed *a limited, though considerable, change in the doctor's personality.*

This statement has always sounded a daunting prospect. Almost as if each member of a Balint-group ought to be in personal therapy in order to learn more about coping with patients. Although it may be a subtle observation of what does happen when a doctor turns to learning psychotherapeutic skills, it is questionable whether it is an essential experience for every general practitioner who spends time with patients who have psychological problems. Indeed in *A Study of Doctors* it is made plain that Balint-training is not effective in helping every general practitioner, even among those motivated to want to join a group. It is unlikely therefore that Balint's observation about the limited though considerable change of personality is appropriate as a training objective so much as a description of one outcome of a successful training in psychotherapy. Many doctors who have joined groups and have seemed to benefit do not, these days, undertake formal psychotherapy as part of their work. Rather, they practice medicine with their emotionally upset patients in a somewhat more sensitive way than before. The emphasis has moved away from attempting to translate psychotherapy into a general practice setting, to helping doctors develop appropriate personal skills in the setting of their everyday work with patients.[4] If the intention is to start trying to assess the process of learning that takes place in a group, I think it may be more helpful to put Balint's observation about personality to one side and try to look more closely at the way the doctor approaches his work. Balint-training may well involve personal change inside the doctor, but it is primarily about the way he looks after his patients.

The development of vocational training for general practice in Britain has encouraged those involved in teaching about general practice to state the educational objectives of their training programs in behavioural terms; emphasising the anticipated achievements of those who undertake training. The discipline of attempting, before starting out, to describe where you hope to be going, is a very useful one. In Balint-training, the individual group members may well grow in different directions in accordance with their personal agendas, so it is probably inappropriate to be too specific about what each will

achieve as a result of training. Nonetheless it is useful to consider the general purpose of teaching family doctors and to specify as precisely as possible what the successful outcome of training ought to be.

It is only by making a clear statement of what is being attempted that a start can be made in assessing whether the training has been successful. It is also a useful preliminary to studying how doctors learn in Balint-groups, for it enables the group-leaders to see in what way they achieve their predicted purpose and to study how some group members carve out their own personal pathways.

It is salutary to be reminded that recently one group-leader, apparently feeling disillusioned by the theoretical basis of the direction taken in group-training wrote, 'Balint-groups seem to cultivate vagueness, vagueness in theory, vagueness of model, vagueness of training, vagueness of project.'[5] I think that the time has come to try to define more clearly what the training and purpose of Balint groups involves. Those who might be interested in joining a group have a right to know what the group is about. Group-leaders might do well too to be clear about what they are trying to achieve.

The broad aims of Balint-training can be seen in three general ways. To start with, the primary purpose must be to encourage doctors to value their interpersonal skills. The technical knowledge that can be such an overwhelming part of all medical student training tends to displace the time that might be devoted to learning how to work with patients as people. For many young doctors, it comes as an exciting release to discover that it is alright to enjoy patients; that it is safe to admit that some patients are more difficult than others and that working with a whole range of personalities within medical practice is difficult and needs skill.

A further aspect of this is to become aware of the limits of one's personal competence; to know what can be done and what cannot. To achieve this it may at first be necessary to encourage trainees to attempt to help even those patients whose problems are in fact beyond their reach. It is impossible for anyone to learn how far they can get to unless they have tried to work with a range of problems, from easy to impossibly difficult.

The next concern is with understanding what patients need to communicate, rather than just hearing what they are saying; perceiving when a patient needs to be in closer touch or perhaps when to leave well alone. Every doctor varies in personal sensitivity so the individual variation in this field may well be wide. The aim is that, no matter who sensitive they were to begin with, training should increase their skills.

The last general aim may perhaps reflect more directly the kind of development that Balint described as a *limited though considerable change.* It is that doctors should become away of their 'blind-spots' in their interaction with their patients. Learning new facts and skills is relatively easy and is a function that all medical students and young doctors undertake readily. It is far more difficult to become aware of previously unknown difficulties and to learn how to give up defensive behaviour. If a doctor can learn to work with patients who previously he could not help, or use approaches to patients that he could not have attempted before, then he must have developed a valuable extension of his professional skills. This would certainly point to his having undergone a considerable personal change as well. Three broad aims of Balint-training can be defined as follows.

