A Balint Seminar in the Family Practice Residency Setting

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British psychoanalyst Michael Balint made important theoretical and pragmatic contributions to family practice, through the seminars of general practitioners he led at the Tavistock Clinic. A weekly Balint seminar, modeled on the Tavistock groups, was held in a family practice residency. The group of second and third year residents, co-led by a behavioral scientist and a family practice faculty member, met for 12 weeks and then re-evaluated topics and discussion format. Issues covered included physician-patient relationships, ethical dilemmas, group therapy concerns, and coping with clinic pressures. Objective evaluation of these seminars, where the goal is attitudinal rather than behavioral change, presents some difficulty. The conclusion is that residents benefited from the seminar, and that some aspects of psychoanalytic theory and technique are applicable to the teaching of behavioral science in family practice residencies.

Behavioral scientists of varying psychotherapeutic persuasions and disciplines have created a rich variety of behavioral science programs in contemporary American family practice residencies. This paper attempts to show what a behavioral scientist with a psychoanalytic viewpoint can offer to young family physicians in a family practice residency. A theoretical beginning can be found in the work of Michael Balint, MD, who, it has been said, "changed the face of British medicine."[1] A Hungarian/British psychoanalyst and himself the son of a general practitioner, Balint used psychoanalytic principles and techniques to train British general practitioners. Recognizing that physicians had neither the desire nor the training to become psychoanalysts, Balint raised the question of how psychoanalytic insights could be of assistance to the family physician. The answer is in the *understanding* of individuals and families that a family physician can develop over a long period of time. The length of this association, even if the contacts are episodic, puts the family physician in a unique position to be sensitive to the central psychological conflicts as acted out in many of his/her patients' lives.

Many of Balint's ideas are similar to those which form some of the theoretical underpinnings for the family medicine movement in the United States today, for example: "whole-person medicine, in which the main task will be to understand the meaning for the person of the complaints and illnesses that he offers to his doctor. The aim of therapy will then be to enable the patient to understand himself, find a better solution for the problem facing him, and thus achieve the integra-

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tion which has not developed or has broken down because of disturbed relationship of the individual with his environment."[2] Balint thus sets the stage for the interpersonal approach so important to the study and treatment of families.

In a series of articles[3-7] and in his well-known book, *The Doctor, His Patient, and the Illness*,[8] Balint (often collaborating with his wife, Enid Balint) set forth his theories about the importance of the relationship between the physician and the patient. These theories were in large part gleaned from weekly seminars with general practitioners led by psychiatrists at the Tavistock Clinic in London. In these groups, general practitioners examined their professional relationships with their patients and looked at their own motives and personalities in the context of these relationships. Balint articulated his major premise: "In medicine we have to do with a special form of emotional understanding—understanding people in a professional capacity—which we may call clinical understanding."[9] It is this understanding, broadly defined, rather than any particular form of psychotherapeutic technique, which Balint sought to communicate to physicians. It is important to note here that these groups focused on the physicians' professional "ways of practicing medicine," not on "private counter-transference" or personal motivations.[10]

Use of these psychoanalytic understandings to teach group process along with individual self-awareness in a family practice residency has received little attention in the American medical literature. The British medical literature, however, has included reports on Balint groups, reassessment of Balint's ideas, and a brief summary of the fourth International Balint Conference, held in London in 1978.[11-14] This article will describe an ongoing group of 8 second and third year residents in a family practice residency within a large cooperative health maintenance organization.

Balint Seminar Series

This Balint seminar evolved according to the needs of the residents and the training of the faculty. Initially a memorandum was sent to all second and third year residents inviting their participation in a group "to discuss your relationships with your patients, particularly those which are causing you or the patient difficulty." Attached to the memorandum was a three-page set of excerpts from Balint's *The Doctor, His Patient, and the Illness*. The purpose of the attachment was to acquaint residents with Balint's ideas about illness behavior and about the groups of general practitioners he led.

