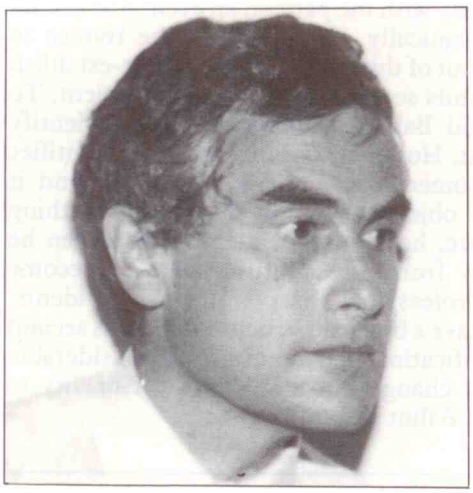
Attitudes Acquired by Trainees Through Balint Seminars*

— Clive Brock



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Curriculum vitae

Dr Clive Brock is Chief of the Family Medicine Unit at the University of South Carolina. He was born in Cape Town in 1940 and graduated at the University of Cape Town in 1964. He entered family practice in Durban in February 1967. Whilst in practice, he was actively involved in the Faculty of General Practice of the College of Medicine (SA), Branch Council of the Medical Association of SA, SA Balint Society (National Vice-President 1979-1981). He left South Africa in July 1981 to take up a post in the Department of Family Medicine, Medical University of South Carolina, Carleston, as an Associate Professor. He received the Golden Oyster Teaching Award, Department of Family Medicine, in 1984 and 1985. He leads a Balint Group for his residents, is Honorary Member of SA Balint Society, an Associate Member of British Balint Society and International Balint Society. He is actively involved in research in family practice on subjects ranging from hypertension, papanicolaou smears, safety of drugs to emphathic understanding for Family Medicine residents.

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Summary

This short feature article evaluates the attitudes acquired by trainees who attend Balint Seminars.

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An attitude is defined by Webster as a feeling or emotion with regard to a fact or state. In other words, how you feel about something. And, as a mental position with. regard to a fact or state; what you think about something. I wish to present these two interpretations as descriptive of the attitude a trainee acquires through Balint seminars: the attitude of empathic understanding and empathic responsiveness.

A Balint seminar studies the relationship between the doctor, his/her patient and the illness in order to see the patient as the person that he/she really is, without distortions. Once the patient is seen in this light, the doctor is in a position to determine the effect of the patient's personality on the illness and its management. The following case will illustrate this point.

A trainee presented the problem he was having with an attractively dressed 35 year old divorced woman, who was the adult child of an alcoholic mother and grandmother. He believed her presenting problems usually represented the tip of the iceberg (for her). She was currently in a relationship with an abusive man, at the same time she was seeing her former husband — an alcoholic who was also physically abusive to her. She seemed to be aware that her physical complaints were "emotional" in origin. The doctor couldn't understand why such a woman who had been through so much in her lifetime would habitually have similar unsatisfactory relationships as an adult. The group members began to understand the patient through the presenter's "tip of the iceberg" metaphor. An iceberg is cold; melts when heated; floats about and has sharp, poorly defined edges which pose a danger to the unwary. Through metaphor, it was possible to propose this understanding of the patient's personality — a woman with a well defended, cold and unstable inner world.

I want to describe the process involved in coming to this different understanding, which many have termed reframing. The presenter asked how a woman, who

had been abused all her life, could still be prone to relationships with abusive people; surely she would have learned something from past experiences. His answer was contained in his own metaphor about the iceberg.

When a presenter uses a metaphor with regard to a patient or illness, it is done spontaneously and without

An attitude is how you feel and think about something.

much thought. The metaphor is to the wakeful state as the dream is to sleeping (the royal road to the unconscious). The metaphor implies an unconscious understanding. I have come to regard the metaphor as one of the significant means whereby a group member will communicate what he/she knows about the patient (through identification). As the group members struggle with the presenter's metaphor, they help uncover the patient's unique personality.

To come back to the case, this patient had indeed learned something from past experiences — not to let anyone get close enough to find out about her secret icy inner world. After all, when icebergs melt away they leave nothingness behind. It might be expected that she would choose a partner who similarly had problems with intimacy. Who would better serve as a husband than a man with a substance abuse problem of his own, or one who was also abused as a child.

Empathy and Balint Training

When a group member makes a spontaneous case presentation, he or she will reveal feelings about the patient through slips of the tongue, omissions, distortions and metaphors. This happens automatically and reflects an unconscious understanding of the patient. This understanding is gained through identification and occurs without conscious effort. In the Balint seminar, the group members try to imagine themselves in the presenting doctor's place. They will

To see your patient as he really is, without distortions.

use slips of the tongue, distortions, omissions, second thoughts, and a metaphor as the means by which the presenter communicates what it was like for him to be with his patient. The group members will assist him in taking a necessary step back to look at those things he has identified with in his patient. I understand this biphasic process to be descriptive of empathy. Empathy is the enabler of the reframing process, much like an enzyme in a digestive reaction. Hogan defines empathy as the intellectual or imaginative appreciation of another's state of mind without necessarily experiencing that person's feelings.