**Aims:**

A) To encourage doctors to value their interpersonal skills and learn to understand their limits.

B) To improve the doctors' perception and understanding of their patients' communication.

C) To allow doctors to become aware of their 'blind-spots' in their interaction with their patients.

We must now specify some detailed objectives to describe the expected behaviour of Balint-group members as they develop increasing experience and skill. The purpose of specifying learning objectives is to offer defined markers against which to measure the predicted changes of behaviour. A list of specific objectives should never attempt to be comprehensive, but should provide indications of the more important lessons learned. In the list that follows, I have tried to choose items that look at both the doctor's personal professional development and his increasing skills with his patients. I have also tried to describe behaviour that can be observed within the group discussions and that which is seen in his professional work in the practice.

**Objectives:**

That each doctor will:

1) Show increasing sensitivity by presenting case histories to the group that show developing awareness of previously unperceived problems.
2) Demonstrate increasing discrimination of the patients' emotional needs by responding more selectively to those areas in which the doctor can be effective in helping.
3) Demonstrate increasing discrimination of the doctor's own capacity to help, by showing that he values difficult patients as worthwhile people without, nonetheless, being overwhelmed by them.
4) Indicate the extension of his therapeutic range by becoming closely involved with patients whose problems he could not previously manage.
5) Suggest the development of a capacity to work at a deeper emotional level with some patients by discussing cases in the group that show how he has used his own emotional responses to the patient to further his personal understanding of the patient's personality and problems.
6) Expose some indication of personal development in accordance with his internal need, by discussing cases that have a common theme that shows developing concern with specific, personally sensitive emotional areas.

7) Declare appreciation of learning new interpersonal skills in a Balint-group by enthusiastic regular attendance at the group meetings.

I hope that others involved in developing training courses may be interested in pursuing further the difficult task of assessing the outcome of Balint-training. I believe that the essential first step towards this requires a more accurate definition of their aims and objectives and this paper has attempted to address this task.

The next requirement will be to develop ways of testing the level of achievement of the objectives described, or perhaps a redefinition of what has been attempted, but in even more specific terms. We need to move towards developing methods of assessment if training-groups are to be successful in attracting support from those who plan and resource medical postgraduate studies. I look forward to critical comments of this approach and the opportunity to develop further this difficult but important task.

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# Obituary

## Dr. PADDY MONK, M.B., B.S., Lond., D.C.H., Eng.

Paddy was born in 1927, an only child christened Patricia, but always called Paddy because her father wanted a boy, (ie "Paddy the Next Best Thing"). She lived in Paris until she was seven, as her father worked there for a British cloth manufacturer.

Her schooling was interrupted by a move to Wales, away from the London air-raids. She decided early to take up medicine. After the great difficulties common for girls in those days, she got into King's College in the Strand and finally qualified from the West London Hospital in 1950. Junior appointments followed at the West Middlesex Hospital, and finally as Paediatric Registrar and Medical Registrar at the West London Hospital where I was Consultant. (L.P.E.L.) But when Paddy was working for the M.R.C.P. she decided in 1958 to get married and look after her own children. She made an excellent mother for her two daughters, born within two years of each other.

She loved gardening and going on holiday. When the girls were very young, Swanage and Brittany were her favourite places. In the past six years we had found a delightful villa on a hillside overlooking the bay of Cavalaire. Paddy's mother also has a nice flat overlooking the Sussex coast at Angmering where we often spend weekends.

Paddy gave up work for a few years when the girls were at school but soon returned to run the staff at University College Hospital with Jean Candy, her friend since student days.

She drove us to our usual villa in the South of France at the beginning of June, 1986, in good health. A few days later, soon after getting up, she complained of feeling 'odd'. Within minutes she was unconscious and was admitted to the Timone Hospital in Marseilles where she died the next day without regaining consciousness. A diagnosis of cerebral haemorrhage was made on the evidence of a brain scan.

She joined Enid Balint's Tuesday afternoon group, later taken over by Bernard Barnett and Cyril Gill, at University College Hospital in the autumn of 1973 and made an immediate impact as a warm, motherly figure devoted to the nurses and resident staff of the hospital.

