MICHAEL BALINT'S GROUP APPROACH: THE BOSTON BALINT GROUP

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Introduction

It is widely written that Michael Balint, a Hungarian-born psychoanalyst, did not impose his psychoanalytic theories upon groups of general practitioner colleagues, but worked in a mutually supportive way, probably derived from his psychoanalytic training. That is, he approached his work with physician groups as an explorer, a researcher interested in the basic relationship between a patient and his doctor. This was quite consistent with his unique approach to psychoanalysis, in which he departed from Freud and other orthodox psychoanalysts of his day. His iconoclastic approach took account of the real (in contrast to the intrapsychic only) relationships of infants with their parents, of the influence of the analyst's personality and style upon his analysands, and of other social influences upon the patient, whether in analysis or general practice. He would create a setting in which every individual could find his or her own voice, with their individual perceptions, assumptions, hypotheses, and responses. It is part of the uniqueness and creativity of Balint that his theories like "the basic fault," (1968) or "primary love" (1952) evolved **out of** personal experience and were not simply imposed in a quest for theoretical compliance.

What is the legacy of Michael Balint's work and what can be said of its application to efforts to heighten the physician's appreciation of the centrality of the doctor-patient relationship in effective medical practice? The oft-quoted reference to the "doctor as drug" (Balint, 1957) was not only an enchanting idea but also an ingenious way to help physicians trained essentially in the traditional medical model to see that they could readily incorporate the skillful use of the doctor into a framework of practice to which they were already accustomed. It is not clear that Balint consciously foresaw this as a way to decrease resistance to a new way of thinking, but it appears to have had great power. It was essentially Balint's way of translating into the medical context his theory that it was the relational aspect of interaction that was curative rather than the drugs that the physician dispensed. New groups of physicians today, when exposed to the teachings of psychiatry, almost invariably gravitate towards a demand for knowledge in psychopharmacology rather than recognizing (*a la* Balint) the potency and the side-effects or adverse reactions of the doctor-patient relationship.

As a psychiatrist and psychoanalyst working with non-psychiatrists on ways to enlarge on the tradition-bound methods of medical education, I have found much that is relevant in Balint's classic book *The Doctor, His Patient and the Illness* (1957) for teaching medical students, nonpsychiatry residents, and practicing physicians a broader view of the patient and his or her illness. The book provides an essential text for physicians engaged in the group experience.

What can be said of Michael Balint as a person and about his --at the time -- revolutionary approach to the application of psychoanalytic insights to medical practice? This curiosity prompts a number of questions: How did this psychoanalyst become interested in working with groups of general practitioners? What factors nurtured the enthusiasm that surrounded Balint's training-cum-research groups at the Tavistock Clinic? How has his body of work influenced the way in which medicine is practiced? And what is the relevance of this work to contemporary medicine, which has changed so drastically in the last 30-40 years? In my reflections on these questions, I will later refer to my own experience with a Balint Group in Boston, of which I was a participant for 8-9 years and which continues to this day (in its 17th year), albeit with some change in constituency.

Medical Application of Psychoanalytic Principles

First, how did Balint become interested in group application of psychoanalytic theories?

It has long been recognized (and stated emphatically in Michael Balint's writings) that a typical medical education does not prepare the physician very well to comprehend and utilize the emotional or artful dimension of the patient-physician encounter for the patient's benefit. In fact, until fairly recently, very little was taught in medical school about interviewing technique or about communication skills. This is all the more astounding when one considers that in a physician's lifetime of practice, he or she will do 160,000 or more interviews (Lipkin & Putnam, 1980).

When Freud (1895, pp. 301-304) began his explorations of psychoanalysis, it became clear to him that much of what happened in the psychoanalytic process required an understanding of the relationship of analyst and analysand as an integral part of the treatment. It was this realization that led to the study of transference and countertransference as unavoidable aspects of the therapeutic relationship. Strange as it may seem, insights into these dimensions were not immediately seen as relevant to an understanding of the importance of the patient-physician relationship in **all** of medical practice.

