

# Introduction to Balintwork

## On Balint Groups - Origins and present state

### Balintwork leads to Psychosomatic thinking and is an advantage to the well-being of patients and doctors

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#### 1. Michael Balint: his life, his ideas

Michael Balint was born in Budapest in 1896.

In the same year Freud used the term "Psychoanalysis" for the first time in his studies on hysteria. And Freud started to analyse his dreams and himself.

A little later Sandor Ferenczi became the first professor of Psychoanalysis in the world at the University of Budapest. One of his special interests was to find out what psychoanalysis can do for GPs. He expressed his thought, that the personality of the doctor often has a deeper influence on the patient than the prescribed drug.

Michael Balint's father was a GP in Budapest. Michael accompanied his father to see patients already when he was a boy. He observed carefully and started to think about the doctor-patient-relationship early.

In 1914 he began his medical studies at the Semmelweis University of Budapest. Shortly after he had to join the war, first was sent to Russia, then to Italy. After two years he was wounded in his thumb and sent back to his home town, where he continued his medical training. His favorite subjects were physics and biochemistry. Later on he wrote his thesis in biochemistry. His other very deep interest was Psychoanalysis. During his medical studies he listened to the lectures of Sandor Ferenczi. In 1917 a female student friend – who became later on his first wife Alice - gave him Freud's book "Totem and Tabu". They both started with their psychoanalytic education in Berlin with Dr. Hanns Sachs and continued the training with Sandor Ferenczi. Michael and Alice Balint lived and worked together, shared their ideas and published together. In 1920 the political circumstances forced them to leave Budapest. They moved to Berlin, where he worked in the biochemical laboratories with Otto Warburg for half a day. The other half of the day he was in the Psychoanalytical Institute, saw patients and treated them with the "talking cure". There he met Karl Abraham and Melanie Klein, Rado and Harnik from Budapest, Helene Deutsch etc.

In 1924 he went back to Budapest to continue his analyses with Ferenczi. 1925 he started to publish his psychoanalytical ideas. He worked in the department of internal medicine and started to develop his research in psychosomatic medicine. He treated patients who showed psychosomatic symptoms with Psychotherapie – the "talking cure". He became a member of the Hungarian psychoanalytic association. He played an important role for the foundation of a Psychoanalytic (Psychosomatic) clinic in Budapest.

In 1932 Hungary was ruled by a radical right wing government, which controlled the work, the discussions and meetings of the psychoanalysts. At that time Balint had invented the first "training cum research group" with GPs in Budapest. He wanted to find out about the possibilities the GPs had to integrate psychoanalytic ideas in their practical work.

Later on it was said, that his motivation might have been to support his father in his daily struggle in the practice as well as to help to make medical care more efficient.

Although the interest was high, he had to discontinue his seminars because of the political situation. They had to tolerate policemen in the group, who took down the names of the participants and the stories they told about their patients. It was impossible to discuss freely. That's why they did not continue their work in Budapest.

Freud and his family had already emigrated to England. Michael, Alice and their son John followed in 1939, because it became more and more dangerous for them as a family from Jewish origin to live in Budapest. They first settled in Manchester. Short after Alice Balint died from a rupture of the Aorta.

Michael Balint stayed in Manchester until 1945. He became the Director of a Child Guidance Clinic. His research now focused on babies, their behavior, their relationships. He started to publish his ideas about "primary love", "primary relation" and the "basic fault".

When he moved to London in 1945 he became a consultant at the Tavistock Clinic.

He was more and more interested – just like his teacher Ferenczi – in the interaction between individuals.

For Freud neurosis based on the intrapsychic conflict of the patient. He saw the doctor – the psychoanalyst – like a mirror reflecting the patient's inner world. Ferenczi and later on Balint were convinced, that the doctor-patient-relationship plays an important role in diagnosis and therapy, that the doctor's and the patient's inner world interfere, that as well as the patient's transference, the doctor's countertransference has great influence on the relationship, on diagnosis and therapy.

## **2. Balint and the GPs**

In 1950 Balint started his group-work with GPs again, this time in London at the Tavistock-clinic and together with his third wife Enid, who was a social worker, "to study the psychological implications of general medical practice".

And they checked their hypotheses, that "the most frequently used drug in general practice was the doctor himself".

In these times many of the GP's patients were traumatized by and during the war. And – as Balint quoted – "a great number of people have lost their roots and connections... the individual thus becomes more and more solitary, even lonely... any mental or emotional stress or strain is either accompanied by, or tantamount to, some bodily sensation... one possible outlet is to drop in to one's doctor and complain..." and "It is here, then, that the doctor's attitude about how to prescribe himself to the patient becomes decisive."