I have a fantasy of her typical case at the time, of a nurse with glandular fever, alone in the Private Wing of the Hospital. Paddy would say go home for the weekend to mother in Crawley or Stevenage, for a rest and good food, and they always came back worse, much to her surprise.

She was very disappointed when they closed the staff clinic and she was transferred to the Early Diagnostic Unit at the Elizabeth Garrett Anderson Hospital in 1984.

Paddy joined the Balint Society and attended meetings regularly and was elected to the Council in 1979.

The warmth of her home was extended to the Council for many meetings where we enjoyed her hospitality. He heart overflowed with tenderness and generosity. For years she belonged to a society engaged in the civilized art of flower arranging. She was also a member of her local Horticultural Society.

Her family meant everything to her, and with them she had been preparing for and keenly anticipating her daughter Susan's wedding.

L.P.E. Laurent
P. Graham

# Did I talk too much? : A Balint-group for patients

John Salinsky,
General Practitioner, Wembley

We are all familiar with the notion of doctors meeting in Balint-groups to discuss their relationship with their difficult patients. But have you ever wondered whether there were any groups for patients to discuss their management of difficult doctors? It is not unreasonable. After all it takes two to make a relationship and doctors must seem every bit as difficult to patients, as patients seem to doctors. And if the doctors can benefit from a Balint-group, why should patients not benefit also?

Well, I can reveal to you that a Balint-group for patients to discuss their doctors really does exist and a few weeks ago I was privileged to attend one of its meetings — strictly as an observer.

The leader of the group was an elderly lady whose gentle cornflower blue eyes seemed to be full of wisdom and understanding. She explained to me that the work of the group was to help patients to manage their doctors and understand their needs. I must realise, she said, that it was in no sense a therapeutic group for the members. Indeed, those who had come expecting personal therapy were advised to seek it elsewhere. The focus was always on the patient/doctor relationship and the feelings aroused in the patient by the doctor's behaviour. Group members were principally there to improve their skills in doctor management. However she did concede that after several years in the group, some members at any rate, would achieve a considerable — though limited — change in their own personality.

As we were talking, the group-members had begun to drift into the room in two and threes, chatting amicably. They all seemed very relaxed and friendly and all kinds of patients were represented. There was a rather frail old lady in a lavender coloured dress and pearl necklace; And a self important looking bald man in a checked suit and bow tie. One was a lad of only about twenty in a tee-shirt and jeans. He had an earring in one ear and rather a lot of acne, poor fellow. Then there was a very intense dark haired woman of about thirty with lots of bracelets which clinked tunefully as she moved or gestured. And several others, I think nine in all. A bottle of wine was opened and when everyone had a glass the leader cleared her throat and said: 'Shall we start? Who has a doctor?'

After a pause of perhaps half-a-minute a stout lady in a green dress said she thought she might have a doctor she could present but she was not sure if he was suitable. The leader assured her that any living doctor was suitable but they preferred not to have dead doctors as there was no possibility of follow-up. The lady in green said her doctor was certainly alive but she had not yet had a chance to study him in depth, having only recently joined his list. However, she went on ominously, it was already clear that there were going to be problems. 'Please . ' said the leader, smiling encouragingly; 'Tell us about him.'

So the stout lady in the green dress began to tell us about her doctor. She had been to consult him about one or two symptoms which were worrying her, and which she wanted to have cleared up. She had been very light headed lately: not exactly giddy, but sort of floating. Then there was a rash on her neck which kept coming and going and a sort of bloated feeling in her abdomen. There was a tingling sensation in her left hand and a terrible tiredness whenever she tried to do anything. What she really felt she needed was a complete check up at a good hospital. Oh yes and something for her cough which had persisted for seven weeks, and clearly needed an antibiotic, but not penicillin as she was allergic.

'As I was talking,' the lady in the green dress continued, 'the doctor seemed to sink lower and lower in his chair. He looked *very* depressed. When I had finished he said, 'you don't need a check-up. And you don't need an antibiotic. Your symptoms, (he said) are all due to your anxiety as I told you last week.' I don't remember what he said last week', said the lady in the green dress, 'because I'd gone in for something quite different. Anyway he wanted to know what was worrying me and whether there were any problems at home with my husband! Well of course I told him there was nothing whatsoever wrong with my husband and the only thing I was worried about was how I could get myself properly checked over at the hospital and get some antibiotics for my cough, but he didn't listen to a word I said! He just repeated that it was all due to my emotional conflicts and I was to come back next week to discuss it in more depth. Well, I mean to say! (said the lady in green, indignantly) what was there to discuss? He clearly had not the remotest idea what was wrong with me and he wouldn't send me to anyone else who did. So what am I to do?'