Therefore, it is of seminal importance that the establishment of a bridge between psychoanalytic insights and medical practice would await the appearance of one who could, with courage and determination, straddle these two domains and to some degree, bridge the polarization that had taken place in Vienna between psychoanalysis and medicine. This person was Michael Balint, whose interests in this endeavor had been brewing since the early 1920s but only emerged in full flower in the 1950s with the establishment of his treatment-cum-research groups of general practitioners.

Historical Background

Michael Balint was born in Budapest in 1896 and received his M.D. in 1920. In a 1966 article, *Psycho-analysis and medical practice,* Balint wrote that Freud delivered a paper at the 1918 Budapest Congress of psychoanalysis in which "he predicted that the time would come when society must accept that the individual has the same right for help in his neurotic or emotional suffering as in his organic illnesses"(p. 54), a sentiment that is still expressed today by all who seek health care reform. It is not clear that Balint knew of this lecture while still in medical school, although the liberal nature of medical education in Hungary permitted him to attend lectures on comparative law, religion, anthropology and so on. History has it that Balint's interest in psychoanalysis was sparked by reading Freud while he was working in biochemistry in Berlin (Hopkins, 1972, p. 317). And even if Balint had known of Freud's lecture in 1918, it is not at all clear that Freud had in mind a merging of psychoanalysis with medicine. Balint raises some doubts of his own in his 1966 paper when he asks "Should we analysts accept responsibility for developing psychotherapeutic techniques to be used in medical practice?" (p. 54). So it is quite clear that in Balint's time of psychoanalytic development, in the first decades of the 20th century, this was quite a revolutionary way of thinking. I will return again to this theme.

Berlin and Budapest

What might we say about Michael Balint personally that permitted him, as a psychoanalyst, to embark on something so revoluntionary at the time as working with general practitioners? (see Journal of the Balint Society, Volume 1, Number 1,1971, for historical details).It was in Berlin that Michael and his wife Alice became very intrigued with Freud's writings and Michael began a personal analysis with Hans Sachs (who later emigrated to Boston). They returned to Budapest in 1924 and Michael resumed his personal analysis with Sandor Ferenczi, a student of Freud's who had a major influence on Balint's theories and techniques. His nontraditional Hungarian psychoanalytic training, in all likelihood, prepared him for his work with general practitioners. Furthermore, in Budapest, he grew up in the presence and surround of a father who had been a general practitioner for about 50 years. Balint said, in an interview with Philip Hopkins, "I knew quite a lot about what general practice was by watching it from the outside and later on when I qualified, I had to stand in for my father and so had some understanding of what general practice was"(Hopkins, 1972, p. 316). Also, his psychoanalyst, Sandor Ferenczi, had previously been a general practitioner as had some of his medical role models. And by nature, as described by those who knew him, Balint was very much a free spirit, with an open mind and great curiosity.

He was also known for his courage as well as a streak of rebelliousness, probably not unusual for one of Hungarian birth. His personal analysis with Ferenczi imbued him with a respect for the method of "mutual analysis"(Rachman, 1957).

We should note that the approach to training in Hungary was different from that anywhere else in the world. Referred to as the Hungarian method, one's training analysis did not separate supervision of case material from one's personal analysis. In this way, the analysand's countertransference problems with his patients were analyzed along with personal historical material. Balint absorbed this method as a valuable way to address the transferences and countertransferences of "live" clinical experience, an approach he seems to have incorporated into his general practice seminars. This focus on the "two-way street" of analyst-patient interaction was a definite departure from the more orthodox one-person focus of analysis of the day and was excellent preparation for his later examination of the complex nuances of the doctor-patient relationship in general practice. Furthermore, Balint strongly believed that more was to be learned by presenting cases which were actively being treated in general practice and that presentations should not be rehearsed or prepared but rather "freely associated to" in the context of the group. In this way, more would be learned about the physician's emotional responses to his patients and his spontaneous reflections, with increased opportunity for learning and personal growth -- much as one might accomplish in personal psychotherapy, but without actually engaging in psychotherapy. The major difference was that it was only the "countertransferences of practice" and not **personal** issues which were fair game for interpretation. Thus the groups were described, not as psychotherapy groups, but as opportunities for "considerable, though limited, change of personality." The groups did share attributes of psychotherapy in having regularly scheduled meetings, on a weekly basis for two or three years, for about 1 1/2-2 hours per session.

