How Balint training the Family

Summary

On entering practice in 1974, I found a big void in my knowledge, that of being able to deal with people as people and not as diseases. The void was filled by joining a Balint group in Cape Town where I developed new insights and better understanding of the doctor-patient relationship.

These new skills have helped me in dealing with the family crises. Through presenting problem cases and listening to other doctors present their problems. I learnt that I could do more for my patients by giving more of myself, and not by prescribing psychotropic drugs. I have been using these skills to good effect, not only in the day-to-day problems, but also in coping with the family in crisis.

I left medical school nine years ago with a basic training in dealing with diseases, but not with training in dealing with people. In General Practice I found that I had to deal with human beings and not organ systems. I also found that many of the problems were not amendable to heroic measures such as major surgery, dialysis, transplantation and powerful new drugs which were propagated as miracle cures at the hospital.

I therefore found myself faced with feelings of strong anxiety and inadequacy in having to deal with much more complex, subtle and demanding intra-personal problems, presented to me by my ongoing contact with patients in Family Practice.

I found that these feelings of anxiety and inadequacy made me feel insecure in my new professional role. I tried to deal with this insecurity defensively by resorting to the old style medical model which had formed part of my under-graduate training.

This however, proved hopelessly inadequate and I began to despair of being able to meet the demands of General Practice. It was then that I entered a Balint Group, and developed an insight and understanding into the nature of my difficulties in my interactions with my patients.

Through presenting patients (with whom I was having difficulty) to the group, I realised my need to cure everyone and to be seen as a good doctor by all my patients was unrealistic, rendering me a less effective doctor. I came to understand better the **realistic** potential of what I could achieve for my patients by understanding my interaction with them better and by being more accepting of what I could not achieve.

I felt very anxious in presenting my first case to the group but found them supportive and constructive in their comments and suggestions – never destructive.

Often I was landed with patients who refused referral to psychiatrists, psychologists or social workers. Here I found the group most supportive in showing me how in fact, by sensitively listening to the patient week after week, I was helping them, although I myself was feeling frustrated and irritated by them. In the early days of my group exposure it was pointed out to me that I was giving advice to patients too often.

I was giving the patients solutions for their problems without giving them the opportunity of working it out for themselves.

By listening to other doctors presenting their problem cases, I learnt new concepts, techniques and skills not taught to me at medical school. These I applied to similar cases in my own practice with good effect. I learnt to empathise, not to sympathise, to level and not to confront; to be able to tolerate silences. I learnt of the door handle syndrome; that patients coming late or not keeping appointments could sometimes be interpreted as an expression of anger towards the doctor. It was a revelation to learn how parents "presented through their children".

This last concept helped me detect emotional distress in young mothers before it became overtly manifest. It was pointed out how body language and the patient's appearance in the consulting rooms was also an important indicator of their thoughts and feelings. Most importantly, I discovered how to cope with my own anxieties in the counselling situation. I also learnt that some of the problems I experienced with certain types of patients were due to factors within myself.

I will now present three cases that illustrate some of these important Balint concepts.

Case 1

Mrs A a very attractive 28-year old patient came to see me in a state of severe agitation. She wanted to see me about her husband, whom she felt was treating her very badly. She claimed that he always belittled her in front of people and called her a half-wit. She felt boxed-in in the marriage and felt that he wasn't allowing her to be herself. She subsequently became very cold towards him.

I had always experienced Mrs A as being seductive. I was genuinely fond of her and her husband and had previously made a mental note that she brought her children to see me for relatively minor complaints. So it never surprised me when she came along to talk about her personal emotional problems.

After a long discussion, she told me she was committed to the marriage. Her husband had told her that had it not been for the children he would have left her years before. I didn't prescribe tranquilisers as I thought more could be achieved by having a combined marital session.

We had a long session where each had a chance to air their feelings about the situation. I tried to make Mr A feel as comfortable as possible and explain that I wasn't on his wife's side and we weren't "ganging up" on him. He told me that he felt their situation had deteriorated to such an extent that he felt irreparable harm had been done to their relationship and that things could never be the same again.

Michael Balint and the

Michael Balint was a Hungarian psychoanalyst who had a special interest in the psychological aspects of General Practice and particularly in the therapeutic potential of the doctor-patient relationship in this setting.

He began taking seminars with General Practitioner groups at the Tavistock Clinic in London from 1949. He was assisted on an equal basis by his wife, Enid Balint from the start.

Several publications emanated from these seminars, the most famous of which is "The Doctor, His Patient, and the Illness"[1]. This has been translated into 12 different languages. Balint groups then sprang up all over the world and an International Balint Federation composed of member national societies all over the world was formed.