'Thank you very much', said the leader. 'A most interesting case. Now (looking round) what do other people in the group think about this doctor?' 'It's my opinion', said the man in the checked suit and bow tie, 'that this doctor has recently been on one of those postgraduate courses in psychological medicine, and he's trying out a few new ideas. Now I've nothing against them going on courses on principle. It's only right that they should try and keep up to date. But it sounds as though this one has come away with some rather half-baked notions. A case of a little learning being dangerous. I would advise you, (he went on, addressing the lady in green), to confront him. Challenge him. Point out that he is not yet qualified to suspect you of emotional disorders.'

'Oh, no, I disagree', said another voice. It was the grey haired lady in the lavender dress and pearls.

Paper given at the International Balint group-leaders meeting in Solothurn, Switzerland, May 9th, 1987.

'I think that would be too unkind'. She went on. 'After all he is doing his best and one shouldn't discourage him. He probably quite genuinely believes that you have a psychological problem, dear, and he's trying to help you'.

'Rubbish', said the lady in green haughtily. The leader looked from one to the other a little apprehensively and then she said; 'I wonder how other people feel about this doctor?- What sort of person do we think he is? Do we like him? Does he make us feel angry — or what?'

'I have no clear picture of him at all', said the young man in the tee-shirt and jeans. 'He's just a blank, a stereo type of medical incompetence, as far as I am concerned. I don't even know what he looks like.' 'Well,' said the lady in green, 'he's about 5 foot six tall, a little overweight, fortyish but looks younger, dark curly hair, glasses. Nice smile when he lets it show. Quite cuddly, really.'

There was a snort of disgust from the dark haired lady sitting next to her. 'Oh!' she exclaimed, jangling her bracelets violently. 'I find that absolutely infuriating. I don't think he sounds in the least cuddly. I mean I've never seen him but when you describe him smiling, it sounds so superior and condescending. And the way he treated you? As if you were a complete imbecile. Just like a man. What we need is more women doctors. We should insist, as women, that every practice has at least one woman doctor so that we have a choice . .'

'Well, I don't know about that,' said the man in the checked suit and bow tie, 'I've met some pretty unsympathetic women doctors in my time, if it comes to that. I remember one I saw years ago who never looked up from her prescription pad. Just said: 'go into the cubicle and take your clothes off . .'

'I think,' said the leader, with a twinkle in her wise blue eyes, 'I think we must try not to get side tracked on to other doctors, however fascinating. We seem to be running away from Grace's doctor. Perhaps he makes us feel uncomfortable, for some reason. I don't know. What do you all think?'

There was silence for a while and then the grey haired lady in the lavender dress said: 'I feel we need to know more about his background. Do you know if he is married? Does he have any children?' 'And what about his own childhood?' said an earnest girl in gold rimmed spectacles. (I think she was a social worker). 'Many of these doctors had fathers who were doctors, you know, and they were forced to go into medicine by powerful parental pressures. He may be quite unsuited to the sort of life-style a GP has to cope with. Do you know if he comes from a medical family?'

There were a number of other questions of this kind and the lady in green filled in the details as best she could. But it didn't seem to get them much further. After a while, the leader intervened gently. I noticed that she only had to raise her voice very slightly to produce a respectful silence. 'What a lot of questions we are asking,' she said. 'And yet all we seem to be getting is answers. Very little else. Perhaps we would do better to look at the here and now. After all we have quite a lot of information about what went on between Grace and her doctor. Her request for a hospital check-up was not so unreasonable. Why did he react so negatively?'

The group was thoughtful for a while. I wanted to say something myself, but as I was only an observer, I thought I'd better not. 'It seems to me' said the man in the checked suit, 'That we have here a doctor who doesn't like being told what to do by his patient. Especially a woman patient. I can understand that. I would feel the same myself. He needs time to make up his own mind about your symptoms; perhaps you gave him too many at once, it's easily done. I usually feed them to my doc one at a time, so he can digest them, so to speak. Now if you throw him all those symptoms at once and then tell him you want at antibiotic and a check-up — it's as if you were making the decisions for him.'