According to John Balint, Michael's son and a gastroenterologist/ethicist in the United States, his father and grandfather had a traumatic falling out when Michael, whose parents were Jewish, changed his name and religious affiliation to protect his family from the antisemitism sweeping eastern Europe at the time. Just before leaving Budapest for England in 1939, there was a reconciliation between Michael and his father, but as the Nazis were about to take Hungary, his parents took their own lives.

It is hard to imagine that these events did not have a profound effect on Michael. The shadow of his father must have fallen on him and generated some degree of ambivalence about career objectives. Nonetheless, between 1926 and 1939, he continued in analytic work, and was appointed a training analyst of the Budapest Institute, which he helped found after what must have been a rather short analysis. During the years prior to this, he was intrigued with the early movement in psychosomatic medicine, especially papers by George Groddeck, Sandor Ferenczi, and Smith Ely Jeliffe, all of whom had been general practitioners. As a member of the Budapest Psychoanalytic Institute, even before his work in London, Balint ran seminars for general practitioners to enhance their psychological understanding of medicine and to promote interest in the work of the psychoanalytic institute.

With his early interest in psychosomatic medicine and general medical practice, it is not surprising that his first psychoanalytic papers brought psychoanalytic application to the problems encountered in general medicine. For example, in 1926 he wrote *On the Psychotherapies for the General Practitioner* (1926a) and *Psychotherapy and Psychogenesis of Physical Symptoms* (1926b). He also wrote a paper called *Psychoanalysis and Clinical Medicine* in 1926(c), based upon a lecture given in Hungary at the request of local practitioners. During the 1930s, he wrote only a few papers related to medicine, including one in 1930 called the *Crisis of Medical Practice* (1930), as well as papers on the psychology of menstruation and emotional aspects of old age, but then confined himself mostly to purely psychoanalytic papers until around 1950.

England and The Tavistock

Increasing political oppression in Hungary brought a cessation to his seminars for doctors and forced him to move to Manchester, England, where he had appointments in the Northern Hospital and the North Eastern and Preston Child Guidance Clinic. During this time he also wrote a thesis on early infancy and qualified for a master's degree in psychology. His wife Alice died just before war broke out and after a brief marriage which ended in divorce, he was invited to be a consultant to the group program at the Tavistock Institute in 1947. It was there, at the Tavistock Clinic, that Enid Eichholz, a case work consultant who was training social and welfare workers through group techniques, invited him to participate in their "case discussion seminars." Of this collaboration, she says "He agreed to work with us and, in fact, took us over completely and started the real work of studying relationships, and [the] unexpected nature of people's requirements from their marriages--and their therapists"(p. 6). They not only became co-workers but also husband and wife and began working out their group approach to psychoanalytic education through the Family Discussion Bureau, of which Enid had been the founder and catalyst. She (1994) wrote "Quite soon after this, in 1950, Michael thought he would like to work with general practitioners as he had done in Hungary many years earlier" (p. 6). Thus, in 1950 began the first seminar for general practitioners in London.

In 1954, he returned to his writing on medicine with a paper in the British Medical Journal entitled *Training General Practitioners in Psychotherapy*, which was subsequently translated into German and French. This was a summary of the Tavistock experience to date.