Now, what does that mean?

First of all the doctor has to listen carefully, he has to understand the message, he has to be cautious with the messages and interpretations he gives. What does the patient need right now? Does he just want to present the somatic symptom, that the doctor should look at or does he really want to go deeper to the conflict, which might be behind the symptom? Is the patient ready for that? Maybe "the doctor administers himself in a too heavy dosage" – as Balint says -, when he does not respect the patient's defences.

On the other hand, if doctor and patient stick to the bodily symptoms and do not look behind, if they both search for a proper illness and then agree on it, the psychosomatic disease will become chronic and the inner conflict of the patient stays hidden. Balint: "Conditioned by their training, doctors in general choose first among the proposed illnesses a physical one, because they can understand it better, they have learned more and so know more about it, and they can express their findings more easily and more precisely. This almost automatic response might – and quite often

does – lead to a great number of unnecessary specialist examinations and to prescribing unnecessary medicines."

This was written in 1955. Nothing changed in general. Nowadays we have more unnecessary examinations and prescriptions than ever. The cost for it is immense.

Balint: "The opposite danger however, is also present. the doctor might be tempted to brush aside all physical symptoms and make a bee-line for what he thinks is the psychological root of the trouble. This kind of diagnostic or therapeutic method means that the doctor tries to take away the symptom from the patient and at the same time to force him to face up consciously to the painful problems possibly causing it. In other words, the patient is forced to change his limited symptoms back into the severe mental suffering which he tried to avoid by a flight into a more bearable physical suffering."

As we all know, it is very difficult to find the "royal way". The GP has to bear a heavy responsibility to make the right decision. To be able to do this it is necessary to integrate psychological thinking into the GP's training.

### **3. The socialization of medical doctors during their training**

In Germany the medical student's first "patient" is the dead body in Anatomy. There he learns how to handle the "material human being". In the beginning the student might still be interested in the life story of "his patient", at least in the story of the bodily illnesses, after a while the interest becomes object-centered. The student takes the body as a scientific specimen, where he has to learn the facts about its structure. During their studies, the future doctors change their attitude: at first they are motivated in an idealistic way, they want to help people who suffer and they are empathetic and able to listen.

Let me give you an example:

One evening a woman in her forties is brought to the hospital. Somebody had found her wandering around in her nightgown, bleeding from a wound at her forehead. Blood was running over her face and she kept screaming: "Fire, fire!" The physician on duty tries to examine her, but she resists with wild gestures. Two strong men of the nursing staff grip her – she goes on fighting. Finally they tie her in bed, angry and helpless – and call the senior consultant for help. Until he arrives, a young male medical student is directed to watch the patient. He takes place besides her bed, puts his hand on her arm, talks to her in a calm, warm and friendly manner. After a short while, the woman stops screaming, she calms down and is able to speak about her panic. She tells about people being in danger in a house on fire. The student listens patiently, not knowing whether it is a true story or if she is under delusion. She permits him to wash her face and clean her wound. He can convince her to have an X-ray made. She holds his hand tight, full of fear. A little later they get the information, that this patient lives in a home for handicapped people, which was on fire.

This patient did not function as we need it in medical business. The student was not yet infected by daily routine. In medical training students often lose their ability for empathy and patience.

The preclinical teachers mostly emphasize a scientific perspective, and the students are left alone with emotionally demanding situations.

And during the clinical training the patients are presented as "cases" and the student has to go on to learn scientific facts. He gets to know all about the illness - which is fine - but nothing about the patient as human being, nothing about the relationship, about hopes, fears, transference, countertransference and resistance, nothing about his own feelings towards the ill person. We teach an illness-centered medicine instead of a patient-centered medicine.

An example:

In a training course students had to examine several patients and fill in a questionnaire about a thoroughly done bodily check-up. The last item was: psyche of the patient. One of the students filled in: exists. None of the teachers complained, probably they did not even notice the last question, while

they were very interested in all details of the results of the bodily examination.

The medical education has a socializing impact on the student.

Investigations show at the end of medical school training an increase in cynicism and a reduction of idealistic, humanitarian attitudes. Students seem to be pressured into adopting a more rational position without their emotional involvement.

But we cannot kill our emotions, we can only ignore or repress them as a defence. As we all know, this can lead to illness and further suffering. Instead of ignoring the emotions we need to find out and talk about them. We learn how to use them as an instrument, "like a surgeon his knife", as Balint said.

That is what we train in Balint-groups. And we try to start early with Junior-Balint-groups at the Universities or integrate students in mixed Balint-groups from their first year on.