'Yes, yes,' said the dark young lady with the bracelets. 'You're castrating him. You are cutting off his diagnostic manhood. No wonder he revenges himself by calling you a psychiatric case. You probably remind him of his mother. I see him as very regressed and totally narcissistic. Don't you agree?' she said, turning to the leader. 'Well!' said the leader, 'I don't think we want to get too involved with technical terms. But I take your point. I think that what both you and Charles are saying is that this doctor likes to feel that he is in charge.'

'It's a bit of a power struggle really, isn't it?' said the lady in lavender. 'I remember something very similar happening with your last doctor. Perhaps you actually like a doctor you can fight with a bit . . .' 'He colludes with her,' interrupted the dark young lady, clinking her bracelets excitedly, 'in a sadomasochistic relationship.' The lady in green, whose name was Grace, didn't like this at all. 'Well, what about that doctor of yours?' she retorted sharply. 'He must be a masochist to put up with you for all these years.'

'Ladies, ladies', said our leader, smiling bravely. I think we should remember that we are here to help Grace to understand this particular doctor and his needs a little better. He certainly arouses some very powerful feelings in the group, doesn't he?. I should guess that he also feels angry; and hurt. Perhaps humiliated. How can Grace help him to deal with that?'

There were various helpful suggestions after that and it was agreed that Grace should keep the next appointment suggested by her doctor and try to get to know him a little better. Various predictions were made about the outcome ranging from a referral to the consultant of her choice to being removed from the doctor's list. She promised a follow up report when she felt that the time was right. The leader then glanced at her watch and announced that time was up. She thanked Grace for her presentation and everyone else for providing such a stimulating discussion. They would meet again next week. The group then broke up; the members finished their wine and dispersed into the late afternoon sunshine. One or two stayed behind to talk to the leader. I heard her say to one of them: 'Did I talk too much?' 'Oh no,' they said in chorus. 'You were wonderful.'

# A Visit to the South African Balint Society

The South African Balint Society was founded by Stanley Levenstein in 1978 when he returned from the London International Conference, full of enthusiasm. He soon started a group in Cape Town and has held a number of Workshops with support from Enid Balint who has travelled out to Cape Town on three occasions to help.

This February I was invited by Stanley to attend the Society's Weekend Workshop and I had a very interesting and enjoyable time there. The Workshop resembles our Oxford weekend in that it enables those who are new to Balint-work to have a brief intensive experience in a group and to discuss how it felt. Unlike the Oxford model, each group takes it in turn to discuss patients, while the other members of the Workshop sit round in an outer circle and listen. After an hour the discussion is opened to the meeting as a whole with the aim of talking about the group process.

The problems of large 'fishbowls' are avoided because of the relatively small numbers present (about 20 in all — just enough for three groups). It was unfortunate that a few people were unable to be present for all the sessions so that the composition of the groups was not consistent from one session to another. Two people left after the first evening, having rapidly decided that Balint was not for them! However those who stayed were enthusiastic and seemed to get a good deal out of the experience. Those present included doctors from Johannesburg, Pretoria and Durban as well as the Cape. It was particularly nice to see Jane Eyre who is an old and valued friend of the British Balint Society.

All the sessions were led by Stanley Levenstein with a different Co-leader from each group. The patients presented were: a young man whose relationship with the doctor deteriorated when his wife asked her to 'do something about his drinking'; a coloured girl living in a township who temporarily abandoned her new born baby and alienated the sympathy of her neighbours — but not that of her GP; a family who all caused the doctor great anxiety and in which it was difficult to decide who was 'the patient'; a lady who called out her thoroughly enmeshed doctor at night 'because I needed to talk to you'; a lady with breast cancer who refused to go for treatment; a lady with a rare bone disease who made her doctor feel he should be doing the impossible.

All the presenting doctors showed considerable sensitivity to their patients and a willingness to examine their feelings in the group. In the open discussions there was, as usual, a tendency to go on talking about the patients, but we also discussed different styles of leadership and the extent to which a group needs to agree and define its agenda.