There followed many papers on this group work, culminating in 1957 in the publication of his classic book, *The Doctor, His Patient and the Illness*, an immediate success which was translated into German, French, Hungarian, Italian, Spanish and later Japanese. The extraordinary interest in this volume was partly attributed to the growing interest of general practitioners after the war in psychosomatic medicine and the treatment of the many returned soldiers in need of psychologically-aware medical interventions. The rise of specialization medicine had also eroded the public image and self-respect of general practitioners and Balint's book did wonders in restoring the general practitioner's sense of worth and relevance.

<u>The Group as Training</u>

Michael Balint conveyed his belief, through group teaching, that the care of the patient must include an appreciation by the physician of the psychological nature of the patient's presentation as well as the interrelationship of patient and doctor in each medical encounter. It was the purpose of the groups not so much to provide therapy for the participants, but to focus on case presentations, a discussion of which was presumed to lead to self-discovery and growth in the physicians, without which he felt training would have to be considered a failure. The group experience, according to Balint, promoted the necessary attributes of self-awareness, empathy, a capacity for feeling and sharing, and an increased comfort with negative affect that he believed every physician should possess.

The issue of "therapy vs. training" continues to be debated regarding the objective of the group experience. It appears that Balint's own intention was not to penetrate the individual psyches of group participants, but rather to understand their personal styles as they influenced and responded to the interactions between patients and their doctors. In the group with which I have participated for 8 years, no members felt that the group was a therapy group. Yet, episodically, the question would emerge whether the work of the group should be more in the direction of "self-disclosure" as contrasted with "self-discovery." It always seemed that this theme would surface when there was a sense of "being stuck" or of the group becoming "stale." One astute member (outside the group experience) suggested that in any constellation of individuals who are together for long periods of time, there may be simultaneous or conflicting wishes for either greater intimacy or greater distance, an insight that has implications for the respecting of appropriate boundaries in the course of ongoing work with patients (whether in medical practice or psychotherapy).

My reading of much that has been written about the early Balint training sessions leaves me with some lack of clarity about whether the general practitioner participants, and indeed some of the leaders of the groups, considered their interactions with patients to be **some** form of psychotherapeutic practice. Some group transcripts skip back and forth between the terms "physician or doctor" and "therapist," and frequently the work of the general practitioner is referred to quite directly as psychotherapy (see Journal of the Balint Society, Volume 22, 1994). It must, in fact, have been difficult to maintain clear lines of demarcation between general medical practice and psychotherapy in such training experiences. But it has been written by both Michael and Enid Balint that it was not the **intent** of the training to turn out mini-psychotherapists or psychiatrists who might practice watered-down psychiatry or wild psychoanalysis. Nonetheless, Balint's possibly unclear motives were suggested in his paper on training general practitioners in psychotherapy (1954).

The groups themselves were remarkably free of psychoanalytic theory or jargon, and Balint's writings (1954, 1957, 1966) about general practice quite clearly warn against the tendency of the general practitioner to engage in some unskilled version of psychotherapy. On the other hand, it is also stated that the experience of the so-called "long interview" was clearly intended to be psychotherapeutic. And a quotation from *The Doctor, His Patient, and The Illness* suggests that the question of the general practitioner as psychotherapist was very prominent. He states: "The question whether a doctor involved in a close psychotherapeutic relationship with his patient should or should not examine him physically has all the time been one of the favorites of the seminar" (1957, p. 207). Perhaps the challenge here was to draw clearer distinctions between what is "psychotherapuetic" and what is "psychotherapy" in the context of general medical practice. In our Boston group, none of the members actually believed they were performing psychotherapy with their patients, although at least one member felt that it was appropriately within the domain of the primary care physician to perform this function with adequate systematic instruction and supervision. What we saw as derivative of Balint's approach was the objective to help the primary physician create a **setting** within the medical encounter in which the patient could trust and make use of the physician most fully for health-promoting purposes. This notion of allowing the physician to tolerate being "used," as it were, by the patient, without being consumed or encouraging boundary transgressions was a major orientation of the group, even if not forcefully or repeatedly stated.

