

The Future Directions of Balint Training

Opening Plenary Session Address

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It really is a rare honor and pleasure to be speaking at the opening plenary session of this 9th International Balint Federation Congress. Being the first speaker and addressing "future directions," gives me the opportunity to bring to you the backdrop of this particular Balint Congress and to help set the frame, while your mind is still relatively uncluttered.

Some 18 months ago, Clive Brock, myself, and a few others were starting to develop the conference. We were struggling over what theme and context we should use. We needed a backbone on which to hang the individual congress experiences. The sub-text "Balint Training in a New World" was stimulated by some of the most difficult issues with which we were dealing in the American Balint Society. The American Society and its leadership were developing quite satisfactorily. However, outside of the Society we became aware of all sorts of activities to which others attached the name "Balint Groups." We felt we needed to deal with some questions that I am sure all of you in your national Balint societies have come across.

These questions form the basis for this congress.

What is, and what is not, Balint Training?

What kinds of group experiences and what kinds of leader-participant roles and relationships are within, and which are outside the term "Balint groups?"

With those questions and armed with our own experience of more "Classical" Balint Training, we set out to explore other activities which had either some similarity or had the name Balint attached. We have looked at Process Groups, Balint Support Groups, Case Discussion Groups, Problem Patient Seminars, Family Systems Balint Groups, Family of Origin Groups, Resident or Trainee Groups, which are much more teaching cum training groups than training cum research groups and, lastly, Monte Verité groups. All of these training opportunities seemed to contribute something valuable to learning about patients but less often concentrated as centrally on the doctor/patient relationship than the Balint Group we know. The emphasis seemed to us to often be very different from the Balint Group as we knew it. They were often more focussed on content issues about the patient or family, or else were a haven to which doctors who felt they had problem or difficult patients could turn for support, if not the answers.

We decided all of these activities were for the most part helpful, positive experiences. They were laudable and sometimes enviable and impressive attempts by their participants to learn about patients, something about the doctor/patient relationship and a way to gain the fortitude to carry on in relationships with patients that were personally difficult. What was *striking was that these activities were happening at all!* They had not existed in the 1950's when Balint training started. We were equally struck by the energy and enthusiasm of the participants. We were excited to perceive a change in attitude and values -- a change which allowed doctors to see these difficulties as central enough to their work to take the time, and the new freedom to own the perception, that they needed help. In our experience, none of the other group activities had as their central gaze, what for me is the shibboleth of successful Balint training. Their learning was not informed by an understanding of the doctor, the patient, and the relationship, which increasingly allows the doctor to be available to the patient in the way the patient needs.

We felt that these other new opportunities to learn about the doctor/patient relationship had occurred because of the change both in doctors and patients and their respective cultures. Balint Training has played its part in this change. A parallel which I feel is germane and illustrative is that a large proportion of the public have little understanding of psychoanalysis, have heard the name Freud and have a few stereotypical images of what he was about. Despite this, many of the terms and concepts of the work of the psychoanalytic movement have entered everyday life -- denial and unconscious to name just two common ones. The same applies to physicians and their lack of familiarity with the work of Balint Training. There is familiarity with the name Balint and they frequently use the approaches that the work has created -- to quote Enid Balint, "in providing to patients the respect which is due to a person who feels ill and is in the presence of someone who is trained to respect (the uniqueness) of people as well as illnesses." In 1980, Enid Balint, visiting Cape Town, South Africa, drew attention to these changes in doctors, patients, and their respective

cultures which had already begun to occur then.

She gave a case example in which a flashily dressed young woman, who had a mild cough, asked her doctor for a certificate or work excuse for a 2 week holiday. He responded, Enid felt, according to the older culture by refusing and giving the patient a moral sermonette. A second doctor in the group suggested what Enid felt was a more modern response. He suggested appealing to the patient's sense of social responsibility. A third doctor suggested asking the patient why she wanted to get more than her fair share -- which Enid felt was becoming a more and more common and more helpful type of response.