#### **4. How does a BALINT-GROUP work?**

This leads us back to Balint's idea of sitting together with colleagues, talking about the relationship between doctor and patient in a "training cum research group". The term points out Balint's interest to train the GP's in psychological and psychosomatic thinking and at the same time find out about the interaction in the group and between the doctor and his patient.

Balintgroups in Germany usually consist of 8 to 12 members. We have mixed groups with students, social workers, nurses, doctors of different specializations or homogenic groups for GPs only or for Psychiatrists or medical students or teachers or priests etc. Every doctor in Germany has to go to a Balintgroup for at least ten sessions in his postgraduate specialist training.. So they all get to know what this group-work can do: develop psychosomatic thinking, relieve from problems with patients and lead to "a slight but important change in the personality of the doctor", as Balint pointed out. If the group works together continuously, they meet every week for one session or every fortnight or once a month. In Germany one session takes 90 minutes for analysing one doctor-patient-relationship.

At the weekend workshops we have the so called "fishbowl-groups", too. That means, that we have an inner circle equivalent to a small group, and other colleagues sitting in the outer circle watching the process. That is, what we will demonstrate afterwards.

One of the members of the small group presents a case, better to say: tells the story of one of his patients. (S)he does not use any medical notes, taken in his office, but reports on his patient and their meetings out of his memories. He talks about the illness and the symptoms, the patient's emotions and about his own feelings towards the patient. Mostly this takes about 10 to 20 minutes. Afterwards the others may ask him questions. Then the group-leader tells him to lean back and relax and listen to what the group members feel and think about the doctor-patient-relationship. Whatever is fantasised helps. Pictures arise, fairy tails may come up, symbols are used. The patient may appear as a lion, the doctor as a mouse. Or the members of the family are seen as trees, the staff members maybe symbolised as sharks in a swimming pool... Nothing is wrong. "Think fresh, think freely" and "Have the courage of your own stupidity!" Balint encouraged the group members. Every idea might give a hint on unconscious contents of the story. "I looked at the report of the presenter as if it was a dream" Balint said, "and the thoughts of the presenting doctor as well as the comments and ideas of the group members were treated like free associations." The case presenter can look at what is going on from a distance. He will find new aspects, his blind spot might be enlightend, he can find out what made it so difficult to get along with his patient. Sometimes he may think that some thoughts are crazy and far away from reality. The group is like a prism or a magnifying glass. It shows all the different colours of the relationship and may focus what the presenter did not look at before. All group members in the course of time gain the ability of a more analytic observation, they are able to go forth and back from emotional experiencing to a rational reflecting position. The group-work has elements of a self experience-process, not only for the presenter but for all group

members, they all get to know more about themselves without talking about their privacy. The focus in the group is not the personality of the doctor and his private life but the doctor-patient-relationship and the understanding of the patient's signals and symptoms and the doctor's unconscious answers.

At the next meeting the presenter gives a feedback. Often it is told, that the patient seemed to be quite different at the next appointment, "as if he had listened to what was said in the group session". The communication between doctor and patient becomes easier and more effective, the compliance gets better. It is a relief for both.

The feedback is a valuable ingredient of ongoing groups.

The GPs, who work in a Balint-group, develop a more analytic way of thinking, they are more aware of their personal influence, they reflect more, they can listen better and get to the roots. There will be a "slight but important change in the personality of the doctor" after at least one year of Balintwork, as investigations show, which turns out to become an advantage for the patient's and for the doctor's well-being.

## 5. Research

Does Balintwork make treatment more effective? What is the change in the doctor's personality and behavior? What difference can you discover in the doctor-patient-relationship after one year of Balintwork?

When I looked through the abstract book for the 16th World Congress on Psychosomatic medicine in Gothenburg last year, I found some papers on the doctor-patient-relationship being important for a good compliance, for coping with chronic illness, for the well-being of the patient.

On the other hand we find some reports on the doctor's burnout, the reasons, the consequences and the risks.

I missed research looking at both: the doctor's and the patient's difficulties, an analysis of their interaction, their relationship.

And that is, what Balintwork does.

Rosin et al. (1989) examined a lot of items with "Balint doctors". they watched Balintgroups at work, they exploited videotaped groupwork, they evaluated questionnaires given to doctors, patients, groupmembers and groupleaders. They counted prescriptions of drugs, demands of blood analysis, referrals to specialists and the number of night calls. And they found, that physicians, who were Balint groupmembers for at least one year describe a significant change in their self assessment like: 98% think, that they are much more aware of what the patients want to tell them, what the hidden message behind their symptoms is and what they really need. 95% are sure, that they feel better in the interaction, that they prescribe fewer drugs, especially psychochemicals and that night calls from their patients decreased.