What Balint called the "apostolic function" (1957, p. 216) of the physician has often been misunderstood. However, it was not so much that Balint considered directive or judgmental intervention **never** appropriate but that it ran the risk of attending too blindly to the **physician's** agenda at the expense of the patient's. He said "It is as a rule difficult for the doctor to avoid showing his hand, that is to say, disclosing what in his opinion is right and proper for a patient to do in a given situation" (p. 217). It was Balint's impression that the doctor-patient relationship should more often be "the result of a compromise between the patient's 'offers' and demands and the doctor's responses to them" (p. 217). It was a risk, Balint believed, that the apostolic function might result in **premature** reassurance, useless advice-giving, dependency-enforcing supportive care, or even the emergence of the "repeat prescription patients" (a much more kindly term than our terms of "crock" or "turkey" to describe such patients) who return time and again only for medications.

<u>The Ferenczi Influence</u>
However, Balint believed that "the patient's attitude towards his illness is of paramount importance" and that the apostolic function was important in educating patients to understand their illness and to become cooperative partners in improving their health (1957, p 242). Together they engaged in what Balint called a "mutual investment company" through which capital (or knowledge of the patient and his family) was held "in account" for further application to the needs of the patient. Such fanciful expressions enhanced Balint's appeal for the general practitioner by using everyday language and avoiding such psychoanalytic expressions as "therapeutic alliance," "incorporation," or "introjection." It was a way of enhancing the ambience of the interaction in the group between the leader and the physician members, nurturing a mutual

analytic interaction. From Balint's psychoanalytic writings one can see the consistency of his approach, whether to patients in psychoanalysis, to members of the group, to his attitude about the general practitioner's patients, or to friends. The importance ascribed by Balint to honesty and mutual respect, especially in physician-patient interaction, has roots in the theoretical concept of "hypocrisy" as stated by Ferenczi (Rachman, 1957). The latter had emphasized the pitfalls in analysis of expecting from the analysand what the analyst would not expect from himself; in medical encounters there was always a temptation to automatically use "false" phrases or jargon that obscured the affective states in the experience of "mutual analysis."

Masud Khan (1969), in an essay on Balint's researches on the theory of psychoanalytic technique wrote of Balint: "What is most salutary in studying Dr. Balint's contributions to the theory of technique is his diligent concentration on the responsibility that devolves on the analyst for setting up the sort of relationship and procedure which should help the patient to discover, recognize and know himself, or to use Balint's exact phrase: 'to teach our patient to distinguish in himself the essential from the accidental'" (p. 238). Commenting on Balint's theory of the "basic fault" and perhaps anticipating Balint's contributions to object-relations theory, Khan quotes Balint's statement: "Apart from being a 'need-recognizing' and perhaps even a 'need-satisfying' object, the analyst must be also a 'need-understanding' object, who in addition must be able to communicate his understanding to his patient"(p. 238). Balint's responsiveness to the ideas of others, according to Khan, "is never unduly marred by rigid private convictions or militant factional loyalties. In him one encounters a robust individual, healthily informed by the virtue of others' thinking" (p. 238).

An anecdote from my own experience underscores Khan's assessment. I had never met Dr. Balint, but I sampled what others describe as his flexibility, his openness, and his respect for others' styles and opinions. For the first issue of a journal I edited (Balint, 1970), I was flattered and honored to receive a manuscript from Michael Balint, one on the "repeat prescription patient," later enlarged by him in the book *Treatment or Diagnosis* (Balint et al, 1970)). It was a very imaginative paper, but somewhat disorganized and in a style not likely to be easily followed by American readers. With considerable trepidation, I embarked on a month-long effort at editing, subsequently returning the paper to Balint with a very apologetic note, indicating my rationale for each and every revision and an explanation of how I had tried and hopefully succeeded in retaining the personal coloration and style of his original paper. I humbly asked if he could accept the edited version of his paper for publication and shortly received a very pleasant note from him thanking me for the "excellent editing" and adding that, by the revisions I had made, "my ideas about these patients have become even clearer to me now than they were before." I had never before or since received such a gracious response to my editing efforts.