So doctors have, in my experience, changed in many ways. It is evident in their attitude and in their publications during the last 10 years. It is also conspicuous in the way they champion patients' causes. The AIDS epidemic and the right to die are two examples.

I think we all know that patients have changed. In my experience amongst many changes, they have become much more aware of the fallibility of medical care. They have become increasingly more empowered to state their own perception of their problem and their entitlement to explore their options.

The number of pathways through which we can learn about patients life worlds and the doctor/patient relationship have increased markedly.

These I would categorize as:

- the literature
- new techniques
- new technology
- new concepts
- and new approaches available for rapidly and reliably entering the patient's life world

Through the amazing amount of technical literature, new techniques such as neurolinguistics, role play, psychodrama, the family circle method, genogram, the BATHE technique; technology like the video camera and recorder with its own techniques, such as Interpersonal Process Recall; and new concepts, such as family systems theory, the biopsychosocial model; new approaches available for rapidly and reliably entering the patient's life world, such as the Patient-Centered Interview, first described by Michael Balint and then further developed by Joe Levenstein and Ian McWhinney, the Hinsdale Contextual Model, the five point skill building plan of Roger Neighbour, described in his book "The Internal Consultation," the three function model of Steven Cohen-Cole and Julian Bird.

So, since the Balint Group Method was established, doctors have changed, patients have changed, and media for learning about the doctor/patient relationship have changed. We all continue to provide Balint Training in what is certainly a different context than Michael and Enid Balint when they started in the 1950's. It seems we are challenged to decide, "What is the place of Balint Training in this new World?" Since this is the first Balint Congress in what *has been* called *the new world*, it seemed like an apt subtitle and context for this Congress.

- In looking to the future, I am convinced that our major "Future Direction" needs to be clarifying our well established and documented method. It is our hope that this 9th International Balint Federation Congress will be part of that elucidation as a future direction for Balint Training. I hope it will be a nodal point for developing a new clarity about
 - what we do,
 - how we do it,
 - what are the outcomes of our work,
 - what aspects of our work are central to those outcomes.

In looking to the future and determining our new directions it might be useful to take stock of Balint Training in the light of this new world.

We have a clearly *established method*. You merely have to read the last chapter in The Doctor, the Patient and His Illness (or, like me, re-read as if much of it is there to re-discover at every reading). Another way to appreciate our method is to have the opportunity to introduce a well-trained psychotherapist to Balint Training. She or he will tell you after a few months that you have a reassuringly consistent way of going about your Group work and focus. She or he will observe that as long as you stick to a rather finite number of rules of process, it works surprisingly well. We are all familiar with the basic rules, such as *allowing anyone who needs to, to be a prima donna*, *allowing everyone the courage of their own stupidity*, and so on.

We have a well "researched" field. By "researched" I mean that we have looked repeatedly at the doctor/patient relationship and published our findings as a discipline extensively. I can count 12 or more books on my shelf which are the products of our work. The American Balint Society, Borris Luban Plozza, as Director of International Library, and our Archives can provide a very extensive bibliography. The kind of research we have done is qualitative, often anthropological and phenomenological, and occasionally quantitative.

I want to issue a challenge to us all. In my opinion, our research and literature will not be widely accepted and our method not clearly understood, without being articulated in the language of the new world. It is sometimes difficult for those of us for whom it was a revelation, to understand how rather painful it is for the new medical school graduate in the United States to read The Doctor, the Patient and His Illness. The medical concepts are old and outdated and the language and cases are hard going and dense for the generation of the *bottom line*. The descriptive and analytical research we have published, while stimulating and illustrative, seems to be poorly validated and grounded even to those who accept the tenets of naturalistic research. In struggling to get a fresh look at our work, we find it very difficult to even enunciate the researchable questions which, if answered, might make our work more plausible and engaging to a wider audience.