Members of these Balint groups are composed of General Practitioners who meet at regular intervals in groups all over the country to discuss problems in the doctor-patient relationship in their practices.

It is generally recognised that the psychological aspects of patient care is a sadly neglected aspect of the medical school training. The South African Balint Society is therefore fulfilling an important role in continuing medical education in General Practice in South Africa.

helped me treat n Crisis

by Dr Saville Furman MBChB, MFGP (SA)

I could not get a positive commitment from him to work towards improving the marriage, although he said he would try. He kept saying that he was a difficult person, very stubborn and couldn't change his ways. (She had previously warned me that he would say this).

The interview went very well and I got them to interact with each other rather than directing their remarks towards me. I was very pleased with the interview and felt very positive about their situation.

The following week I received a phone call from Mrs A saying that things had never been so good. It was almost like being on honeymoon again. This re-inforced my feeling that I had helped them and I felt very good about it. However, over the next few weeks Mrs A made frequent contact saying that her husband was having doubts about them ever being able to repair the harm done. She was getting desperate and she asked me to send them to a psychiatrist. They went to see the psychiatrist who straight away realised that Mr A had more or less in his own mind decided to leave his wife, and thus it was impossible for any form of marital therapy to get off the ground. I then played a supportive role in helping Mrs A through her crisis. Mr A subsequently left home about two weeks later.

During the crisis Mrs A was attending a course at Life-Line and she felt that being at Life-Line and seeing me had helped her over the separation. Six weeks later she came bouncing in my surgery and told me she'd worked through all the denial, anger and acceptance and that she was "wonderfully well again".

To me this seemed rather a short time to get over the separation. Feeling concerned and anxious, I presented the case to the group. One member of the group expressed the feeling that I hadn't really followed the case up after this very good session where the situation seemed to have improved. He felt that it wasn't my usual style and that I should have given the patient a commitment to come and see me more regularly. I felt rather guilty about this.

The group members were also rather sceptical of the patient having worked through her separation so quickly and this proved also to be correct, as one day she came to see me and told me how depressed she was and said : "Forget about it, it's impossible to work through it all in six weeks!"

It soon became evident that when she originally came to see me, her husband was having an affair with another woman. She was very angry and felt very hurt and we spent quite a lot of time on working through her feelings.

One group member pointed out that perhaps I should let her see for herself how she allowed herself to get boxed-in the way she was. He felt that my emphasis on helping her was being mis-directed. She subsequently entered into a new relationship with a man very similar to her husband and after a while said to me : "You men are all the same!" We were able to work through the fact that he was feeding into her neurotic needs as her husband had. I saw her in a supportive role, while I received support from the group.

She subsequently entered into a new and more stable relationship.

Case 2

A certain group of patients, namely drug addicts and alcoholics made me feel angry. I thought it was perhaps because I was a non-smoker and a teetotaller. When I talked of this in the group, I was encouraged to present the case before we discussed it.

Miss C was a nurse who was addicted to marijuana, barbiturates and benzodiazepines. With big pleading eyes she managed to manipulate me to prescribe her a few sleeping pills. She would telephone me at night and once threatened to commit suicide if I didn't prescribe her tablets, even less potent sedative-hypnotics. She committed fraud and had to appear in court.

I felt very sorry for her despite the fact that she evoked much anger in me. I also felt guilty as after I refused to prescribe the drugs, she stole a cheque book to purchase drugs on the black market.

When I presented this to the group one member pointed out that alcoholics and drug addicts tend to relapse, which tarnished the image that I had of myself, ie. "the knight in shining armour" and as I couldn't cure them, they made me feel

Balint Movement

impotent. Once I recognised the dynamics, I was better able to tolerate this type of patient as I lost some of my need to succeed with every patient. I realised it was okay to fail without shame.

Case 3

Mrs D telephoned me sounding rather anxious asking if she could see me right away. I explained that I was on my way to assist at an operation and would be back later in the afternoon. She asked, "please wait for me as I have something very important to show you". She arrived very aggitated, then opened up a tissue and showed me some marijuana.

She had found it in her 18-year old daughter's bedroom. She was most upset and appeared rather angry. She wanted to go home, confront her daughter that if she wanted to live a life of sex, sin and drugs, she would throw her out and she could go live somewhere else.

I explained to her that at her age most of her peers were experimenting with drugs and didn't necessarily mean to say that she would go onto more potent drugs (which was her greatest fear). I tried to get in touch with her feelings.

Unfortunately, I was already running late and asked her to come back later that afternoon. An appointment was made for her, so that we would discuss these issues in greater detail. I asked her in the meantime to try to refrain from confronting her daughter till we had a chance to speak again.