THE BOSTON BALINT GROUP

The Boston group, now in its 17th year, was begun by two internists, both of whom had had prior experience in exploring nuances of doctor-patient relationships in a work group that met annually for a week to explore matters of relevance to general medical practice. Others were invited to join the group and the fact that each had had some previous interest in and commitment to this kind of study assured the group of some cohesiveness. I was invited to join the group not as the leader but as a physician participant with specialized knowledge as a psychoanalyst and psychiatrist.

The group met evenings in one another's homes to present cases, to offer advice and support, and to provide a context for unburdening oneself of the rigors of a busy day in practice. The openness with which members addressed their feelings was spontaneously established at a level that both the individuals and the group could tolerate. On those occasions when one or another member persisted in "deeper" exploration, the group would find its own level of tolerance. Such moments would often revive the issue of how much self-disclosure was considered useful in juxtaposition to self-discovery. As the psychiatrist member, I would sometimes minimally

moderate such discussion, but experienced uneasiness when the feeling was that my comments might be taken as interpretation of individual or group dynamics. It is the psychiatrist's special challenge to avoid theorizing or offering jargonistic explanations or to jump in prematurely when a particular physician intervention appears ill-advised according to "good" psychiatric principles. Self-restraint in these matters, as it is so often with patients, is usually the most productive. Didactic or other formal teaching, as in Balint's original groups, was not part of the format.

The Meetings

Ongoing bimonthly meetings throughout the years fostered a shared knowledge of some aspects of each member's life, such as the nature of their jobs (most worked in agencies, hospitals or medical school), personal information about their families, places they vacationed and avocational interests they enjoyed. And sometimes discussions centered not so much around cases, but around problems individuals were experiencing with their administrations, job changes, academic promotion, and even with more global issues such as health care reform, the future of medicine, and other worldly matters. When such diversions appeared to distract the group from its intended purpose, someone would usually remind them of the inherently accepted parameters of the meeting. In spite of the intimacy of the group, there was always a thin line between professional and social interaction beyond which members did not go, an observation which has its parallel in the medical encounter.

The Topics

Members of the group viewed meetings essentially as an opportunity to convene with like-minded colleagues, to experience surcease from the rigors of intense daily practice and to reflectively exchange views with each other about "problem patients" and other interesting cases. The focus was a mixture of advice-giving, support, and exploration, with only occasional disquieting probing for deeper responses of the physicians to their patients' behavior and presenting complaints. As mentioned earlier, the issue about self-discovery and self-disclosure periodically surfaced but usually individuals achieve their own style, depth and comfort level and react negatively to any member's efforts to drive the process further. Members attribute the durability of the group to its value as an "anchor" in a rapidly changing medical climate, a place where personally-cherished values of medical practice can be reinforced. But new jobs, new interests, and growing families have altered the membership over the years. Newer members have joined, including a "new" psychiatrist/psychoanalyst with an interest in primary care medicine, while a core of original members remain and continue to meet on a fairly regular basis. The intensity and demands of the work day sometimes cut into the schedule, but a strong commitment sustains the group even as the changing seas of health care organization swirl around them.

Perceptions of the Group

Members interviewed outside the group could not say definitively how learning and growth in the group context was applied to daily practice. There was a sense of improved tolerance for difficult patients, with a tendency to recall remarks by the psychiatrist/psychoanalyst such as "Don't just do something, sit there," or "There are times when you simply have to tell a patient that there is nothing more you can do for him" as self-reassuring reminders. One member experienced the group as a kind of "fellowship" that expanded upon the practice culture in her work setting. Sessions were often "issue-related," e.g. assessing competency of the patient or the need for guardianship, rather than "affect-related." Some found the group helpful in addressing medicolegal issues, learning to deal more effectively with office staff, matters of confidentiality, or how to set limits with demanding patients.