To us, the results of our work are obvious. We can see and feel the difference in most of our group members after two years. If we wish our work to be more widely credible, we need to find ways to demonstrate our outcomes. In the United States, results oriented research is *the* new emphasis in medicine. I feel that given a clearer literature, given a more rigorous, mainstream and current research methodology, and with outcomes research backing our hypotheses and subjective experience, we would have more participants in our groups and our method would find a more central place in the training of health care professionals -- not only doctors. Perhaps a good focus would be what Michael Balint called the "limited though appreciable change in personality" which happens with the acquisition of new skills through Balint Training.

Our work meets needs of a distinct proportion of doctors and other health care professionals. Could we adapt it and have it appeal to the needs of a wider group? What kind of change would this take? Could our Balint Group leaders bring their skills and insights to some of the different settings and learning opportunities I mentioned earlier? This would bring them into useful contact with learners to whom Balint Training does not appeal. Could we run different types of groups? Do we already?

We feel already that the change our group members' experience is more profound and more deeply internalized than the newer, apparently easier, methods of learning the doctor/patient relationship. Is this true? How can we demonstrate it?

We have a dedicated group of Balint Training leaders which fairly often are well-supported by departments and residencies. Our groups sometimes breed suspicion and are perceived as a threat. If we were more able to articulate our work and show its outcomes, would the support be greater and by outside agencies as well?

Clearly, what we have experienced in the United States and I know occurs also in England, is a credibility gap. I feel sure that answering the kinds of questions and filling the information void with more easily readable and pithy information would assist us in gaining the kind of

credibility our rigorous method deserves.

So we need an attractive and succinct literature and a more easily acceptable body of research. Having reached that conclusion, we felt it would be very exciting to invite a group of very well established naturalistic (or qualitative) researchers to join us at this conference. They will watch us, assist us to define researchable questions, be available for consultation and perhaps collaborate with us through research projects we may initiate. Our field seems eminently researchable by the methodologies they use daily. Perhaps if they can help us focus on outcomes we will be even better served.

By and large, our work is poorly funded. Even at the International level, the Federation is funded by dues from its members' countries who struggle to collect them. Perhaps the climate is right for better funding. It will be interesting to speak to our Polish and German colleagues. They must be experiencing higher priority funding since there is such a strong expectation of required training in their countries. In the United States and Britain and many other countries who are trying to manage the cost of their health care, if we can show that Balint-trained doctors use fewer resources to care for their patients and their outcomes are at least equivalent, we could tap into major new funding streams.

Without addressing some of these issues and taking hold of some of our opportunities, there is the threat that the Balint movement will falter and perhaps remotely could even become of mainly historic importance. We could avoid this if we continue to train and credential leaders and prepare those leaders to be flexible with the Balint Training model to meet the needs of their learners. We should find a way to take their insights and approach to personalized care of the whole patient, into some of the newer channels for learning about the doctor/patient relationship. On the other hand, with increasing flexibility of both the process of the Balint Group and using our Balint-acquired knowledge, skills, and attitudes in other learning modalities, we need to be aware of the potential threat of the loss of Balint identity. We need to keep the classical model alive by using it for continuing to train those for whom it was developed -- the practicing general practitioner/family physician.

What will be the place of Balint Training in our new world amongst doctors, patients, and doctor/patient relationships which have all changed markedly since the first research cum training groups?

How can the International Balint Federation facilitate this process in our global village? Can we use the new technologies to stay more connected between international meetings and, using the uniqueness of each setting, help to answer some of the questions of colleagues who are more isolated? The facsimile and the internet or satellite transmissions are new ways to communicate. Are there ways in which we can find the funds to support the International Balint Federation to provide that kind of technology? Some years ago, we had a crude early attempt at a Balint Meta-Group by conference call.

How can the International Balint Federation help their national societies meet the particular needs of their individual countries and cultures? I wish I was familiar with these personally so could detail some of them here. The rest of us need to understand the special role in the countries who were previously within or under the control of the Soviet Union. I hope during the conference breaks, evenings and networking time, we will all make use of the time to get to understand the place and needs of each others' special circumstances, contexts, cultures and countries.