The aspects of Balint's work which were stressed in the excerpts were: the physician as the drug, the importance of the physician's emotional response to the patient, the offering of illnesses by the patient and subsequent negotiation with the physician, the patient's need for a diagnosis, the relationship between physical and psychiatric illness, the "collusion of anonymity" between family physician and consultants, and the practice of psychotherapy in a primary care setting.

It is interesting that Balint himself suggests that the kinds of groups he ran for general practitioners are more helpful for those who have practiced for a period of time than for students or residents. At this point, the goals and functions of this kind of group in a residency differ somewhat from those of a group in general practice in different offices. The main common goal in the two, however, is the search for self-awareness, to be used in the clinic and hospital setting with patients.

The group was set for a mid-week lunch hour, which meant that the discussions ran about 45 minutes. At first, presenters were selected from among the group on an ad hoc basis, at the beginning of each meeting. Later, advance commitments were requested by the leaders, or residents requested the opportunity to present difficult cases. One or two family practice faculty and the residency behavioral scientist (a social worker) attended and co-led the group. The faculty internist also frequently attended. Attendance of residents varied, due to rotation schedules, clerkships, and other commitments. Attendance rates regularly increased over the course of the first 13 weekly sessions. An occasional first year resident would also attend.

Goals of the group within this residency were formulated at the beginning of the seminar: (1) encouraging residents' awareness of their own particular sensitivities with patients; (2) encouraging open sharing and trust among residents and faculty; (3) examining collegial relationships with other family physicians and with consultants; (4) exposing attitudes or differing value systems that might be detrimental to patient care. It was understood that the initial dilemmas of the group, as

with many beginning groups, would be: (1) dealing with the residents' need to appear competent in the presence of colleagues; (2) the establishment of an atmosphere of trust and supportive confrontation where the pain of self-scrutiny could be mitigated by the caring of the group; (3) the importance of seeing group members as similar, and yet different in some ways.

Notes on the cases presented by each resident and the major issues dealt with in each group were kept by the behavioral scientist. At first, careful attention and vigilance to the goal of self-awareness necessitated much active leadership by faculty. If this did not occur, the discussion would focus on the patient, not on the physician, and the ways in which residents all react in similar ways to "difficult" patients. During the course of the group, residents seemed to "catch on" to asking probing questions of the presenter which encouraged him/her to think about his own individual reaction to the patient and to the relationship. Thus, the group has progressed from a typical "beginning" group to one exhibiting the more close and open characteristics of a "middle" or later group.

The first five sessions of the group focused on a wide variety of problems and tended at times to center more on the patient than on the physician. In the first session the central theme was a resident's wish to cure a patient who flattered him ("you're the only doctor who has ever listened"), and his consequent unrealistic expectations for her treatment. Another early session focused on a therapy group being co-led by the behavioral scientist and a resident. The therapy group had raised questions about the competence of its two leaders, and the discussion in the Balint seminar focused on sharing of feelings the residents have as physicians when their competence is threatened. The fourth session centered on encounters with consulting specialists, the "teacher-student" relationship, particularly with residents, and group members' feelings about this sharing of responsibility. The fifth session focused on a resident's feelings when a patient becomes angry.

By the sixth session, group norms began to be established about the focus on the physician, so that more of the confronting was now initiated by group members than by the co-leaders, and relationships were now seen more in terms of, to use Balint's phrase, "clinical understanding." Themes now included the need to be liked by patients, feelings about patients who handle their own feelings in quite different ways, the interpersonal consequences and meanings of gift giving patients, the physician's response to sexual material brought up by the patient, painful dilemmas about quality care vs clinic patient pressures, and a resident's feelings about the death of an infant. This latter discussion involved a lively group interchange about male vs female physicians' expression of feelings.