A recurring theme in the group related to the frustration and anger engendered in doctors by the very demanding somatizing patients that the British call "heartsink patients" (physicians' hearts would "sink" on seeing these patients on their daily visit list). Most members felt that setting lower expectations decreased guilt about not being able to cure them and increased tolerance of their "illness behavior." Physician members could examine issues of helplessness and lack of control in such cases and what these feelings meant in terms of the doctor's identity and self-image.

Other issues revolved around questions of being a doctor to one's own family or friends, whether to call patients by their first or last names, what touch or gift-giving means in the doctor-patient relationship and whether the physician should attend important events in patients' lives such as funerals, wakes, marriages, and so on. One member felt that boundary issues may have been one of the biggest questions in the group. With difficult patients, one member felt that just sitting with the case in the safe context of the group made it more tolerable. All members felt that the group provided some kind of relief from the stresses of work, or as one member said, "the antihumanistic forces in contemporary medicine."

Balint's Perception of the General Practitioner

Michael Balint wrote repeatedly of the enriching experience of working with general practitioners in studying the dimensions of the doctor-patient relationship. This promises to continue to be one of the enduring attractions of the Balint Group. Balint envied the advantage that he felt the general practitioner had over the psychoanalyst in that "they may know, and often do know, the patient before he becomes overtly ill, when he is alone with his illness" (1957, p. 256). Balint believed that the general practitioner had an important "preventive" role to play by using this knowledge and acquaintance with his patients. And he wrote that "the most rewarding task for psychiatrists of the future will be to study, in cooperation with general practitioners, the fundamental pathology of the "basic fault" (1957, p. 291) for it was from this early developmental foundation that he believed all illness evolved. The "basic fault," he said, was in the biological structure of the individual, "involving in varying degrees both his mind and his body" (1957, p. 255) This grew out of the discrepancy between the needs of the infant in its earliest formative months and the care and nursing available at the relevant times. Although such deficiencies were rarely reversible, it was Balint's belief that the general practitioner was best positioned to help compensate for these deficiencies in the largest number of people.

The Future of Balint Groups

What is the future of Balint groups? There is no doubt that the classic volume *The Doctor, His Patient and the Illness* continues to be read by those interested in the nuances of doctor-patient relationships. One of the members of our group who had read the book in the beginning of her residency years found that it had an indelible impact on her. Physician graduates in Family Medicine residencies usually see this as essential reading. While many of the ideas contained there may not now seem new, the lucidity and pleasure of the writing are in themselves reason enough to read the book. But Balint groups as originally conceived and practiced may be diminishing. Groups continue to exist for medical students, internists and primary care physicians, residents, social workers and others, but probably in forms which might not even be recognized by Balint were he alive today. The world has become faster, more technologized, more time- and productivity-conscious than it was in the 1950s. In that regard, we need Balint's insights and patience more than ever, but they have been obscured by the pressures and demands of a new style of medical practice, one in which the physician has little time for reflection, where the doctor-patient relationship has been intruded upon by outside agencies, insurers, managed care companies, utilization reviews and the like.

This shift in medical practice has made the challenge of achieving a comprehensive style, where psyche and soma can be addressed together, all the more remote. Perhaps England's National Health Service in the '50s and '60s was more hospitable to Balint's pioneering explorations. But even in 1957, Balint, an otherwise very optimistic man, wrote: "Perhaps it is not too ambitious to hope that during the next hundred to a hundred and fifty years our future colleagues will be able to standardize a reliable routine for the 'long interview' and even for its combination with a physical examination" (1957, p. 288). But in fact, the trend is precisely opposite to this. It is towards briefer encounters with patients, and innovation that takes the form of developing standardized questionnaires to be administered by computer, telephone, or physician's assistant, in order to screen for "psychosocial" factors of which the physician, as primary care "gatekeeper" should be aware, but studies repeatedly show that he is not.