How shall we best train and accredit future group leaders? How much does it matter if the process and method of groups is very different. Is the outcome that different?

One of our frustrations has been the limited proportion of doctors we can reach with our method. We usually interpret their lack of participation as resistance. (I understand that what I am going to say does not describe the experience in Germany, where everyone who wants to do any psychotherapy has to have Balint training.) Most of us have experience, and Michael Balint described in "A Study of Doctors" that when you start a group, only about one-half of the people who you thought might be interested arrive at the first group meeting. Of those, probably about

three-fourths will stay in the group until its conclusion. In this new world, is that less troublesome?

Was there any reality to our hope through the years that we might reach some of those who were not in our groups by the halo phenomenon?

Now -- especially with trainees or residents, do we know that a combination of the halo effect and the other techniques, concepts and approaches I mentioned earlier, are more effective than Balint Training in helping them be more contextual, empathic, have better listening skills and more able to be who their patients need them to be?

Are there some trainees and doctors who do not need Balint training and why?

I believe that the future directions we need to follow are:

- continuing with leading our groups in the way we have,
- leading others in a way which is more flexible to meet the learning needs of particular learners such as trainees/residents/doctors very new in practice.
- Another direction I feel we need to follow is participating outside of our groups in also teaching the doctor/patient relationship through the newer *techniques*, using the newer *technologies*, being conversant with and in addition to our Balint-acquired insights using *the newer concepts* such as family systems theory and the biopsychosocial model,
- integrating the *new approaches available for the consultation or office visit for rapidly and reliably entering the patient's life world.*

A central thrust must be to use new research methodologies like those you will be hearing about at this Congress from our qualitative researchers to better answer questions about our work, questions they will help us formulate. Perhaps we could start by answering some or all of the questions I have raised in this address. Many of the questions I have asked us have actually been kindled by conversations with many of you, so you will probably recognize them.

As I read through my notes for this talk, I realized that what I have put together is a wake-up call, or call to action. That helped me clarify in my mind, the central focus of my message.

My message is that although our Balint work is rigorous and demanding, although we have its value demonstrated for us every day, if Balint work is to gain its rightful place within the mainstream of medical thought, the work we have done so far is not enough.

As far as I am aware, development of the Balint Movement has always consisted of interesting people in the idea, one by one. That was my understanding of how it started in England and how I have been fortunate enough to play a part in its development. The development so far has been so dependent on one-to-one contact that we frequently have facetiously traced its path as a lineage.

In most of our countries we have brought thousands to our groups and done excellent work in the penumbra of medical culture. Change has occurred and our Balint work is no longer so far ahead of its time that it need remain a different or counter-subculture. It is now the expectation, not the revelation, of a much greater proportion of young family doctors that they need to pay equal attention to the psycho-social as to the physical domains of our patients' lives.

The mainstream medical culture has never been so ready for us to make our contributions, but we have to bring ourselves and our work with us. We need to do this by developing a new more easily digestible literature, by publishing research which demonstrates the outcomes we find so gratifying.

In looking at our future directions, I have asked perhaps so many questions as to confuse. I can do no better than to quote Enid Balint who when referring to change breeding confusion said, *"perhaps it is worth quoting from the last session of a conference that I attended recently, which had been arranged by the International Institute of Strategic Studies. The subject of the conference was the future of Strategic Nuclear Deterrence. Most of the conference as you can imagine dealt with the problems of technology and tried to evaluate technological developments in the strategic nuclear field. All this was well above my head, but throughout the conference the importance of*

human relationships, of the power or impotence of the strong nation over the weak and so on, was discussed realistically and in his summing up, the organizer of the conference made the following statement, which could have been made by any doctor or certainly by anybody who is familiar with working in any depth with human beings.

"If you are not confused, you cannot understand. If to be confused means to understand, we are going in the right direction."

I hope we are too.