As this was South Africa, I was naturally interested to find out whether the benefits of Balint-training were available to black doctors and black patients. The doctors present were all white with the exception of one coloured lady. It was explained to me that the Group Areas Act prevents non-whites from living in white designated residential areas although they may go there to work. This means that a white doctor practising in a white suburb will have no black families living in his practice area, although he may treat a few black workers on a casual basis. White doctors otherwise treat black patients only in free clinics, known as day-hospitals which exist in non-white areas and townships. I visited one of these clinics with Stanley's brother, Dr Joseph Levenstein who teaches general practice to Cape Town University medical students.

We talked to four students who had just had their first exposure to general practice medicine and were trying to make sense of patients who had a lot of symptoms, but no diseases that could be found in the textbook to account for them. The histories they related to us might have come straight from the first chapter of 'The Doctor, his Patient and the Illness'!

These students had never heard of Balint but they responded to a seminar on the benefits of 'patient-centred medicine' with great interest and intelligence. I was cheered by their obvious kindness and concern for the hardships of their coloured patients. Whether this would have extended to giving them democratic rights I am afraid I did not find out!

The South Africans are about to launch Vocational Training for general practice and one of the participants in the workshop, Dr Ron Henbest will be closely involved with it. He is a lecturer in primary care at the new Medical University of South Africa (Medunsa) which is situated in Bophuppatswana, one of the so-called Black Homeland states which the republic has created. Dr Henbest is enthusiastic about Balint and has already started a group for the staff at Medunsa. He is hoping to incorporate Balint-training into the postgraduate general practitioner training programme when this starts. The trainees, I was told will be 50% black and 50% white, so here at any rate there will be an opportunity for black doctors to take part in Balint-groups. As always, there will be a problem in finding or training suitable leaders — an area in which we in Britain might be able to help.

During my stay I also had the opportunity of watching Stanley at work, putting the Balint-approach into action with his patients in the surgery. He practises in partnership with his father and brother, Joseph who is also a Balint enthusiast. I was envious of the generous amount of time they had for their patients — I was assured that the day of my visit was unusually quiet for a Monday!

I have to admit that I also did a fair bit of sight-seeing. Cape Town is a strikingly beautiful city with wonderful views of the sea and the everchanging Table Mountain which dominates every vista. To quote the title of one of Alan Paton's books: 'Ah, but your land is beautiful'. The 'BUT' leads one to the wish that the stubbornly entrenched Afrikaaners could be persuaded by peaceful means to share the land more equitably with the other racial groups whose suffering and hardship unhappily continues.

It would be nice to be able to attend a truly non-racial South African Balint Workshop in which black and white doctors and their patients were all

equally represented. Until that is possible I feel that it is better to support those whose hearts are in the right place, than to turn one's back on the country.

I am grateful to the members of the South African Balint Society and their president, Dr Saville Furman for their kindness and help during my stay. As they say in South Africa: 'Go well, my friends'.

JOHN SALINSKY

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# The School of Balint Method

Dubrovnik, Yugoslavia

The work of the Dubrovnik Inter-University Centre of Postgraduate Studies has been extended by the opening of the School of Balint Method. The Opening Ceremony took place during the week of May 17th to 23rd, during which time the theme of the School was the Development of Balint-groups all over the world.

The Directors of the School are:

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|---|---|
| Muradif Kulenovic<br>Vladimir Zoric<br>Ante Budak | University of Zagreb |
| Roger van Laetham | University of Brussells |
| Endre Schnell | University of Budapest |
| B. Luban-Plozza | University of Locarno |
| Enid Balint<br>Jack S. Norell | University of London |

The School is designed for general practitioners, psychologists, psychiatrists, psychoanalysts, social workers and students of these groups, and the intention is to bring all these professionals closer together through the use of the Balint method to increase their sensitivity to the needs we are all trying to help.

Book knowledge, nor love alone is sufficient to make people understand each other better. Only direct experience and personal contact can counter the dehumanising effects of the increasing use of technology.

The first year's work will attempt to explore the interactions in a Balint-group and to find out how the Balint movement is progressing in Yugoslavia and throughout the world.