At the tenth session, the family practice co-leader presented a case. This session seems to have been a turning point, with the group able to sort out issues related to the reality of the patient's demands vs the internal reality of the physician's expectation of himself. Clearly, the role modeling of openness on the part of the faculty member in being willing to examine his own motivations was important to the residents. At this point the behavioral scientist's notes state: "Everyone seems to be catching on to the purpose of the group." Within the next couple of sessions, the specific topics of discussion of the group changed a bit, partly as a result of a re-evaluation of the group's goals at the end of the 12th session. The focus was still on the internal difficulties of the residents, but the topics broadened to include dealing with the stresses of a busy clinic practice, dealing with boredom, and the triggering of strong affect in the physician by the patient (in this case, anger). In addition, "follow-up" sessions were held in which cases previously discussed were brought up again and more recent developments examined.

A written evaluation of the group experience was requested at the 12th session. Residents were asked to respond to three questions: (1) "Do you feel the group has established enough trust for us to talk openly about thoughts and feelings about difficult patients/situations?" (2) "Has presenting a patient been helpful to you, either in terms of your future relationship with the patient, understanding something more about yourself, or in relationship to other similar patients?" (3) "Are there any changes you would like to see that you feel would make the group more effective?" The level of trust was seen by the residents who responded as higher than it had been, but requiring the vigilance of the leaders as "benign, but assertive role models" to keep the discussion open. Residents felt that when they presented, they learned, and the evaluation provided a stimulus for

broadening the discussions (occasionally away from care issues, but maintaining the focus on residents' feelings and professional concerns).

Comment

The question of how to evaluate objectively this kind of seminar is a difficult one since the goals for changes in the residents are attitudinal and emotional rather than behavioral. Howard Bacal, a British psychiatrist, has evaluated seminars on the Balint model held at the Tavistock Clinic in London.[15] He conducted 12 interviews with pre-seminar physicians and 12 with post-seminar physicians. His two criteria were: (1) the physician engages in work commensurate with his own limits and he makes appropriate use of available consultant help; and (2) the interference by his own psychopathology in his work is minimal. Bacal's conclusion, after rating the post-seminar physicians significantly higher on these criteria, is that the criteria are "a measure of the doctor's ego-functioning in the task of testing and using his capacities realistically in relation to the demands of his work."

There are, of course, a number of limitations to this small-sample study conducted by one admittedly biased interviewer. As already noted, any more systematic attempt to evaluate Balint seminars in the context of a family practice residency would need to take into account residents' differential learning needs, improvement in resident-faculty interaction, faculty development, important ethical dilemmas, and the creation of an atmosphere of trust in the residency as a whole.

One of the ways in which the group described is clearly different from those held at Tavistock, is that group members interact with each other intensively on a day to day basis outside the group as well as within it. Most of Balint's general practitioners did not see each other outside of the group. The group topics thus seem more integrated into the professional lives of the residents, and the discussion on group topics goes on during the rest of the week. An additional advantage is the raising of the level of trust with the faculty, so that more open and comfortable teaching relationships are facilitated. As the range of possible topics broadens, the one point of the group remains: that it is to talk about us, how we are similar, but also how our reactions are individual and therefore more understandable by examining them in depth. Strong feelings have emerged during the course of the group, and residents have been learning not to be afraid of eliciting these in others and then helping them deal with them, a skill of inestimable value in dealing with their patients and with other life relationships. With this, the focus has been maintained on the professional, rather than personal, dilemmas which residents face.

The advantage of a Balint group in a residency setting is that the residents are already in a learning situation, and are facing daily the important ethical and emotional dilemmas in family medicine. This has meant they seize readily on the opportunity to talk about their own and their patients' feelings, to learn that the presenting problem is not always as it seems, and to ask the questions: "What does this behavior mean?" "What does my feeling about this patient mean?" In other words, residents have developed a new way of thinking and introspecting, in some measure using psychodynamic concepts of relationships as discussed, modeled, and taught in the group. Balint's goals of "limited personality change" for general practitioners may not apply here, but the goal of increased openness and tolerance for one's own and one's patients' feelings is certainly reachable and crucial in the development of a caring family physician.

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