When I returned to my surgery that afternoon I found she had cancelled the appointment, but had made one for the following morning. I felt very disappointed, that I had let a golden opportunity for intervention slip through my fingers. The next morning she kept her appointment and her opening words were "Thank you so much for your understanding yesterday afternoon, it really helped me!, I went home and cried and cried, and cried, I felt terribly guilty, I really felt I was a worthless mother, and against your advice, I decided to speak to my daughter. I didn't shout, I didn't get excited like I did last time there was a crisis. I asked her to look into my eyes and said : "Darling can you trust mommy, can you confide in me?", to which she replied NO. I then opened up the tissue and asked her "well what is this?". To which she replied "you should know what it is, so why ask me?" She then told her mother it belonged to a friend of hers who was hiding it in her room, as he didn't want his family to find out. He had been warned about smoking marijuana before.

She told her daughter that she had come along to talk to me about it which upset her daughter as she felt that she wouldn't like me to think ill of her. I asked her to tell her daughter that it was okay by me and that any time she felt that she wanted to come and talk to me about it, she was quite welcome. This opened the door for her to discuss other issues including contraception and I asked her to tell her daughter that at any time she felt that she wanted to go onto the Pill, she could come along to me and we could talk about it quite confidentially.

The patient then poured out her heart to me and discussed her own bad marital situation, leading to a very fruitful discussion. Mother and daughter now felt much better that they had brought matters into the open and that there hadn't been hysterics like on previous occasions. The mother in fact felt that the relationship between her and her daughter had improved and she felt very grateful that before she blew off steam, she first came to speak to me about it.

I presented this case to the group in retrospect as I wanted to know how they would have handled the case. There was no consensus of opinion, as one member felt I should have seen mother and daughter together, whilst another thought I should have seen the daughter alone.

The group serves to act in an advisory role and also dissects out the dynamics of what is happening in order to provide greater understanding. There is never an absolute correct or incorrect approach. As it happens, the management of this patient turned out for the better, as the doctor-patient relationship was enriched by this encounter.

Conclusion

Thus, as Shakespeare once wrote "each man in his own life must play many roles"[2] so as a General Practitioner I had to play many roles, as can be seen from the different cases presented. Despite seeing them for their emotional problems I still attended to them and their families for "physical" problems.

My undergraduate training gave me a solid foundation in organic knowledge but was completely inadequate in enabling me to meet the demands of General Practice. Balint training has made me more self-aware, and has helped me to understand my patients more successfully. It has also helped me to tolerate my own feelings and the feelings of medicine in general; to dispel some of the myths about myself as a doctor; to set a realistic goal for the degree of patient recovery, while being an educational process.

My exposure to a Balint group has helped me to be a more competent doctor by understanding the doctor-patient relationship better.

References

1 The Doctor, His Patient and the Illness, 2nd Ed. ed. Surrey : Pitman Paperbacks.

2 Shakespeare : As you like it

Academy Diary

Enid Balint to speak in Cape Town

Enid Balint, the prominent British psycho-analyst who has made a major contribution to the understanding of the doctor-patient interaction in General Practice will give a talk on "Learning to Listen" to our Patients" which will be followed by discussion.

Mrs Balint is a world authority on this topic and it is hoped that as many doctors as possible will take advantage of the opportunity to attend this meeting. The meeting will be held on Wednesday, 13th April, 1983 at 20h15 at the D3 Lecture Theatre, Red Cross Children's hospital, Rondebosch, Cape. Refreshments will be served. The meeting will be sponsored by Lederle Laboratories.

Workshop: Human Sexuality in General Practice

The SA Academy of Family Practice/Primary Care (Cape of Good Hope Region) will hold a full day workshop on "Human Sexuality in General Practice – problems and management". The workshop will be led by Prof Domeena Renshaw and Dr Robert Renshaw who are both from Stritch School of Mdeicine, Loyola University, Illinois, USA.

The meeting will be held on Tuesday 31st May, 1983 (Public Holiday), from 9am - 5 30pm at the Function Room in the Amenities Centre, Medical School Anzio Rd, Observatory.

The Registration fee is R25 which covers the cost of a Buffet and teas. This fee is to be paid by 16th May, 1983. Cheques are to be made payable to the SA Academy of Family Practice/Primary Care and posted to Medical House, Central Square, Pinelands, 7405.

All doctors and allied health professionals are welcome to attend the meeting which will be partially sponsored by Ciba Geigy.

For further information regarding both meetings please contact Rose Jonker at (021) 53-8205.