To sum up, in assessing the application of Balint's group techniques to today's medical scene, we must compare the times that Balint lived in with our own. It is likely that a convergence of factors accounted for the success of the Balint Group approach.
These are:

1- **The strength of Michael Balint's character**. He was a man of grace, sincerity, and tolerance, with a capacity to encourage others to think and behave as creatively as he did himself.

2- **His overdetermined interest in and attachment to general practitioners**. Although very committed to psychoanalysis, his early attachments to (and conflicts with) his father, as well as his personal analysis with the former general practitioner-turned-psychoanalyst Sandor Ferenczi, laid the foundation for applying psychoanalytic insights to general medical practice.

3- **His special skill in translating and applying Hungarian style psychoanalysis to a medical setting.** Balint had a rare capacity to transpose the jargonistic language of psychoanalysis like "therapeutic alliance," "transference and countertransference," "resistance," "hypocrisy concept," and "mutual analysis" into language that could help groups of general practitioners see, feel and incorporate the nuances of everyday doctor-patient relationships into therapeutic encounters.

Other social and political events of the times may have cultivated the soil in which Balint and his coworkers could thrive. These include:

1- **The devaluation and lack of self-regard of the general practitioner at a time when medicine showed a high reverence for specialists**. Physicians welcomed the supportive, empathic and facilitating ambience of the training-cum-research groups at the Tavistock Clinic. The details of these adventures are reported in the book *A Study of Doctors* (1966).

2- **A post-war climate of intense interest in the newly developed field of psychosomatic medicine**. The high incidence of psychiatric disorders during World War II and the effectiveness of brief psychological treatment brought new respect for the emotional side of illness.

3- **A National Health System (NHS) that enhanced continuity of doctor-patient relationships**. Although the NHS was woefully lacking in funding for psychotherapy, the mandated long-term relationships between general practitioners and patients fostered opportunities for meaningful interventions in peoples' lives.

Conclusion

Surely, the fields of psychiatry, psychoanalysis and general practice are richer for Balint's innovative and even revolutionary contributions and his group approach to training physicians. His unstinting giving of himself to the mutual exploration with general practitioners of doctor-patient relationships lived the reality of the biopsychosocial model, too often these days only paid lip service to. He upheld the importance of the doctor in health promotion at a time when it was beginning to erode in the face of increasing specialization and technology. Michael Balint concluded his five years of study of training-cum-research groups with the remark: "My diagnosis is that general practice is seriously ill, but the illness is benign and, provided the right therapy is applied, the prognosis is good"(1957, p. 292). Whether the utopian state in which "people will come for help earlier and will be able to complain about their conflicts before they develop an illness" (p. 290) is attainable in our current health system remains to be seen, but it is much less likely without the involvement of people like Michael Balint who can uphold the preeminence of "patient-centered medicine" and "overall diagnosis" over "illness-centered medicine" and "traditional diagnosis"(1957). Self-selection obviously limits the numbers of physicians who will obtain exposure to the group experience, although the hope is that these few may then expose others to their style of practice and thereby serve as second-messenger teachers. Even in Family Medicine residency programs in the United States, where group participation is encouraged, perhaps less than a third of the participants find the experience acceptable or compatible with their own orientation, mind-set, or lifestyle and practice. Balint himself acknowledged the mixed

feelings of the group volunteers. Describing the attitudes of the group participants, Balint observed that "what they resented most was that their work and their responsiblity had not been made easier by their new experience and their newly won skill. ...As they learnt to see more, more exactly and more deeply, their work became more complicated, their responsibility heavier. All of them without exception complained about this, but all of them without exception found their work incomparably more interesting and more rewarding" (1957, p. 293).

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