It is hoped to hear from doctors who were among the first to work with Michael and Enid Balint, and who were the founders of the Balint movement; to learn from them about the setting up and running a Balint-group, the qualities and training required for Balint-group leaders, and the duration and termination of a group.

The School courses will run for a week, with morning and afternoon sessions. The actual subject matter of each course will be flexible and depend on specific requirements. The working language will be English. Accommodation can be arranged if required. Inquiries about the School should be addressed to:

The Secretariat of the Inter-University Centre of Postgraduate Studies,
Frana Bulica 4,
YU — 50,000 Dubrovnik,
Yugoslavia.

or to:

Professor M. Kulenovic,
Centre for Mental Health,
Kuspaticeva,
12 Rebro,
41,000 Zagreb,
Yugoslavia.

PHILIP HOPKINS

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# Book Reviews

**La Technique en Question: Controverses en Psychoanalyse. André Haynal.** (Pp. 206. 130 Fr. ISBN 2-228-22400-6) Paris. Payot. 1987.

André Haynal studied philosophy in Budapest, medicine in Zurich, and spent many years in neurology and neuro-surgery before turning his interest to psychiatry. He has been practising as a psychoanalyst for over twenty years in Geneva, has been president of the Swiss Society of Psychoanalysis and is a professor in the Faculty of Medicine in the University of Geneva.

Haynal has written several books on psychoanalytic themes and on psychosomatic medicine. In this new offering, he leads his readers through an original and fascinating inquiry into the problems concerning the 'psychoanalytic technique', largely based on Michael Balint, the psychoanalyst and his place in the discussions, i.e. the legacy of Freud and Ferenczi.

The role of the psychoanalyst in the psychoanalytic situation is a topic of great interest, especially for those of us who, although outside the world of psychoanalysis, have been drawn into trying to understand something of its concepts through our working for so many years with, and being influenced by Michael and Enid Balint.

Not only is my French dictionary more thumb-marked, but somehow I seem to understand better the way in which the relationship between the analyst and analysand can be reflected in that between the Balint-group leader and its members, and in turn, between the doctor and his patient, whose problems are the subject of the group's discussions.

Haynal's new perspective was made possible by the availability of unpublished material, including the voluminous correspondence between Freud and Ferenczi, and the collection of Michael Balint's manuscripts, memoranda, letters and other materials, which Enid has generously given to form the basis for the Balint Archives at Geneva.

The first four of the book's seven chapters are devoted entirely to psychoanalytic controversies. The fifth chapter entitled, 'The analyst — the unknown — and his regressed patient. The work of Michael Balint', and his approach to psychoanalysis. In particular with regard to the way in which he worked within the framework of Freud's premises, yet adding his own innovations to them. It becomes evident why Michael is regarded as one of the 'Independent group', as described in another recently published book edited by a psychoanalyst member of the Balint Society, Gregario Kohon.[1]

It is suggested that Ferenczi's interest in the psychological aspect of medical practice even before meeting Freud,[2] and his concern about the psychology of the doctor and its repercussions on his patients, and his observation that, '. . . the personality of the physician often has a greater effect on the patient than the medicine prescribed'. This observation, Haynal suggests, was the point of departure for Michael Balint's ideas on medical education.

He also refers to Ferenczi's comment on the demands made by psychoanalysis on the physician's need to have 'untiring sensitivity' to all his patient's psychological needs, for which the doctor must have a flexible and receptive mind, which can only be attained by being analysed. He wrote, 'How the future medical student will acquire this profound self-knowledge is a difficult question to answer.'[3]

Haynal suggests that by way of reply, Michael set up 'training-and-research groups' for general practitioners along the lines of the Hungarian psychoanalytic training programme, in which the trainee-analyst associates freely in their own analyses around the cases they are treating. Inspired by this experience, it is further suggested that Michael thought it should be possible to create a training for general practitioners that would bring about the required 'considerable though limited change of personality . . .'

But, Haynal states that, 'The time has not yet come to make a definitive evaluation of Balint-groups . . .' and that, 'Balint's dream of promoting the psychological dimensions of medical education has only partially come true . . .' Some readers may be disappointed that he has under-estimated the influence that Michael's work has already had on the practice of medicine all over the world, but on the other hand, perhaps it may be wise to be cautious, and not invite criticism of being unrestrained and over-enthusiastic about a treatment that has not yet been accepted and thought to be adequately proved to satisfy the more scientifically minded colleagues among us. Although in the long term it will be our patients who will accept or reject what we offer them.