K. Köhle and R. Obliers from the University of Köln/Germany started in 1993 to evaluate "the development of the dialogue between doctor and patient after Balintwork" in a psycholinguistic study. Their hypotheses was, that the doctor learns in Balintgroups to recognize his emotions, unconscious reactions and answers and his affective resonance to the patient's behaviour and somatic offer. He would be able to reflect his relationship to the patient. His discourse then must become more patient-orientated than illness-orientated. The research-group videotaped interviews at first appointments before and after one year of Balintwork and documented the differences. One of these very interesting developments was, that the amount of words the doctor uses is 43% of all words in the dialogue before and 27% after one year of Balintwork, while the patients share rises from 57% up to 73%. What does that mean?

It shows, that the Balint doctor gives more room to the patients, to their explanations. He listens more to what the patient wants to express. The contents of the dialogue changes, too. The doctor

f.e. puts open questions instead of suggestive questions. He follows more often the thoughts of the patient and does not only try to explain his own ideas, give advice and convince the patient. He is able to focus the patient's perspective and not to follow his – what Balint calls – “apostolic function”. Nevertheless he is as interested in the somatic disorder as before, at the same time his interest in the emotional and social background of the patient grows. He gets a lot more information without using more time!

Dorthe Kjeldmand from Sweden presented her research-results at our last International Balint Congress in Portoroz 2001. A combined qualitative-quantitative questionnaire was answered by 52 GPs from the southeast region of Sweden, half of whom had participated for more than one year in a Balintgroup. Results: The questionnaire showed, that the Balint doctors felt more in control of the work situation. They less often thought that the patient should not have come. They were less inclined to refer patients or to take unnecessary tests in order to put an end to the consultation. They less often found Psychosomatic patients a time consuming burden. The differences increased with longer time in a Balintgroup.

In the interviews the doctors reported development of control and well-being in the consultation, awareness of own feelings, increasing interest in the whole patient and better control in the whole working situation, which avoids burnout. No negative effects of Balintgroup participation were found.

Another research group from Israel (A. Mandel, B. Maoz et al.) found similar results: they asked primary care physicians about burnout, care of patients and coping with the doctor's feelings. Those, who were members of a Balint group expressed the higher degree of satisfaction with their work, less burnout, most notably in the fields of doctors' awareness to their own feelings and particularly in their ability to cope with feelings of helplessness.

In all parameters there was a marked rise in the sense of well-being related to the group's work after more than two years of participation.

Balint's observation of a “slight but important change in the personality of the doctor” and a better doctor-patient-relationship is confirmed by letter research results. Doctors and patients profit from the supportive effect of Balint groups.

## **6. Dissemination of Balint's ideas**

Balint started his work with groups in London in the fifties.

In the 60s he travelled all over Europe together with his wife Enid. She played an important part in the development of Balint groups. His book: “The doctor, his patient and the illness” had been published in 1957 in England and was translated into German in 1964. There was a great interest in Balint's research, many psychoanalysts and GP's from all over the world read it and came to discuss their problems and ideas with Balint.

Balint groups were founded in several countries.

Group-leaders were psychoanalysts, who were interested to work together with GP's.

Around 1970 the first national Balintsocieties were founded: in France (1967), in England (1969), Italy (1971) and in Belgium (1971). In 1972 the International Balint Federation (IBF) was born.

The goals are:

1. To keep contact with the member countries.
2. To help develop Balintsocieties all over the world.
3. To advise group-leaders and help to find guidelines for their education
4. To integrate Balintwork into medical education, especially for GP's.
5. To organize an International Congress every 2nd year.

The last one was in Portoroz last year, where we heard very interesting results of research in Balint-work. The next International Congress will be in Berlin in October 2003.

Today we have 36 member-countries with national Balint societies and a number of individual members. The delegates meet twice a year to exchange experiences in practical work, in research, in leader's training etc.

Now – as I am from Germany – let me say some words about the German Balint society: It was founded in 1974, and in 1976 it became a member of the IBF. In 1989 there was a society founded in the former DDR. Right after the wall had fallen the two societies west and east united. The society is organizing weekend-work-shops (around 16 a year in different parts of Germany) with original Balintgroups and training-seminars for leaders. We now have about 500 leaders around the country. Balintwork is an important factor in the post-graduate-studies, especially for GP's. So we are happy to offer a great number of permanent Balintgroups all over Germany. The groups meet every week or every fortnight. Many of the participants do not only stay as long as they have to for their post-graduate training but continue this work for their own benefit and well-being. Since the beginning of 2000 we publish the Balint-Journal four times a year. It contains articles from all over the world, reports from the groups, research in Balint-work and other subjects. We hope, that every doctor has the opportunity to experience Balintwork, to get along better with his patients, to understand them better, to work more effective and more satisfying.