Michael Balint has often been quoted as saying that in order for a doctor to be psychotherapeutic, he needs to undertake training to enable him to undergo a considerable though limited change in his personality. A metaphor if ever I've heard one, and open to different interpretations. My interpretation is that the doctor must first identify with the patient, an event that occurs naturally/automatically. The trick for the trainee to learn is to step out of this identification and re-establish the personal limits separating him and his patient. To paraphrase Enid Balint, a doctor must first identify with his patient. However, once an observer identifies himself with someone or something, he will find it difficult to feel objectively about that person or thing again. Therefore, he must first identify, and then he must withdraw from the identification and become an objective, professional observer again. The identification must have a biphasic structure. It is this second phase of identification that requires the considerable though limited change in the doctor's personality to which Michael Balint referred.

. . . the effect of the patient's personality on his illness and its management.

In summary, it is this biphasic process of identification that I understand empathy to be. Empathy has an affective cognitive structure. This fits with Webster's definition of attitude as feelings about someone or something, and also adds an understanding of what these feelings *mean.* In the professional setting it is important to feel with one's patients and then to think about these feelings. It is through an interpretation of the feelings one has when one is with a patient, that one develops an attitude of understanding for a patient as the person he or she really is. Once this understanding is gained, the doctor is in a position to determine the effect of the patient's personality on the illness and its management.

Thus I believe that *the* attitude a trainee learns through Balint seminars, is empathy. To be empathic, a trusting supportive relationship needs to be developed in which the patient feels accepted by the physician. Acceptance occurs through being nonjudgemental, nondirective, and congruent — all attitudes which a trainee learns in Balint seminars.

Do Trainees Need Seminars to Enhance Empathy?

Empathy is regarded as the most important determinant of patient satisfaction and adherence to medical management. Just as a medical student would be

expected to hear but not interpret auscultatory findings on an examination of the lungs, so might one expect the student to be open to emotional states without being able to interpret them. In both cases experimental training with guidance is necessary in order to acquire and interpret the data. Balint training is to the acquisition of an empathic attitude, as the bedside is to physical diagnosis.

A group, including myself, and a clinical psychologist, an educational specialist, a child psychiatrist, and the chairman of the medical school's curriculum committee designed a cross sectional study to determine the levels of empathy in freshmen and rising senior medical students. The result showed that freshmen were significantly more empathic than rising seniors. A multi-variate analysis showed that this difference was due to the level of their training and not to such variables as age, sex, marital status or MCAT scores. Only a longitudinal study would answer whether the difference between the two groups is the result of a medical school experience. A daunting thought indeed.

Does Balint Training Enhance Empathy? — Probably.

Dr. Ron Stock and I developed a questionnaire to survey Balint group activities in the USA. Under the section entitled "attitudes you believe your group members attain through Balint training," the vast majority of respondents recorded "an understanding of the feelings generated when with patients," as the most attainable attitude.

Work in the future will need to be done to measure empathy before and after training to confirm these clinical impressions.

From the journals

Changes in the Attitude of General Practitioners as a Result of Participation in a Balint Group

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Abstract An investigation was carried out in an attempt to measure whether there were any limited changes in a doctor's personality as a result of participation in a Balint group. Twenty-two general practitioners applied originally to join two Balint groups. After two years the groups had been combined and only eight doctors were still participating.

A questionnaire was designed in order to measure changes in personality. The conclusion was that the personality of the doctor did not change fundamentally as a result of participating in a Balint group. But, it could be said that working in the group gradually lead the participants to deal with their patients in a different and more competent manner. The participants became aware of the fact that patients were much more problematical than they originally thought. In the end the participants were able to deal with this insight in a competent way. It emerged from the investigation that a considerable shift had taken place in the type of patients with whom the doctor said they had difficulty. There were some characteristics of patients — an average of 5,13 per doctor — with which the doctors had difficulty at both the beginning and at the end of the course; an average of 6,38 characteristics had disappeared, but their place had been taken by an average 3,25 other characteristics. At an individual level the differences were extremely large.

Association between mortality among women and socioeconomic factors in general practices in Edinburgh: an application of small area statistics

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Abstract Women aged 45-64 in 78 general practices in the city of Edinburgh were followed up for five to seven years and all causes of mortality noted. Standardised mortality ratios were calculated for the individual practices. Postcards were available for a 20% sample of these women and were used to retrieve relevant measures of social class and deprivation from the 1981 census for the smallest division, the enumeration district. Weighted averages gave socioeconomic variables at the level of the general practice. High positive correlations were found between standardised mortality ratios and the socioeconomic variables, with the highest being for percentage overcrowding.

This study established that the relation between deprivation and excess mortality can be shown in general practices in one large city and gave a direct relation for women without reference to their husbands' occupations, thus obviating problems of assigning social class. The data also partially refute the "social drift" hypothesis as an explanation of the association between mortality and social class.