Chapter 6, 'From Budapest to London: The life of Michael Balint'. is devoted to a short biography, with emphasis on his life and work in England, will probably be the most interesting part of this book for general practitioners. There is an Appendix listing the dates and venues of all the congresses of the International Association of Psychoanalysis, and another one which lists the bibliography of Michael's works.

An English translation is to be published and will make an interesting addition for the practice library of any doctor who has felt the effects of Michael Balint's ideas.

PHILIP HOPKINS

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**An Outline of Psychotherapy for Medical Students and Practitioners. Ed. H. Maxwell.** (Pp. 107. Paperback. ISBN 0 7236 0849 0. £6.25p.) 1986. Bristol. Wright. This is a welcome addition to the 'Outline' series, and to the growing number of books about psychotherapy which, as Steven Hirsch, Professor of Psychiatry at Charing Cross Hospital Medical School, states in his Foreword, is attracting a growing appreciation by the medical profession, as well as 'an exploding interest on the part of the public.'

Harold Maxwell makes no apology in the preface, nor does he need to, for giving his readers such a practical outline of various aspects of psychotherapy. He sets a high standard in the first chapter in which he describes in his general introduction to the subject, the basic elements of the principles and main features of the different forms of psychotherapy.

No chapter in any book can be comprehensive, but nevertheless he manages to consider adequately the sort of clinical conditions, as well as the factors involved, in evaluating their suitability for psychotherapy. In addition, he starts the description of psychoanalysis, 'the special method of psychotherapy invented by Freud' which is developed in more detail in the second chapter.

Here, David Alexander, senior lecturer in mental health at the University of Aberdeen, has written one of the best brief accounts of psychodynamic therapy, dealing with many of the main issues involved, that I have had the pleasure to read.

In subsequent chapters, Jon Sklar, consultant psychotherapist at Addenbrooke's Hospital, Cambridge, deals with the emotional responses of medical students, and their need for help in learning how to deal with the repeated assaults on their emotions resulting from their training. Chris Thomas describes his work as a consultant liaison psychiatrist with patients in a general hospital, who are emotionally disturbed by the effects of their physical illness.

Andrew Elder's chapter reflects his keen interest and considerable experience in the place of psychotherapy in general practice. Other chapters deal with the place of group, family and behaviour therapy.

This is not a book about how to practice psychotherapy, but one which provides the outline intended about its development possibilities, and as such can be highly recommended for medical students, trainee general practitioners and indeed all clinicians who wish to improve their understanding of it.

P.H.

# Residential Balint Weekend at Pembroke College, Oxford

From 6 p.m. Friday, September 18th to 1 p.m. Sunday, September 20th, 1987

General practitioners, whether trainees or established principals, experienced teachers of general practice, and course organisers, are invited to sample the experience of attending a Balint-group for a weekend.

There will be an initial demonstration group, consisting of a few volunteers, on Friday evening: following an interval, there will be an open discussion of the group's work. Most of the rest of the weekend will consist of work in Balint-groups, each having two experienced group-leaders.

All who attend are requested to come with suitable case-histories to present for discussion, and all group-members will be expected to be committed to stay for the full course of four group-meetings on the Saturday and Sunday.

Accommodation will be available for a few husbands/wives who may wish to spend a weekend in Oxford, and who may wish to share the meals, including the Conference Dinner on Saturday evening, but sadly, they will not be able to attend the meetings. They will be welcome to join in the walking tour of Oxford which will be arranged.

Section 63 approval is expected.

Further details and programme/booking forms are available from the Secretary:

Dr. Peter Graham,
149 Altmore Avenue,
London E.6.

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The editor would welcome personal views of members, details of new appointments, lectures given and so on, for publication in the Journal.

Lists of publications by members, together with reprints, will be useful for the Society's library.

Manuscripts and communications for publication in the Journal should be forwarded to Dr. Philip Hopkins.

They should be typewritten on one side of the paper only, with double-spacing and with margins of 4 cm.

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.

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